

GHS02

THE SAFE AND EFFECTIVE USE OF BED AND TROLLEY RAILS POLICY

Contents		
Sections		Page
1.0	Policy Statement	2
2.0	Definitions	2
3.0	Accountabilities	4
4.0	Policy Detail	7
5.0	Financial Risk Assessment	13
6.0	Equality Impact Assessment	13
7.0	Maintenance	14
8.0	Communication and Training	14
9.0	Auditing and Monitoring Arrangements	14
10.0	References	15
11.0	Relevant Policies	

Appendices

Appendix 1: [Bed / Trolley Rail Decision Aid](#)

Appendix 2: Inpatient Bed Rail Assessment

Appendix 3a: Community Bed Rail Assessment (WHT)

Appendix 3b: Community Bed Rail Assessment (RWT)

Appendix 4: Trolley Rails Assessment for Assessment/
Interventional and Day case areas.

Appendix 5: [Paediatric Nursing Risk Assessment booklet \(WHT\)](#)

Appendix 6: [Grab Handles \(WHT Community\)](#)

Appendix 7: [Bed Dimensions guide](#)

Appendix 8: [Key messages for the use of bed and trolley rails](#)

1.0 Policy Statement (Purpose / Objectives of the policy)

The Group aims to take all reasonable steps to ensure the health and safety and independence of patients in their care. The correct use of bed and trolley rails may reduce the risk of patients falling and incurring harm

The risk of a patient falling from bed or trolley can be for many reasons including poor mobility, dementia or delirium, visual impairment, and the effects of their treatment, condition, medication, or substance abuse.

The purpose of this policy is to:

Provide advice and guidance for managing those patients who are at risk of falling from bed or incurring bedrail associated injury, but the use of Bed or Trolley Rails presents further risks, and alternative options should be scoped.

To ensure compliance with the Medicines and Healthcare products regulatory Agency (MHRA) Guidance 2021 and the National Patient Safety Alert (NPSA) 2023 Medical beds, trolleys, bedrails, bed grab handles and lateral turning devices risk of death from entrapment or falls.

To recognise opportunities for learning from incidents or near misses in relation to the use of bed and trolley rails.

2.0 Definitions

Bumpers

Padded cushions that can be fitted to the inside of bed or trolley rails to reduce the risk of impact injury. These must be sourced from regulated suppliers through the NHS supply chain and compatible with the bed or trolley being used. Any bumpers sourced need to meet all infection prevention and control standards.

Complex Delerium and Dementia Team (CDDT) (WHT)

A trust team of specialist nurses and practitioners who support the clinical team with advice, guidance, and interventions in caring for patients who present with mental health conditions.

Enhanced Supervision

The provision of an enhanced level of supervision following an appropriate risk assessment, by clinical staff, for those patients who are deemed at an increased risk of falls and the risk would be reduced. There are four levels of supervision, 2 hourly, 1 hourly, the provision of a dedicated bay nurse, supervisor, and one to one. Enhanced supervision would be determined by individual patient assessment. Consider "Behind Closed Doors" deprivation of liberty principles.

ESR Electronic Staff Record

An electronic system to maintain staff personal information including education and development modules for training purposes.

HSE Health and Safety Executive

Britain's national regulator for workplace health and safety.

ICES Integrated Community Equipment Store (WHT)

A community-based store that provides specialist equipment for those patients requiring resources at home in Walsall.

ICS Integrated Care Services (WHT)

An acute hospital and community team who assess and provide services, care and resources for patients to transition from acute to community care in Walsall.

IPC Infection Prevention and Control Policies

Policies developed by the Infection Prevention Control team aligning to national guidance and regulations relating to cleaning and decontamination of equipment used within the clinical setting by staff and patients.

Learning Disability Team LD

A Trust team of specialist learning disability nurses who provide expert advice, guidance, and interventions to support staff across Walsall Healthcare Trust. This advice includes the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

Matron's Forum (RWT)

A committee of senior nurses, midwives, health visitors and allied health professionals from Corporate and Directorate teams, formed to discuss key nursing, midwifery and AHP matters, scope options, agree actions and report to the Senior Leaders Forum.

