1 Introduction

Patients in hospital may be at risk of falling from bed for many reasons including poor mobility, dementia or delirium, visual impairment, and the effects of their treatment or medication. Bedrails (also commonly known as cot-sides, safety rails and side rails) can be used as safety devices intended to reduce the risk of patients accidentally slipping, sliding, rolling or falling from bed.

Bedrails may also be used as reassurance for patients who are anxious about falling from bed. Bedrails used for this purpose are not a form of restraint, where restraint is defined as ‘the intentional restriction of a person’s voluntary movement or behaviour’ (see Restraint Policy). Bedrails will not prevent a patient leaving their bed and falling elsewhere, and should not be used for this purpose. Bedrails are also not intended as a moving and handling aid.

Bedrails are not appropriate for all patients, and using bedrails involves risks. National data from the National Patient Safety Agency (NPSA), 2007 suggests around 1,250 patients injure themselves on bedrails each year, usually scrapes and bruises to their lower legs. Statistics show 44,000 reports of patient falls from bed annually resulting in 11 deaths, while deaths due to bedrail entrapment occur less than one in every 2 years and could probably have been avoided if advice had been followed (NPSA, 2007). Staff should continue to take great care to avoid bedrail entrapment but need to be aware that in hospital settings there is a greater risk of harm to patients from falling from beds.

2 Policy Scope

This policy is relevant for all staff caring for adult patients in in-patient areas in the Trust. Guidance is for the use of bedrails with the use of the Trust standard bed which uses integrated bedrails. Bedrails should not be used with the Trust low level bed and therefore this policy does not apply if a low level bed is in use.

3 Aim of the policy

The development of this policy is in conjunction with recommendations published by the Medicines and Healthcare Products Regulatory Authority (MHRA) 2006 (06): Safe Use

It aims to:
- Reduce harm to patients caused by falling from beds or becoming trapped in bedrails
- Support patients and staff to make individual decisions around the risks of using and of not using bedrails
- Ensure compliance with MHRA and NPSA guidelines
- Ensure all reasonable steps are taken to promote patient safety and independence while respecting the rights of the patient to make their own decisions about their care if they have capacity
- Identify other steps that should be taken to reduce the patients risks from falling from bed e.g. low level bed without bedrails

4 Duties – Roles and Responsibilities

Trust Board: are responsible for ensuring the appropriate Health and Safety and risk management arrangements are in place throughout the Trust.

Directorate Managers, Clinical Directors and Heads of Department: are responsible for supporting staff in complying with the policy, including ensuring that the necessary systems, processes and equipment are in place to facilitate adherence to the policy.

Ward Sister/Charge Nurse/Department Lead: are responsible for ensuring compliance with the policy, the completion of individual patient risk assessments and the implementation of the assessment recommendations. They must ensure that all staff have the appropriate knowledge and skills to deliver care in accordance with the policy.

They should also ensure that all patient falls from bed or incidents involving bedrails are reported on the Trust’s incident reporting system and that any fall from a bed which results in injury graded moderate or above is reported directly to Clinical Governance and Risk Department (CGARD) so that a Root Cause Analysis (RCA) investigation can be undertaken.

If a fall from bed occurs where as a result the patient suffers injury graded moderate or above it is their responsibility to react within the guidelines of the Being Open Policy (see hyperlink below) and the following must be completed:

a. The patient or their family/carer must be offered a verbal explanation/apology and this should be documented in the Patients Health Care Records. An offer of written information/explanation should also be given (and if required Matron to be informed to action).
b. The above explanation/apology should be included in the RCA investigation indicating the date of the conversation and who led the conversation with the patient /relative.

**All staff:** who provide care to patients must be fully aware of, and act within the confines of the policy at all times, ensuring that all necessary patients have a risk assessment completed and that the assessment outcome recommendations are implemented. All staff have a duty to report any incident involving patient harm and bedrails e.g. a fall from bed or entrapment, and report any non-adherence with the policy to their line manager.

Staff also have a responsibility to provide efficient communication support to ensure the use of bedrails (or not) is fully understood by the patient for example provision of an interpreter for non-English speaking patients.

