NEWS & VIEWS

A Complimentary Newsletter from Med-Net Concepts, LLC
and its Network of Independent Affiliated Companies

Volume 4. Issue 5
May 2018

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To Use or Not to Use-That Is the Question When It Comes to Bed Rails and Bed Safety in Nursing Homes

Med-Net Concepts, LLC

To Use or Not to Use-That Is the Question When It Comes to Bed Rails and Bed Safety in Nursing Homes

By:
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"Hospital beds" have been traced historically as far back as the middle ages when hospitals were founded simply for the poor. Medieval hospitals were a charitable response to the needs of people who could no longer work and take care of themselves-the handicapped, the elderly-people with no family to care for them and keep them from begging on the streets.

The term "hospital bed" describes any kind of bed that was used to care for and comfort patients, and in medieval hospitals they were more like what we call stretchers today. They were basically "two poles with a sheet spread across" allowing a patient to be moved and carried by two people-one on each end of the "bed" with a pole in each hand. These "litters" as they were called date back even farther than the middle ages to Ancient Egypt and Rome.

Hospital beds with adjustable side rails were first used in England in the first quarter of the 1800's and required a manual crank to move the rails into the desired position. Modern day adjustable beds were invented in the early 1900's by Dr. Willis Dew Gatch. Dr. Gatch was the chair of the Department of Surgery at Indiana University School of Medicine. His idea was to have a hospital bed that could elevate both the head and the feet by having mechanically adjustable and divided sections. Consequently, Dr. Gatch is credited with being the inventor of the hospital bed.

In 1945, hospital beds were further modernized when an electronic control panel was implemented to replace the manual cranking and adjusting to reposition the bed. Originally, these beds incorporated a toilet with the idea that it would eliminate the use of the bed pan. However, that aspect of the electronically controlled beds turned out to not be very feasible and so it was removed.

Today, hospital beds are more technically sophisticated even to the point of knowing how much the patient lying in them weighs.

Many of the beds used in nursing homes are basically hospital beds and come equipped with bed rails. The Food and Drug Administration (FDA), the agency responsible for hospital bed safety, lists a number of definite benefits associated with bed rails and some definite risks as well. Here are some of the potential benefits of bed rails:

- Aid in turning and repositioning a resident within the bed
- Provide a place to grab hold of to assist getting in or out of bed
- Give a sense of comfort and security
- Reduce the risk of the patient falling out of the bed when they are being moved
- Provides an easy access to bed controls and personal care items

Here are potential risks associated with bedrails:

- Can cause strangling, suffocating, bodily injury or death when patients or a part of their body gets caught between rails or between the bed rails and the mattress
- May cause more serious injury from falls when a patient climbs over the rails
- May cause skin bruising, cuts and scrapes
- May cause patients to become agitated when bed rails are used as restraints
- May cause a patient to feel isolated or unnecessarily restricted
- Prevent patients who are able to get out of bed from doing routine activities like going to the bathroom or getting something from a closet

Two Case Studies Advocating Two Perspectives Regarding Bed Rails

Case Study #1:

This story is about a 102-year-old Grandmother residing in a nursing home who died from complications of a fall from her bed after her bed rails were removed. Her story began when her family members could no longer care for her in their home because she was having problems with her equilibrium. The family looked for and felt like they had found a nursing home, that would provide good care for their "Granny." Initially, the woman had bed rails on her bed, but when the Centers for Medicare & Medicaid Services (CMS) issued new guidelines for nursing homes, the bed rails were removed. No notification about their removal was provided to the woman's family. The guidelines stipulated that bed rails could not be used as physical restraints or "out of convenience." The rationale behind this is the potential for a resident to be injured or to feel imprisoned. The woman's family took this position: "Somebody is in a facility and that's why you put them there, to have 24-hour care. We were having trouble keeping her from falling at home. We expected that care to be given to her."

Case Study #2:

An 81-year-old mother was found dead in her room due to strangulation from getting her head caught in the side rails that were used to keep her from rolling out of bed. The woman's family had moved her to an assisted living home that offered around-the-clock care because she was suffering from dementia, had wandered away from home several times and they could no longer care for her.

The woman's daughter, after her mother's death, had a desire to prompt local, state and federal officials to instigate a review of bed rail deaths. She began writing to the Food and Drug Administration (FDA) and the Consumer Product Safety Commission (CPSC). What she discovered was that both agencies had been aware for many years about the deaths associated with bed rails, but neither had done much to regulate the companies that manufactured them. Through her letter-writing, she was influential in prompting a study about the issue.

