Bedrails are intended to reduce the risk of accidentally slipping, sliding, rolling or falling from bed. In NHS acute hospitals, 26% of patients have bedrails raised at night.

Death or serious injury has occurred through entrapment, with 21 bedrail-related deaths over seven years recorded by the Medicines and Healthcare products Regulatory Agency (MHRA) (Healey, 2007).

The MHRA has provided hospitals with advice on how to fit bedrails safely and identify and remove unsafe equipment (MHRA, 2006). The National Patient Safety Agency (NPSA) and the MHRA have also advised hospitals on assessing patients individually (NPSA, 2007; MHRA, 2006).

If the combination of bedrails, bed frame and mattress complies with MHRA guidance on the safe design and fitting of bedrails, there should be no "entrapment gaps" where a patient could trap their neck, head or chest.

Case study
Mary is a staff nurse at a community hospital. Two nurses are on duty over the evening shift and she is in charge. At the far end of the ward a young man is shouting at his elderly father, who is struggling to sit up. Mary sees the patient’s head has fallen between the pillow and the rail and that he is breathing quickly.

Immediately she moves the pillow and sees the patient is in danger of falling through a gap in the bedrails. Calming him down, Mary manages to pull the patient’s head back and sits him up. Reassuring him and his son, she arranges to sit the patient in a chair while she organises another bed.

Recognising a possible never event
Mary recently attended a presentation about new never events including entrapment in bedrails. She remembered this when she saw the patient struggling at the side of the bed.

While she acted promptly, this episode is a “nearly never event” and should not have happened in the first place.

Prevention
This nearly never event needs to be reported and any action decided and carried out to prevent a repeat with more serious consequences, resulting in a never event.

Mary talks with her manager and agrees that this nearly never event should be investigated and flagged up with the commissioner. Reports should be forwarded to the National Reporting and Learning System for national analysis and learning. Putting “possible never event” in the text should alert people to the issue.

Risk management around bedrails is usually carried out on admission to this hospital, and had been done correctly in this case. The patient was assessed as being at high risk of falling out of bed. He was not confused but was unable to walk alone, so bedrail use had been deemed appropriate, and the patient had agreed.

The bed seemed a little different from others on the ward, and the bed and mattress were measured. They were not the recommended size, so there was potential for this to happen again. A few of these old beds were still being used in the hospital and need to be replaced with those complying with MHRA guidance.

Mary puts her story in the staff newsletter and on the intranet to share the findings of the investigation and actions. In this case, there was no death or severe harm to the patient, but there were still lessons to be learnt from this nearly never event, and reporting and investigation has improved the care of patients.

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