Medical Physics and Clinical Engineering (MPCE)

The department responsible for managing and maintaining medical devices.

MHRA

Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices, and blood components for use in the UK.

NICE National Institute for Clinical Excellence

NICE is a national organisation that scopes evidence, effectiveness, safety, experience, and best practice and develops guidelines for use within the NHS to ensure patients have optimal outcomes and experience.

NMAAF Nursing, Midwifery and Allied Health Professionals Forum (WHT)

A committee of senior nurses and allied health professionals from all directorate's representative of the wider team, formed to collect information, scope options, report as a collective and to make decisions.

RCP Royal College of Physicians

The Royal College of Physicians is a British professional membership body dedicated to improving the practice of medicine, chiefly through the accreditation of physicians by examination.

Senior Leaders (Nursing, Midwifery, Health Visitors and Allied Health Professionals) Forum

A committee of senior nurses, midwives and allied health professionals from Corporate and Divisional teams, formed to maintain oversight of the nursing, midwifery and AHP agendas, scope options, report as a collective and to make decisions.

Safeguarding Team

A team of specialist nurses and practitioners who provide expert advice, guidance, and interventions to support patients who present with risks to their safeguarding as outlined in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

3.0 Accountabilities

The Chief Nursing Officers

Are responsible for leading the falls and deconditioning prevention agendas for the group, with oversight and assurance for the implementation of all associated policies and procedures.

Group Heads of Nursing and Midwifery

Are responsible for:

- Ensuring the bed/trolley rails policy and associated bed/ trolley rails assessment are implemented and followed in their areas of responsibility.
- Supporting in or leading incident investigations in line with the groups patient safety incident review framework (PSIRF) in the event of any patient safety incidents occurring relating to bed /trolley rails or falls.
- Ensuring there is divisional representation at the monthly Fall Joint Safer Mobility Group and any falls oversight meetings as outlined within the Group's PSIRF (Patient Safety Incident Response Framework).
- Responsible for ensuring that audits, reviewing of results, and implementing changes are undertaken as per the Group policies.

Matrons

Are responsible for:

- Ensuring the bed /trolley rail policy is implemented and followed within their areas of responsibility.
- Supporting in or leading incident investigations in line with the Group's PSIRF process in the event of any patient safety incidents occurring relating to bed/ trolley rails or falls.
- Supporting and undertaking clinical audits, shared learning, and development of quality Improvement actions.

Ward/ Departmental Managers

Are responsible for:

- Ensuring all staff have access and are aware of the principles of the bed /trolley rails policy.
- Ensuring the bed / trolley rails assessment is available for use and all staff receive appropriate education and training in the use of the assessment tool and application of its guidance.

- The day-to-day implementation of the policy and associated practices, including the use of bumpers.
- Ensuring that appropriate beds / trolleys and associated equipment is available.
- Escalating any shortfalls in appropriate equipment being available.
- Overseeing, escalating, and reporting equipment faults.
- Ensuring staff are made aware and are applying systems and processes in relation to Infection prevention and control policies and upkeep of bed/trolley rails and equipment.
- Reviewing all falls incidents relating to their area, identify lessons learnt, facilitate shared learning with the team and develop actions for discussion and sharing.
- Adhering to the Group's patient safety incident review framework in the event of any patient safety incidents occurring relating to bed / trolley rails or falls.
- Ensuring that local audit, reviewing of results, and implementing changes are undertaken as per the Groups policies.
- Managing any non-adherence to this policy in their area.
- Ensuring there is departmental representation at associated Shared Decision-Making Groups.