The data gathered from the study of death certificates and elderly patient visits to emergency rooms over a nine-year period revealed 150 deaths of mostly older adults that resulted from being entrapped in bed rails. Additionally, during that same period 36,000 mostly older adults (about 4,000 per year) were treated in emergency rooms for injuries related to bed rails. The report also indicated that these numbers were probably understated because "bed rails" are not always listed as a cause of death.

New Guidelines Advocate for Declining Bed Rail Use in Long-Term Post-Acute Care Facilities
The revised CMS guidelines for §483.25(m) Bed Rails (F700) point to reducing the use of bed rails in general and for alternative methods to be evaluated, tried and documented prior to using bed rails. The revised guidelines for bedrails that went into effect November 28, 2017 involve these essential elements:

- Carefully evaluate a resident to ensure bed rails are an appropriate choice and are not being used to replace proper monitoring-especially for a resident with a high risk of entrapment.
- Follow the FDA's recommendations in "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" and the Hospital Bed Safety Workgroups publication.
- Select the appropriate size bed rail which takes into consideration the size and weight of the person

using the bed rail.
- Know that "not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds." Because most mattresses and bed rails are bought separately from the bed frame, the manufacturer should be consulted to ensure compatibility.
- Follow the healthcare facility's procedures and/or the manufacturers' recommendations and specifications for installing and maintaining bed rails for the specific bed frame and bedside rails used.
- Select appropriate bed rails and place them in a way that discourages a resident from trying to climb over the rails to get in and out of the bed and possibly falling.
- Regularly inspect and check the mattress and bed rails to ensure that they are installed correctly and there are no areas for possible entrapment and falls. No matter how wide the mattress or how long and deep the bed frame, there should be no gaps in any place wide enough to entrap a resident's head or body.

The publication, "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care (LTPAC) Facilities and Home Care Setting" developed by the Hospital Bed Safety Workgroup defines entrapment and provides reasons that an elderly or frail resident might become entrapped-
"Entrapment is a risk factor for residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that causes them to move about the bed or try to exit from the bed. The absence of timely toileting, position change and nursing care are factors that may also contribute to the risk of entrapment. The risk may also increase due to technical issues such as the mis-sizing of mattresses, bed rails with winged edges, loose bed rails or design elements such as wide spaces between vertical bars in the rails themselves."
The new guidelines also point out that air-filled mattresses or a therapeutic air-filled bed used to prevent and treat pressure injuries may also pose an entrapment risk different from rail entrapment with a regular mattress. Consequently, when a resident who is at risk for entrapment is placed on an air-filled mattress, precautions should be taken to reduce the risk of entrapment and may involve not only following the manufacturers' equipment alerts but also an increase in supervision of the resident.

Because of the risk factors and these new standards that advocate for the removal or rendering bed rails inoperable, LTPAC facilities and assisted living centers are seeking alternatives to bed rails for their residents and trying to phase out any use of bed rails.

For example, a nursing home in Williamsburg, Virginia is focusing on resident safety. They are training staff and using simple devices to help keep their residents safe. They place thickly padded floor mats by some of the residents' beds to reduce the impact of a fall and residents who are fearful about falling out of bed are given wedge-shaped pillows. They have also made all bed rails inoperable. However, the bed rails can be made operable if a physician says they are medically necessary. Other alternatives being used are lowering a resident's bed closer to the floor and installing weight-based alarms that alert staff when a resident gets up.

Listed below are key elements that surveyors will look for regarding bed rails and may use to cite a facility for its failure regarding §483.25(m) Bed Rails (F700):

- Installing bed rails without first identifying and using appropriate alternatives;
- Installing bed rails without assessing the resident for risk of entrapment;
- Failure to assess the risk vs. benefits of using bed rails and not reviewing them with the resident or the resident's representative;
- Failure to obtain an informed consent before installing bed rails;
- Failure to use the resident's size and weight to ensure the proper dimensions of the bed;
- Failure to make sure that the bed rails were properly installed according to the manufacturer's directions and specifications;
- Failure to ensure that installed bed rails are used correctly; and/or
- Failure to have regular scheduled maintenance performed according to the manufacturer's directions and specifications on any bed using bed rails.

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