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To:	Adult Day Care Adult Family Homes Ambulatory Surgical Centers Community-Based Residential Facilities Facilities Serving People with Developmental Disabilities Home Health Agencies Hospices Hospitals Nurse Aide Training Programs Nursing Homes Residential Care Apartment Complexes	ADC 04 AFH 06 ASC 02 CBRF 07 FDD 03 HHA 03 HSPCE 04 HOSP 05 NATP 01 NH 07 RCAC 06
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Danger of Entrapment Associated With Bed Rail Use

Recent national attention has again focused on deaths and injuries directly related to bed rails, particularly when used with elderly adults. Bed rails continue to be used in a number of facilities regulated by the Division of Quality Assurance (DQA). In 1999, DQA issued an original alert to the dangers associated with their use. The purpose of this revised memo is to alert healthcare providers to the ongoing safety concerns associated with the use of bed rails.

Serious injury or death can occur when a resident or patient becomes caught (entrapped) between a bed rail and mattress or within the rail, or from injuries sustained as an individual attempts to climb over the bed rail. Bed rails may serve to restrain an individual in bed or, in some cases, to

aid independence in mobility and repositioning. The use of bed rails is always accompanied by risk, regardless of their purpose.

Any person is at risk for injury. Persons at greatest risk for entrapment are those who are cognitively impaired, of low body weight, or who have uncontrolled, poorly coordinated or restless movements. An individual may be too weak, frail or cognitively impaired to correct his or her own position as a life-saving measure. Bed rail entrapment can lead to asphyxiation, strangulation, chest compression and subsequent death. Fractures and serious circulatory impairment can result from entrapment of limbs. Falls from attempts to climb over the rails or footboard may result in fractures and head injuries.

Types of bed rails consist of full length, three quarter length, half length, quarter length and split. Entrapment can occur with all types of bed rails, as well as with other similar devices, whether or not they meet the definition of a restraint for that individual. Those devices that are not properly matched to the bed frame or mattress or that are improperly installed can present greater risk.

Providers are responsible for the individual assessment of persons receiving care when considering the use of bed rails. That assessment should address the need for the device, whether or not it meets the definition of a restraint, less restrictive options and the potential risks associated with use. Anticipating and meeting the night time needs of individuals can enable providers to prevent those persons from attempting to get out of bed without assistance.

If the ongoing risk of physical injury to an individual is determined to be greater than the risks associated with the use of bed rails, protective measures need to be implemented to minimize those identified risks. The assessment may determine the individual is safer *without* a bed rail than *with* a bed rail, indicating the need for other alternatives such as lower beds and floor mats.

Providers are encouraged to review their practices for initiating the use of bed rails and to re-evaluate the safety of those devices currently being used. Immediate removal of devices without appropriate assessment, intervention and monitoring may also place individuals at great risk. Each provider must assess each person individually and determine the need for appropriate preventative and protective measures.

Applicable Federal/WI Administrative Codes Related to Safety

The following is a list of the applicable federal or state regulation related to safety for each provider type:

Adult Day Care

ADC Standards I.A(5). PARTICIPANT RIGHTS. A written document of the following participant rights shall be posted and/or distributed to participants and adhered to by the program:

- a. The right to be treated with respect and dignity....

ADC Standards I.C(2)(a). A comprehensive written assessment of the participant's functional abilities and disabilities, strengths and weaknesses, personal habits, preferences and interests, likes and dislikes, medical condition and any other information helpful to developing the service plan, such as a life review

ADC Standards I.C(2)(b). A statement of the services and activities the program will provide in order to meet these needs and personal interests

Adult Family Homes

DHS 88.10(3)(L) A resident shall have all of the following rights... To a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or handicap.

Ambulatory Surgical Centers

42 CFR §416.50(c) Standard: Privacy and Safety. The patient has the right to –
(2) Receive care in a safe setting.

Community-Based Residential Facilities

DHS 83.32(3)(g) Each resident shall have all of the following rights ... Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident's primary physician or advanced practice nurse prescriber... The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident.

DHS 83.32(3)(n) Each resident shall have all of the following rights ... Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents' conditions or disabilities.

DHS 83.35(1)(c)7 The assessment, at a minimum, shall include all of the following areas applicable to the resident... risks, including, choking, falling, and elopement.

Facilities Serving People with Developmental Disabilities/Intermediate Care Facilities for Individuals with Intellectual Disabilities

42 CFR 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. (W285)

Home Health Agencies

DHS 133.14 (2) (b) The registered nurse shall regularly reevaluate the patient's needs.
42 CFR §484.30 (a) regularly re-evaluates the patient's nursing needs.

Hospices

42 CFR 418.110(c) Standard: Physical environment. The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

Hospitals

42 CFR 482.13(e)(4) The use of restraint or seclusion must be -
(i) In accordance with a written modification to the patient's plan of care; and
(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

Nursing Homes

42 CFR 483.25(h) The facility must ensure that—(1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (F323)

Residential Care Apartment Complexes

DHS 89.26 A comprehensive assessment shall be performed prior to admission for situations or conditions which could put the tenant at risk of harm or injury.
DHS 89.34(17) A tenant shall have all the rights listed in this section...To a safe environment in which to live.

Resources for Additional Information

Please see the following resources for additional information:

“Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings,” developed by the Hospital Bed Safety Workgroup

https://www.ecri.org/Documents/Patient_Safety_Center/BedSafetyClinicalGuidance.pdf

US Food and Drug Administration Guide to Bed Safety

<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm123676.htm>

Minnesota Department of Health, “Safety without Restraints”

<http://www.health.state.mn.us/divs/fpc/safety.htm>

Oklahoma Foundation for Medical Quality, “A Family’s Guide to Bed Safety”

<http://www.ofmq.com/Websites/ofmq/Images/NEWBedSafetyBrochure.pdf>

Pennsylvania Patient Safety Advisory, “I’m Stuck and I Can’t Get Out! Hospital Bed Entrapment”

[http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2006/Dec3\(4\)/Pages/15.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2006/Dec3(4)/Pages/15.aspx)

Wisconsin Department of Health Services

http://www.dhs.wisconsin.gov/rl_dsl/Publications/Restraint.pdf

<http://www.dhs.wisconsin.gov/publications/p6/p63113.pdf>

http://www.dhs.wisconsin.gov/rl_dsl/Training/focus12/a8-b8-ho3.pdf

http://www.dhs.wisconsin.gov/rl_DSL/Publications/pdfmemos/95047.pdf

http://www.dhs.wisconsin.gov/rl_DSL/NHs/NH98-003.htm