Clinical Staff (Acute and Community)

Are responsible for:

- Ensuring they are conversant with this policy and its supporting documents.
- Ensuring they have undertaken any necessary training in the use of bed /trolley rails, Bumpers and any other associated equipment.
- Ensuring all patients have an up-to-date bed or trolley rails assessment undertaken as per policy and risk assessment requirement and discuss the outcome of the assessment with the patient, family and carers as appropriate.
(Appendices 1,2,3a,3b & 5)
- Ensuring further required reassessment is completed as per policy and risk assessment requirements
(Appendices 1,2,3a,3b &5)
- Ensuring bed /trolley rails and bumpers are used appropriately in conjunction with the patient.
- Ensuring that children or adults with atypical anatomy are provided with the equipment which is compliant with BS EN 50637:2017 unless there is a reason for using a non-compliant bed. Record this on the risk assessment and put in place measures to reduce entrapment risks as far as possible. Documenting actions clearly in the patient record.
- Escalating any risks or concerns that require additional mitigation and management
- documenting in the patient record. For example, tools for assessing enhanced supervision requirements.
- Communicating effectively with the team, patients risks and requirements.
- Reporting any incidents or near misses of harm to patients relating to the use of bed or trolley rails and falls in line with the Groups patient safety incident reporting system.

Any injury to a patient associated with the use, failure or positioning of bed or trolley rails must be reported via the Trust incident reporting system. Where injury has occurred, the Health and Safety Team must be made aware to determine whether the incident is reportable to the Health and Safety Executive under RIDDOR. Only the Health & Safety Team are authorised to report such events to the Health and Safety Executive.

- Complying with Infection Control and Prevention (IPC) policies and procedures relating to decontamination and cleaning of rails and beds and trolleys.
- Ensuring beds, trolleys and rails are inspected prior use to ensure they are fit for purpose.
- Any defects or faults found by the user should be reported immediately via the Medical Physics and Clinical Engineering (MPCE) Helpdesk and quarantined from clinical use.
- In the event of having nonintegral bed rails It is essential that all bed rails are fitted correctly to an appropriate bed base by a competent individual, who has undergone the Trust moving and handling training, to ensure correct fitting to prevent entrapment and/or harm.

The Procurement Team

Are responsible for:

- Ensuring (alongside MPCE) adjustable and profiling beds have compatible, integral bed rails available from the manufacturer. These are preferable to other systems that may not fit as well.
- Ensuring that there is a procurement processes for standalone bed /trolley rails to ascertain compatibility with the Trusts beds and trolleys.
- Ensuring that all manufacturers of beds/trolleys and rails provide a statement of compliance to the current MHRA guidance and NPSA alert 2023.At
- Ensure all procurement policies are compliant with the current MHRA guidance and NPSA alert 2023.

Medical Physics and Clinical Engineering (MPCE)/ Estates

Are responsible for:

- Ensuring ongoing maintenance arrangements and schedules are in place across the group to maintain the safety of beds and trolleys with integral rails and similar equipment that fall under the remit of MPCE.
- Specifically for RWT, as per risk 6021, Medical Devices Group (MDG) will be seeking that Divisions /Directorates, for non MPCE managed contracts, will provide into MDG, self – declarations that their locally held maintenance contracts are being serviced correctly by the external service providers or visible management of external maintenance contracts are on Astamis Platform.
- For contracts managed by MPCE maintenance schedules are in place and are monitored through KPI's, with oversight by the Head of Clinical Engineering. Standalone (non-integral) bedrails will be inspected upon request.
- Ensuring processes are agreed contractually with suppliers or locally, documented, and managed for equipment that falls under the remit of MPCE. Divisions/Directorates will be responsible for this where they have direct contractual links with suppliers and will manage accordingly.
- Accepting and responding to faults and issues reported to them by clinical teams in line with agreed National Performance Advisory Group (NPAG) guidance.
- Contribute to ensuring all relevant policies are compliant with the current MHRA guidance and NPSA alert 2023.

The following must be considered by clinical users and during maintenance checks:

- Adjusters, clamps, and fixings can wear, work loose, crack, deform or be missing completely, giving rise to unwanted free play which can increase important gaps.

- Material fatigue can also occur. Bed /trolley occupants who rattle the rails can exacerbate this tendency.
- Telescopic components can become loose or jammed, discouraging correct adjustment.
- Plastic components can degrade due to age, exposure to light and some cleaning chemicals.
- Poor transport and storage can also cause damage to components.
- Duvets, blankets, sheets, and valances may need to be removed to check these areas properly.

ICES Integrated Community Equipment Store (WHT)

Will ensure appropriate risk assessments have been undertaken prior to supply of bed or trolley rails, bed grab handles, bariatric beds or lateral turning devices.