### 5 Definitions

**Bedrails** – Also known as bed side rails, cot sides, safety sides and bed guards are used in the health and social care sectors to protect vulnerable people from falling out of bed.

**Integral bedrails** – These are incorporated into the bed design and supplied with it, or are offered as an optional accessory by the bed manufacturer to be fitted.

**Padded bedrail covers** – These are an optional padded cover for bed rails and the head and foot of beds that are primarily used to prevent impact injuries but can also reduce the potential for limb entrapment between the bed rails.

**Restraint** is defined as ‘the intentional restriction of a person’s voluntary movement or behaviour’ (see [Restraint Policy](#)).

### 6 Safe Use of Bedrails

#### 6.1 Risk Management in relation to bedrails

If bedrails are considered for a patient, it is essential any risks are balanced against the benefits to the user. This decision should take into consideration the assessors’ professional judgement in conjunction with the outcome of the Trust risk assessment (NUTH409) in Appendix 1.

Any risk associated with the use of bed rails should be included in all local training of electric beds.

All wards and departments using bed rails should have manufacturer instructions. Maintenance of equipment is an important part of the risk management of bed rails.
6.2 Risk Assessment in relation to bedrail use

Decisions about bedrails need to be made in the same way as decisions about other aspects of treatment and care as outlined in the Trust’s Consent for Examination or Treatment (with reference to the Mental Capacity Act 2005) Policy. This means the patient should decide whether or not to have bedrails if they have capacity. Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them.

Staff can learn about the patient’s likes, dislikes and normal behaviour from relatives and carers, and should discuss the benefits and risks of bedrails with relatives or carers. However, relatives or carers cannot make decisions for adult patients (except in certain circumstances where they hold a Lasting Power of Attorney extending to healthcare decisions under the Mental Capacity Act 2005).

If the patient lacks capacity, staff have a duty of care and must decide if bedrails are in the patient’s best interests. The potential risks of using bedrails are detailed below and require careful consideration:

- Falling out of the end of the bed
- Falling over the top of the bedrail
- Entrapment between the bedrail and mattress
- Entrapment between the bedrail and the head of the bed
- Entrapment between the bars of the bedrail

The assessment process in Appendix 1 will help to determine if there are more suitable alternative ways of protecting the patient, other than the use of bed rails (e.g. Trust low level bed). This should be completed within 12 hours of admission and should be re-evaluated in the following instances:

- Patient has a fall/roll/slip/slide out of bed
- Following a change in the patient’s condition
- As part of a weekly review of falls risk

For patients who are assessed as requiring bedrails but who are at risk of striking their limbs on the bedrails, or getting their legs or arms trapped between bedrails, padded bedrail covers should be considered.

If a patient is found in positions which could lead to bedrail entrapment, for example, feet or arms through rails, halfway off the side of their mattress or with legs through gaps between split rails, this should be taken as clear indication that they are at risk of serious injury from entrapment. Urgent changes must be made to the plan of care. These could include nursing the patient on the Trust low level bed.

If a patient is found attempting to climb over their bedrail, or does climb over their bedrail, this should be taken as clear indication that they are at risk of serious
injury from falling from a greater height. The risks of using bedrails are likely to outweigh the benefits, unless their condition changes.

6.3 Bedrails and falls prevention

Decisions about bed rails are only a small part of preventing falls. The Trust falls risk assessment tool should be used to identify other steps that should be taken to reduce the patient’s risk of falling not only from bed (see Management and Prevention of Patient Slips, Trips and Falls Policy),

Bedrails should not usually be used:
- If the patient is agile enough, and confused enough, to climb over them;
- If the patient would be independent if the bedrails were not in place.

Bedrails should usually be used:
- If the patient is being transported on their bed;
- In areas where patients are recovering from anaesthetic or sedation and are under constant supervision.

The behaviour of individual patients can never be completely predicted, and the Trust will be supportive when decisions are made by frontline staff in accordance with this policy.

