Decisions on bedrails must not be made through emotive arguments

The highly emotive debate on bedrails has obscured the real issue of weighing up the risks and benefits for each individual patient, argues Frances Healey

In 1984 The Lancet published an editorial castigating the use of bedrails, suggesting that their use was as inappropriate and outdated as ‘the use of fetters in schizophrenia’ (anon, 1984).

At that time, I was a newly qualified staff nurse with memories of my ‘geriatric’ placement – nursing staff had been caring but the use of bedrails and Buxton chairs was routine.

Had I read The Lancet editorial at that time, I would probably have wholeheartedly agreed with it.

The debate has hardly become less emotive since. At the International Falls Prevention and Bone Health conference in 2007, the case against bedrail use was illustrated by images of restrained prisoners in Guantanamo Bay.

It seems there is nothing quite like bedrails to provoke polarised views.

For most of my years in practice, I worked with older people whose needs crossed mental health and acute hospital boundaries.

For this patient group, falls prevention was a constant concern, and balancing the risks of using or not using bedrails was a constant challenge. So, as I moved into research, management and patient safety, the issues remained uppermost in my mind.

I had some formative experiences along the way. When I was a newly appointed ward sister, a patient in a neighbouring hospital died from bedrail entrapment. Such a distressing and lonely way to die; it was little wonder that my manager’s reaction was to send a porter to confiscate all our bedrails.

I found myself fighting to keep bedrails at least for those of my patients who were confused, restless, hoist-dependent hemiplegics on alternating pressure mattresses.

Analysing hospital bedrail policies influenced me, too. Some were excellent – but it would have been a brave nurse who dared to use bedrails in a hospital where the policy stated the devices were restraint. Restraint without written consent was common assault, and this offence could be punished by a jail term of up to six months.

The aspect that made me saddest was that for every 10 policies warning that bedrails could kill, there was barely one telling staff how to avoid this.

I was also privileged to be allowed to survey bedrail use overnight in several hospitals, and to ask nurses about their reasons for using or not using them (National Patient Safety Agency, 2007).

What was reassuring was that frontline nurses were usually making decisions based on the wants and needs of individual patients.

However, some staff who had made perfectly sensible decisions to use bedrails felt they had to apologise for the decisions.

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Focus groups with patients (NPSA, 2007) also left me quite embarrassed at how emotive the debate had become. Patients were pragmatic, and some appeared slightly amused by how seriously we took what they considered to be a minor aspect of care.

For all the experience and the emotion in the bedrail debate, what is the actual evidence? On page 20, Professor David Oliver and I summarise this.

Limited though it is, it suggests that both the ‘old school’ that advocates routine bedrail use and the ‘new school’ that advocates their abolition are equally wrong. Decisions on the risks and benefits of bedrail use can only be made case by case in partnership with individual patients.

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