Will ensure all equipment in store or loaned has been procured as per the trust procurement guidance noted above.

Will ensure all equipment to be loaned has complied with servicing and maintenance as per the Trust guidance noted above

The Group Lead for Falls

Is responsible for:

- Reporting monthly to the Joint Safer Mobility Group, any trends relating to good practice and incident referencing issues with bed and trolley rails.
- Supporting the implementation and embedding of this policy and its associated tools.
- Supporting any associated education and training requirements of clinical areas.
- Revising and updating associated Trust education and training modules as appropriate.
- Revise and updating this policy following revisions in practice, process, and national guidelines.

4.0 Policy Detail

4.1 Scope

This policy applies to all locations across acute and community settings areas where Trust staff are caring for patients in beds and on trolleys. Temporary employees, locums, agency staff, students, and visiting clinicians.

Bed and trolley rails should only be used to reduce the risk of patients accidentally slipping, sliding, falling, or rolling out of a bed or trolley. Bed and trolley rails **MUST** not be used as a form of restraint. They are not designed or intended to limit the freedom of people by preventing them from intentionally leaving their bed or trolley; nor are they intended to restrain people whose condition disposes them to erratic, repetitive or violent movement. Bed and Trolley rails are not intended as a moving and handling aid.

Whilst it is recognised that the safe use of bed and trolley rails can help prevent falls from beds/trolleys and subsequent injury to patients, it is also documented that injury can be sustained by restless patients hitting their heads or limbs on a rail, attempting to climb over, falling, or incurring entrapment. For these patients, alternative methods to reducing the risk of falling from their bed or trolley and incurring harm should be considered.

The use of bed/ trolley rails must be considered on a patient-by-patient basis as part of the holistic assessment of the patient, carefully considering the balance of risk, the patient's wishes, their mental capacity, and changes in condition. In the event of bed /trolley rails being contraindicated following completion of the risk assessment, alternative strategies should be considered such as, the use of low-rise beds, crashmats, documented assessment of enhanced supervision needs, and interactive activities.

The bedrail /trolley rail risk assessments included within this policy, consider all protected characteristics including disability.

Patients and carers, on occasion, request bedrail usage against the assessment advice. If this situation arises then risks versus benefits need to be explained to the patient /carer and any conversations related to this clearly documented within the patients' medical records and on the daily risk assessment. Clinical judgement and patient safety must take priority during any decision making with regards to this.

Medicines and Healthcare Related Products Agency (MHRA 2021) guidance recognises the reports of adverse incidents in relation to asphyxiation after entrapment and is an NHS 'Never events' (number 11 chest or neck entrapment in bed rails). The MHRA guidance should be used as a reference for the safe use of bed/trolley rails, from risk assessment through to the purchase/ selection to correct fitting, special considerations, maintenance, legislation, and standards.

In August 2023, the MHRA released a revised alert following the 2021 alert stating: 'The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks).

Chest or neck entrapment in rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS.

According to investigations, deaths were found to involve factors including inadequate risk assessment, maintenance issues and children and adults of small stature using beds which are designed for use by adults with atypical body dimensions. Other risk factors (such as inappropriate use or incompatibility) are included in the 2023 MHRA's updated guidance on the management and safe use of bed /trolley rails and should be considered as part of an appropriate risk assessment.

Bed/ trolley rails should be routinely incorporated in the clinical assessment of all patients.'