The safety of patients with bedrails may be enhanced by frequently checking that they are still in a safe and comfortable position in bed, and that they have everything they need, including toileting needs. However, the safety needs of patients without bedrails who are vulnerable to falls are very similar. All patients in hospital settings will need different aspects of their condition checked, for example, general observations. Consequently, observing patients with bedrails should not be treated as a separate issue but as an important part of general observation within each ward/department. This is therefore included in The Trust’s intentional rounding tool, the FOCUS Chart (see Appendix 2) and the level of observation a patient requires should be assessed using the guidelines in Appendix 3.

6.4 Consent for the use of bedrails

If the outcome of a risk assessment, in addition to clinical judgement indicates bedrails are an appropriate option to prevent a patient falling out of bed, then nursing staff must endeavour to discuss the rationale for using or not using bed rails with the patient. Consent must be sought from the patient prior to using them. Details of consent are to be documented in the patient’s notes. If the patient is unable to give consent due to their present condition or illness, then responsibility lies with a registered nurse, to make the decision based on their professional judgement as they act in the patients’ best interest.
For more details on patient consent see the Trust’s Consent for Examination or Treatment (with reference to the Mental Capacity Act 2005) Policy

6.5 **Bedrails requested by the patient or relative**

Often a patient or carer will request the use of bed rails. Initially a full risk assessment should be performed to identify suitability of bed rail use. Should the assessment indicate bed rails are not required or ideal, this should be explained to the patient and/or relative, an alternative should then be agreed. Full documentation of assessment and agreed alternatives must be documented in the nursing notes.

6.6 **Alternative methods to bedrails**

The following alternatives to bed rails should be given consideration e.g.
- Trust standard beds should be used in the lowest position
- Low level beds
- Bed alarm system to alert carers that a person has moved from their normal position or wants to get out of bed

6.7 **Maintenance**

It is a duty of the Trust to ensure that bedrails are adequately maintained/repaired and therefore fit for purpose. As part of Planned Preventative Maintenance (PPM) programmes the Estates department review all Trust beds on a 12 monthly basis. This includes an assessment of bedrails.

It is the Ward Sister / Charge Nurse responsibility (or their delegate) to ensure maintenance checks are carried out on equipment held in their area. Any faults identified should be reported to the Estates Department for management.

6.8 **Patient Trolleys**

The MHRA has not issued any specific advice on the use of side rails on patient trolleys, with no real relevant incidents reported. An important point to consider is that patients are generally left unsupervised in beds overnight, when patient entrapment can go unnoticed. Trolleys are not normally intended to be used in the same way, and the risks are therefore not the same as with beds. A risk assessment should be carried out in areas nursing patients on trolleys to identify if and when the rails should be used.

Points to consider:
- Trolleys are narrower than a bed
- If sides are not erected the patient could fall from a greater height than a bed just turning over
- If a patient climbs over erected sides the height of a fall is even greater.
- Patients nursed on trolleys should ideally be cared for in highly visible areas, have staff in attendance, or ensuring a patient has means of summoning assistance as required
- Patients likely to climb over or become entrapped must be observed at all times, the possibility of nursing these patients in a chair should also be considered

7 Training

The Newcastle upon Tyne Hospitals ensures that:
- all staff who make decisions about bedrail use, or advise patients on bedrail use, have the appropriate knowledge to do so;
- all staff who supply, maintain or fit bedrails must have the appropriate knowledge to do so;
- all staff who have contact with patients, including students and temporary staff, understand how to safely lower and raise bedrails and know they should alert the nurse in charge if the patient is distressed by the bedrails, appears in an unsafe position, or is trying to climb over bedrails.

