Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Patient Safety Notification

Bed rails/cot sides – falls prevention and safety practices

52

The number of incidents relating to bed rails/cot sides reported on NIMS in a three-month period

Unwitnessed fall in bathroom…found sitting in the middle of the room on the floor. Bed rails in situ but service user climbed out and mobilised without suitable footwear or mobility aid

Example of an incident from NIMS

Incorrect or inappropriate use of bed rails/cot sides can result in:

- **Harmful falls from beds/trolleys**
- **Entrapment involving the head and limbs**
- **Allegations of inappropriate restraint**

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The State Claims Agency has provided this advice with reasonable care and skill, based on analysis of the information available on NIMS and best practice guidelines and research.

Advice for safer bed rail/cot side care practices

Bed rails are used widely in health and social care settings. Their use may be considered as part of the service user's care plan to reduce their risk of accidentally slipping, sliding or rolling from the bed. Bed rails must not be used as a restraint to prevent the person from leaving the bed and to do so can cause harm. Prior to initiating their use, best practice requires relevant policies, procedures, protocols and guidelines (PPPGs), a documented risk assessment and full consent. Ongoing reassessment is required to ascertain the continuing appropriateness of their use. The Clinical Risk Unit in the State Claims Agency has noted the occurrence of incidents relating to bed rails/cot sides and has prepared the following advice.

Risk Considerations

A number of risk factors have been identified which may contribute to the occurrence of incidents involving bed rails/cot sides. These include:

- Service user factors:
  - confusion, agitation, delirium or dementia
  - altered levels of consciousness
  - learning disabilities
  - communication problems
  - a history of falling from bed or climbing over bed rails
- Equipment factors:
  - outdated design
  - incorrect assembly
  - incompatible combination of bed rail/cot side, mattress, bed/trolley type
  - incorrect bed trolley type for occupant/service user
- Inadequate PPPGs for the safe use of bed rails/cot sides
- Insufficient education and training in the safe use of bed rails/cot sides
- Low staffing levels and skill mix resulting in their inappropriate use as a restraint.

Advice for Safe Practice

- **Undertake multifactorial risk assessment and implement interventions** to address modifiable risk factors for falls if using bed rails/cot-sides in a service user's care plan. The **rationale and consent process** for usage must be documented clearly.
- Make sure bed rails/cot sides are fit for purpose and are assembled according to **manufacturer's guidelines** and recommendations.
- Ensure **inflatable or padded bed sides** are compatible with the bed and mattress. **Assess** bed rails and mattress to ensure there are no risks of **entrapment**.
- Explore options to minimise the use of bed rails including:
  - Ensure **mobility and social aids**, including the call bell, **are within easy reach** to prevent over-stretching and potential harmful falls from bed/trolley.
  - Obtain special nursing care supports where appropriate.
  - For those at high risk of falling, put in place **fall mats** to **reduce the severity** of impact.
  - Where possible use **pressure sensitive alarms** that alert when the service user is getting out of bed/trolley/chair.
- **Educate** service users and their carers, where possible, of the **risks associated with bed rails/cot sides** and enable them to request **reassessment** if concerned about increased risk or changes to service user's medical condition.

References and further reading:

1. HSE (2021) Preventing the Need for Restrictions Guiding Principles. Access here
2. HIQA (2019) Restrictive Practice Guidance. Access here
3. MHRA (2023) Safe use of bed rails. Access here
4. HSE AFFINITY National falls prevention and bone health project. Access here
5. Colthorpe, A. (2019) Medicines and Falls. Access here

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