4.2 Exclusions

None

4.3 Standard Operating Procedure for the Safe and Effective Use of Bed and Trolley Rails.

4.3.1 All patients

- Should be involved in the decision to use bed or trolley rails, providing they have been assessed as having the mental capacity to do so.
- Any assessments to determine mental capacity should be completed and recorded as stated in RWT [OP11 Administration of the Mental Health Act 1983, in an acute Hospital Setting Policy](#) / WHT Mental Capacity Act policy MH 960 This is a legal requirement.
- Should the patient lack the capacity to make the decision then clinical staff have a duty of care to decide if bed or trolley rails are in the patient's best interest, following discussions with other members of the team, this may include the Safeguarding Lead Nurse, the Older People's Mental Health team, and the patient's family of carers. All discussions held must be clearly documented.
- Decisions regarding the use of bed or trolley rails should be made in conjunction with the falls assessment as detailed within RWT [CP42 Prevention and Management of Adult and Paediatric Inpatient Falls Policy](#) and WHT, [WHT CP922 Slips Trips and Falls policy](#)
- All patients should be assessed on an individual basis for the use of bed or trolley rails; there should not be a default position of using bed / trolley rails as routine.
- Bed and trolley rails must not be used as a form of restraint or in a way which impacts on the patient's independence.
- The decision to use bed / trolley rails or not and any other mitigating actions must be communicated at handover, during safety huddles and on transfer to another ward or department.
- The use of bed / trolley rails should be used in conjunction with assessing the patient for enhanced supervision requirements to reduce the risk of falls.

4.3.2 Inpatients

- All inpatients MUST be assessed for the use of bed rails within 6 hours of admission or transfer ([Appendix 1, 2&5](#)).
- Reassessment for all inpatients will occur on change in the patient's condition or otherwise, weekly as a minimum.
- Following assessment, if bed rails are deemed appropriate and are in use then daily reassessment should be undertaken and documented.

4.3.3 Community

- Nationally community settings have a higher number of incidents in relation to bed rails.
- All patients cared for within the community, including in their own home, that are identified as potentially requiring bed rails will be assessed using the Trust's community bed rail decision aid prior to application of bed rails. Patients will be assessed monthly or on change in the patient condition. ([Appendix 3a \(WHT\) and 3b \(RWT\)](#))
- Adult bed rails should only be used for patients over 1.46m in height (4ft 9in) or are compliant with BS EN 50637:2017.
- A risk assessment should be undertaken for patients that do not meet these criteria and special consideration given as to how the bed is established to mitigate the risk of entrapment as the space will have to be smaller.
- The ordering of a bed with rails from community equipment Stores for placement into patients own homes must be based on a documented patient risk assessment.

4.3.4 Emergency/Assessment areas

- All assessment units using trolleys to accommodate patients e.g., Emergency Departments, Emergency Assessment Units, Ambulatory Emergency Care units, Frailty Assessment Units, Paediatric Assessment Units **MUST** have a trolley assessment completed on arrival to the department and reassessed every shift as a minimum. (Appendix 4)

4.3.5 Interventional areas and day case

- All clinical intervention areas using trolleys to accommodate patients e.g., Radiology Endoscopy, Theatres, Cardiac Intervention Suite, Medical Day Case Unit, Surgical Day Case Unit, Chemotherapy Unit, **MUST** have a trolley assessment completed on arrival to the department. (Appendix 4)
- **N.B** Where it is expected and mandated that the patient is never left unsupervised on a trolley or bed, locally held standard operating policies can be applied.

4.3.6 Bed and Trolley rails can be used:

- If the patient is being transported between areas.
- In areas where patients are recovering from an anaesthetic or sedation and are under constant observation such as critical care.
- If the patient is considered, following a documented risk assessment, as being at risk of falling/rolling from the bed or trolley.

4.3.7 Bed and Trolley rails can be considered:

- If the patient requests bed / trolley rails. Ensure a bed /trolley rails assessment is completed and documented.
- Patients requesting bed /trolley rails must have capacity to make this decision.
- Documentation must include that the patient has the capacity to make this decision and understands the risks/benefits if rails are not recommended.

4.3.8 Bed and Trolley rails **MUST NOT** be used:

- If the patient is at risk of climbing over or around the rails, injuring themselves or incurring entrapment.
- If they would restrict the movement of an otherwise independent patient.
- For restraint purposes.
- In the event of bed / trolley rails not being a suitable option consider enhanced supervision for the patient using the trust enhanced supervision assessment tools.
- If the condition of the bed/trolley rails are assessed as not fit for purpose, which should then be quarantined and raised on the Medical Devices Helpdesk

Decisions regarding the use of bed and trolley rails should be a balance between competing risks. Staff should use their professional judgement to consider the risks and benefits for individual patients using the following questions for guidance.