These points are achieved through:
- Ward induction packs
- Inclusion of bedrails in falls prevention training
- Moving and Handling training

8 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Process for Monitoring Compliance with the Policy

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedrail assessment completed appropriately</td>
<td>Audit of documentation included in the RCA tool</td>
<td>Falls Prevention Coordinator</td>
<td>Clinical Risk Group</td>
<td>Annually</td>
</tr>
<tr>
<td>Appropriate use of bedrails</td>
<td>An audit of patients’ nursing notes will be carried out to determine if an assessment has been carried out and documented indicating appropriate use of bed rails</td>
<td>The audit will be carried out by the Falls Prevention Coordinator and Health and Safety Team</td>
<td>Results will be presented at Clinical Risk Group and Falls Taskforce Group</td>
<td>Audit will be conducted monthly</td>
</tr>
</tbody>
</table>
10  Consultation and Review

This policy will be reviewed every two years by the Falls Task Force Steering Group. Comments, queries and suggested amendments should be addressed to the Falls Prevention Coordinator. The Policy will be ratified by the Clinical Risk Group and Clinical Policy Group.

11  Policy Implementation

Trust staff will be made aware of the requirements of this policy via the CGARD Policy Newsletter. It will also be shared via the Matrons and Clinical Leaders Forums.

12  References

- MHRA 2006 (06) December 2006 Safe Use of Bedrails
- MHRA Device Alert 2007/009 Bedrails and Grab Handles
- NPSA 2007 Resources for Reviewing or Developing a Bedrail Policy

13  Associated Documentation

- Management and Prevention of Patient Slips, Trips and Falls Policy
- Moving and Handling Policy
- Nurse Staffing Strategy
- Reporting and Management of Accidents and Incidents Policy
- Restraint Policy
- Strategy for the Prevention of Slips, Trips and Falls
Bedrails Risk Assessment:
Record of Decisions Document

This document will aid you in the decision making process of whether to use bedrails or not. Clinical judgement can override the decision but a reasoning process must be documented in these instances.

Step 1: Consider the following 3 questions then proceed to Step 2. Place a ✔️ (tick) in the boxes that apply.

1. Patient uses bed rails at home
   - Yes – GO TO STEP 2
   - No – GO TO STEP 2

2. Patient has expressed wish to have bed rails (and has the mental capacity to make this decision)
   - Yes – GO TO STEP 2
   - No – GO TO STEP 2

3. Patient has compromised sensation and therefore bed rails could result in unnoticed focalised pressure (even with padded covers)
   - Yes – GO TO STEP 2
   - No – GO TO STEP 2

Step 2: Consider patient’s mobility and mental state. Place a large X over the box that applies.

<table>
<thead>
<tr>
<th>MOBILITY</th>
<th>Patient is very immobile (bed bound or hoist dependent)</th>
<th>Patient is unable/unsafe to mobilise alone</th>
<th>Patient can mobilise without help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is confused and disorientated</td>
<td>Use low level bed or use bed rails with care*. Go to Step 3</td>
<td>Bedrails NOT recommended. Skipped to Step 3 Qu. 2</td>
<td>Bedrails NOT recommended. Skipped to Step 3 Qu. 2</td>
</tr>
<tr>
<td>Patient is drowsy</td>
<td>Bedrails recommended. Go to Step 3</td>
<td>Use low level bed or use bed rails with care*. Go to Step 3</td>
<td>Bedrails NOT recommended. Skipped to Step 3 Qu. 2</td>
</tr>
<tr>
<td>Patient is orientated and alert</td>
<td>Bedrails recommended. Go to Step 3</td>
<td>Bedrails recommended. Go to Step 3</td>
<td>Bedrails NOT recommended. Skipped to Step 3 Qu. 2</td>
</tr>
<tr>
<td>Patient is unconscious</td>
<td>Bedrails recommended. Go to Step 3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Where bedrails are recommended to be used ‘with care’, the level of observation of the patient should always be considered e.g. patient in a high observation area in close proximity or direct view of staff to be able to react if the patient attempts to get out of bed or over bedrails.

Step 3: Consider the following questions. Place a ✔️ (tick) in the boxes that apply.