- Will the rails stop the patient from being independent?
- Might the patient climb over or around the rails?
- Could the patient injure themselves on the rails?
- Could using rails cause the patient distress?
- Is the patient at risk of becoming entrapped in the rails?

If any answer is yes, it may not be appropriate to use the rails.

If the rails are not used then all reasonable measures must be put in place to avoid the risk of harm from a fall, such as low-rise beds, crash mats, interactive therapy, enhanced supervision.

Bed / trolley rails should only be used if the benefits outweigh the risks.

4.4 Air mattresses/ mattress overlays.

Care is needed when using some air mattresses or mattress overlays with bed and trolley rails due to the reduction in the effective height of the bed rail relative to the top of the mattress.

Under height rails may allow the occupant to roll over the top of it; if this possibility exists, height extensions for rails must be used.

The hazard of entrapment between the side face of the mattress and the rail may be exacerbated due to the soft, easily compressible nature of the mattress edge.

If an air mattress is in use with a bedrail, then the mattress supplier should be contacted for advice. Extra height bed rails are available from several suppliers. MPCE MUST be consulted as per [HS11, Management of Medical Devices Policy](#) or WHT medical devices policy [Medical Devices Policy](#) prior to any purchase.

4.5 Special beds:

Additional vigilance is required when using bed rails with adjustable/ profiling beds. Many beds have a single piece bed rail along each side of the bed; when the bed profile is adjusted entrapment hazards can be created which are not present when the bed is in the all-horizontal position.

Many beds, particularly special care beds such as low air loss or air fluidised beds, have two pairs of bed rails fitted, one pair at the head end and one pair at the foot end. These are known as split side rails. Again, additional vigilance is required when using split bed rails because the space between the head and foot end rails varies according to the bed profile adjustment; therefore, entrapment hazards may be created when the bed is adjusted to profiles.

Gaps between split rails **must** exceed 120mms.

Care should be taken to use the rails as instructed by the bed manufacturer e.g., where split bed rails are fitted, both pairs (one pair at foot and head of bed) must be used together. Some beds are supplied with timber or composite bed rails. If these are particularly flexible, it may be possible for the rail to deform under force and create an entrapment hazard between the rail and side of the mattress.

4.6 Additional Resources to be Considered.

Bed /Trolley rail bumpers

- The use of bumpers must be based on risk-based assessment, considering potential entrapment and suffocation risks.
- If risk assessed and suitable, only use bed/trolley rail bumpers recommended by the manufacturer of the rail. Ensure they are fitted securely and effectively.
- Use of bumpers must be clearly documented, and review and reassessment undertaken each shift, on transfer and on change in condition.
- Their integrity must be checked each shift.

- They must be decontaminated and stored appropriately after use.

4.6.1 Patient size: Paediatrics and Adults with small anatomy.

Most bed/trolley rails on the market are designed to be used only with individuals over 1.46 m in height (4 foot 9 inches), which is also the height of an average 12-year-old child. A risk assessment (Appendix 5) should always be carried out on the suitability of the rail for the individual child or adult with atypical anatomy, as bar spacing, and other gaps will need to be reduced. It is recommended that all gaps between the rail bars should be a maximum of 60 mm. Equipment being procured and used must comply with BS EN 50637:2017.

Paediatric wards and departments caring for children of less than 1.46m in height must scope and source alternative options such as beds/trolleys with rails with gaps as per the BS EN standard, low rise beds with crash mats or assure constant supervision.

In the event of suitable equipment being not available to purchase, appropriate mitigation must be in place, use of bumpers, constant supervision, low rise trolleys, paediatric beds with appropriate rails for example.

Larger anatomy

Consideration for options of alternative deeper bed and trolley rails should be considered if a patient's habitus presents a risk of the rails not being deep enough to prevent them from rolling out of bed. Consider Bariatric beds that comply with bed rail guidance. Consideration for options of alternative deeper bed rails should be considered if a patient's habitus presents a risk of the bed rails not being deep enough to prevent rolling out of bed.

4.6.2 What to avoid.

From investigations, the MHRA has identified several potential risk areas that, if they had been avoided during the selection process, may have reduced the likelihood of adverse incidents occurring. For example, avoid:

- Gaps of over 60 mm between the end of the bed rail and the headboard which could be enough to cause neck entrapment.
- Gaps over 120 mm from any accessible opening between the rail and the mattress platform.
- Filling any gaps using blankets, bedding, or pillows, as these can be compressed and may increase the risk of entrapment.
- Using bed rails designed for a divan bed on a wooden or metal bedstead, this can create gaps which may entrap the occupant.
- Using unsecure fittings or designs which permit the bed rail to move away from the side of the bed or mattress, creating an entrapment hazard.
- Using only one side of a pair of bed rails when the other side is against a wall if this is not specifically permitted by the manufacturer – the single rail may be insecure move. Some manufacturers supply a mattress retainer for use with single sided bed rails which reduces this risk.
- Mattress combinations whose additional height lessens the effectiveness of the rail and may permit the occupant to roll over the top. Extra height rails are available if mattress overlays are to be used.

- Mattress and rail combinations where the mattress edge easily compresses, introducing a vertical gap between the mattress and the rail.
(Appendix 7)

4.6.3 Cleaning and Decontamination

Bed and trolley rails must be cleaned as per the Trust IPC policies and procedures and in line with manufacturer's instruction when contaminated, soiled, between patients and as part of any decontamination regimes required.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources? The full implementation of this policy will be subject to certain funding and business cases as replacement stock for any compliant equipment is made. N.B At the time of writing the policy the bed stock replacement project, which included scoping the best replacement to increase the number of low-rise beds is in progress. Equipment such as crashmats to support with not utilising bed and trolley rails where contraindicated may incur additional costs. If any residual risk with non-compliant stock is identified this will be added to the local and trust risk registers.	Yes
2	Does the implementation revenue resources of this policy require additional funding?	No
3	Does the implementation of this policy require additional manpower?	No
4	Does the implementation of this policy release any manpower costs through a change in practice?	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff?	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
√	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include:

7.0 Maintenance

The policy will be kept within the clinical policies section of the Groups intranet. The policy will be reviewed by the Head of Nursing – Quality and the Groups Falls Leads. Any amendments to the policy will be approved by the Group Safer Mobility Steering group.

8.0 Communication and Training

Dissemination of the policy will be via staff trust communication strategies, targeted emails to all ward managers, senior sisters and matrons, presentation at the Joint Safer Mobility Group, Nursing, Midwifery, Health Visitors and Allied Health Professionals Leaders Groups, Shared Decision-Making Forums, face to face education and training sessions for Falls Prevention.

Reference to the standard operating procedure will be incorporated into the falls' prevention training on My Academy and any face-to-face training. Training in use of the revised decision aid for bed / trolley rails will be included in any training session developed as part of the nursing documentation review program of work as well as Safe Moving and Handling Training for clinical staff. The Nursing Quality team will undertake dissemination of the policy and training supported by the Trusts educational teams.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Patients who have incurred a fall from a bed or trolley	The Group falls lead	Review of patients who have incurred a fall with any level of harm from a bed or trolley with or without bed rails in place. Review such falls in line with the Groups patient safety incident review framework. Involvement of the clinical teams to determine whether bed /trolley rails were appropriate or not and whether other options of maintaining the patient safety had been explored and mitigated. Review of falls incidents within the Groups incident reporting systems Review of clinical audits undertaken via the Groups audit methods.	Bi -Monthly	The Groups: Safer mobility steering group meeting Bi annual RWT/WHT QSOG reports as and when required. Monthly Medical devices group as required

		Review of the outputs from clinical Accreditation processes.	
--	--	--	--

10.0 References - Legal, professional or national guidelines

Gov.UK (2021) Bed rails: management and safe use

<https://www.gov.uk/guidance/bed-rails-management-and-safe-use>

National Patient Safety Alert (2023) Medical Beds, trolleys, bed rails ,bed grab handles and lateral turning devices : risk of death from entrapment or falls.