1. If bed rails recommended (or recommended with care); are padded covers required to reduce the risk of entrapment / injury?
   - Yes – USE PADDED BED RAIL COVERS
   - No – USE BED RAILS WITHOUT COVERS

2. If bed rails not recommended; does patient require help to get up from bed and fails to use call bell?
   - Yes – CONSIDER USING A BED ALARM. GO TO QU. 3
   - No – GO TO QU. 3

3. Are further measures required to minimise risk of injury arising from a fall from bed?
   - Yes – USE ULTRA LOW OR LOW LEVEL BED. GO TO QU. 4
   - No – RECORD ANY ADDITIONAL INFORMATION IN SUPPORT OF YOUR DECISION BELOW

4. Is there significant risk of patient rolling off low level bed and sustaining injury e.g. due to osteoporosis?
   - Yes – CONSIDER THE USE OF A CRASH MAT (HAVING WEIGHED UP IP&C RISKS)
   - No – RECORD ANY ADDITIONAL INFORMATION IN SUPPORT OF YOUR DECISION BELOW

Additional information in support of your decision:

__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________

Signature: .......................................................... Print name: .......................................................... Date & time: ..........................................................
THE FOCUS CHART

GUIDANCE

Use the FOCUS Chart for patients who are at risk of falling, developing pressure damage (Braden <17) or with Delirium/Dementia.

<table>
<thead>
<tr>
<th>AT RISK OF FALLS</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEDRAILS TO BE USED? (as per assessment)</td>
<td>Yes / No / NA</td>
</tr>
</tbody>
</table>

**DATE**

| DATE | 05. | 06. | 07. | 08. | 09. | 10. | 11. | 12. | 13. | 14. | 15. | 16. | 17. | 18. | 19. | 20. | 21. | 22. | 23. | 24. | 25. | 26. | 27. | 28. | 29. | 30. | 31. |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

**Footwear**

Ensure appropriate footwear is in situ when required.
Heels elevated in bed.

**Orientate**

During usual conversation inform patient (don’t ask patient to tell you) of time, date, who they are, what is happening. Chat to the patient about what is going on.

**Continence**

Ask once a day: ‘Have you moved your bowels today?’
Ask: ‘Do you need to go to the toilet?’

**Understanding patient needs**

Ask: ‘Do you have any pain?’

Ask: ‘Would you like a drink?’

Ensure water is available, make sure call bell, bedside table, walking aid, are within easy reach. Ensure patient has correct and clean glasses on; has a working and available hearing aid.

**Skin / Position**

Ask: ‘Are you comfortable?’
Turn patient as per level of care. Stand hourly if seated in chair. Offer hourly positional changes to ensure comfort. Rearrange pillow and covers. If incontinent, change.

**Braden**

<table>
<thead>
<tr>
<th>Sensory perception</th>
<th>Activity</th>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction and Sheer</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>D</td>
<td>MATTRESS</td>
<td>PROVIDED</td>
<td>Yes / No / NA</td>
</tr>
</tbody>
</table>

**Level of care**

<table>
<thead>
<tr>
<th>3 hourly turns</th>
<th>2 hourly turns</th>
</tr>
</thead>
</table>

**Staff Member Initials**

| Blank not assessed | ✔ checked | ✔ done | T toilet/commode/urinal/bedpan | C catheter checked | S stoma checked | I incontinent | Pain: | Comfortable | Hydration: | Drink | Nil by mouth | Mouth care | Safety: | AH everything | AT hand | L left | R right | B back | S stood | W walked | T turned | U assisted to sit in chair | P assisted back to bed |
|-------------------|----------|--------|-------------------------------|-------------------|-----------------|-------|-------|--------|-----------|----------|--------|--------------|-----------|--------|------------|---------|--------|---------|--------|----------|----------|---------|------------------------|---------------------|

**THE NEWCASTLE UPON TYNE HOSPITALS**

NHS

Affix patient identification label in box below or complete details

- Surname
- Patient i.d.No.
- Forename
- D.O.B.
- Address
- NHS No.
- Sex. Male / Female
- Postcode
Enhanced Nursing Observation Level Guidelines

Levels of Observation for Patients in Relation to Falls Risk

These guidelines are to be used with any patients who currently have the Falls Care Bundle in place.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 hourly checks using FOCUS Tool.</td>
<td>1 hourly checks using FOCUS Tool.</td>
<td>Location of bed within direct view or cohort bay and at least 1 hourly checks using FOCUS Tool.</td>
<td>At least hourly checks using FOCUS Tool. Require 1:1 assistance during high risk activities e.g. toileting. Not to be left alone during these activities.</td>
</tr>
<tr>
<td>Minimum level for all patients at risk of falls.</td>
<td></td>
<td>E.g. patients who are at high falls risk and significant risk of harm but do not require 1:1 supervision**.</td>
<td>Patients at highest risk of falls and harm e.g. elderly, cognitively impaired patient who may suddenly stand up.</td>
</tr>
</tbody>
</table>

Inform patient and/or carers/relatives

Of the level of observation and the reasons for this decision.

Equipment and Referral

Ensure appropriate equipment is provided to address patient’s needs (e.g. low level bed, bed/chair sensor alarm) and referral to specialist teams/individuals for specialist advice (see Falls Care Bundle)

Review

Nurse in charge in consultation with members of the MDT (as appropriate) to review and document patient’s level of observation based on clinical need/assessment at a minimum of every 24 hours.

*Cohort nursing – refers to the process of nursing patients who are assessed as being at risk of falls into one bay and allocating a member of staff to maintain continuous presence in this bay. Should that member of staff be involved in any delivery of care to a patient (that would eliminate their ability to observe the other patients) another member of staff must be informed to maintain continuous observation.

**1:1 supervision – is the allocation of one staff member to observe and/or assist one patient. This should be used with highest risk patients who are confused and frequently attempt to mobilise and are likely to fall and cause harm. At times this may be carried out by family members or carers.

Depending on the patient’s individual needs, 1:1 supervision will required for different periods of time; patients may require 24 hour supervision or during higher risk times/activities e.g. overnight or when in bathrooms.
The Newcastle upon Tyne Hospitals NHS Foundation Trust/
Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 09/10/2014

2. **Name of policy / strategy / service:**
   Policy for the Safe and Effective Use of Bedrails

3. **Name and designation of Author:**
   Rachel Carter

4. **Names & Designations of those involved in the impact analysis screening process:**
   Rachel Carter, Falls Prevention Coordinator & Lucy Hall, E&D Lead

5. **Is this a:**
   Policy x Strategy Service
   
   **Is this:**
   New x Revised

   **Who is affected:**
   Employees x Service Users x Wider Community

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

   - Reduce harm to patients caused by falling from beds or becoming trapped in bedrails
   - Support patients and staff to make individual decisions around the risks of using and of not using bedrails
   - Ensure compliance with MHRA and NPSA guidelines
   - Ensure all reasonable steps are taken to promote patient safety and independence while respecting the rights of the patient to make their own decisions about their care if they have capacity
   - Identify other steps that should be taken to reduce the patients risks from falling from bed e.g. low level bed without bedrails
7. **Does this policy, strategy, or service have any equality implications?**

Yes but these are addressed through the policy.

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. **Summary of evidence related to protected characteristics**

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups related to this policy/service/strategy – please refer to the Equality Evidence (available via the intranet Click A-Z; E for Equality and Diversity. Summary on front page and more detailed information in resources section)</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance equal opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Interpreting policy The policy highlights that people may be agitated because they don’t understand why bed rails aren’t used.</td>
<td>If interpreters are not used when needed patients may become agitated.</td>
<td>No</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Chaplaincy Team</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Age</td>
<td>Forget Me Not initiative Delirium and Dementia Screening Policy refers to: patients who lack capacity, staff have a duty of care and must decide if bedrails are in the patient’s best interests. Age is referred to in the associated Falls Policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disability — learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>If disabled patients have capacity they can decide whether they want to use bed rails. Interpreter policy Learning Disability Liaison Nurse Psychological and Mental Health Services</td>
<td>If interpreters are not used for BSL users when needed patients may become agitated.</td>
<td>No</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
9. Are there any gaps in the evidence outlined above. If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement No

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No If patient’s have capacity they can decide whether they want to use bed rails or not.

PART 2

Signature of Author

Print name

Date of completion

09/10/14

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)