[NatPSA bed rails 30 8 23.pdf \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/115863/natpsa-bed-rails-30-8-23.pdf)

Health and Safety Executive (HSE) (2021) Safe use of bed rails

<https://www.hse.gov.uk/healthservices/bed-rails.htm>

Mental Capacity Act 2005

[Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9)

Related Group Healthcare Policies

[CP42 Prevention and Management of Adult and Paediatric Inpatient Falls Policy](#)

WHT-CP922 Slips Trips and Falls Policy

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=5230>

[CP59 Restraint Policy](#)

WHT-MH1059 V1 Restrictive Practice Policy

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=11586>

[HS01 Management of Health and Safety Policy](#)

WHT-HS01 Health and Safety Policy

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=9204>

<http://trustnet.xrwh.nhs.uk/strategies-policies/corporate-policies-procedures-guidelines/infection-prevention-and-control-policies/>

WHT-IP1011 administration of infection prevention & control within WHT

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=5318>

[OP10 Risk Management and Patient Safety Reporting Policy](#)

[HS11 Management of Medical Devices Policy](#)

WHT medical devices policy

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=9063>

[CP66 Policy For Care Of Patients Requiring Enhanced Care](#)

OP41 / WHT-OP41 mandatory training policy

http://intranet.xrwh.nhs.uk/pdf/policies/OP_41_Policy_Printable_Version.pdf

Safe Moving and Handling Policies and Procedures

<https://intranet.walsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&mid=4041&fileid=6221>

Part A - Document Control

Policy number and Policy version: GHS02 Version 1.0	Policy Title Safe and Effective use of Bed and Trolley Rails	Status: Final		Author: Group Falls lead Chief Officer Sponsor: Chief Nursing Officers
Version / Amendment History	Version	Date	Author	Reason
	1.0	March 2026	Group Falls Lead	New Group Policy (Supersedes previous single Trust-wide versions i.e., RWT CP16 and WHT OP983 Safe and Effective use of Bed and Trolley Rail policies combined to make group policy)
Intended Recipients: The document applies to all Group clinical staff in all locations				
Consultation Group / Role Titles and Date: Safer mobility Steering Group. Health and Safety team. Patient Moving and Handling team. Medical Physics and Clinical Engineering (MPCE) December 2025				
Name and date of Trust level group where reviewed		Safer Mobility Steering Group December 2025 (Group meeting) Group Policy Meeting – March 2026		
Name and date of final approval committee		Group Policy Meeting – March 2026		
Date of Policy issue		April 2026		
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)		March 2029 – Every 3 years		
Training and Dissemination: Dissemination of the policy will be via staff the Trusts communication strategies, targeted emails to all ward managers, senior sisters and matrons, presentation at the Safer mobility steering group, , Matrons and Sisters Forums, Divisional Safety Huddles, Shared Decision-Making Forums, face to face education and training sessions for safer mobility and Falls improvement. The nursing quality team will be responsible for dissemination.				
To be read in conjunction with : RWT/WHT Policies : Falls Prevention policies, Restraint Policies, Management of Health and Safety Policies, Risk Management and Patient Safety Reporting policy, Management of Medical Devices Policies, Infection Prevention and Decontamination Policies, Safe Moving and Handling Policies, Care of Patients Requiring Enhanced supervision policies ,Mandatory training policies, Medical devices policies.				

Initial Equality Impact Assessment (all policies): Completed Yes Full Equality Impact assessment (as required): Completed / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904	
Monitoring arrangements and Committee	The policy will be monitored and reported to the Joint Safer Mobility Steering Group. By the Falls lead
Document summary/key issues covered. To ensure compliance with MHRA Guidance, Bed rails management and safe use. To incorporate learning from NPSA alert (2023) Medical beds, trolleys, bedrails, bed grab handles and lateral turning devices risk of death from entrapment or falls. To provide criteria and guidance for the appropriate risk assessments, purchase, selection, maintenance legislation, use of Bed and Trolley Rails and decision support tools To provide advice and guidance for managing those patients who are at risk of falling from a bed or trolley or incurring bedrail associated injury, but the use of bed rails presents further risks, and alternative options need to be scoped.	
Key words for intranet searching purposes	Bedrails, Trolley Rails, Cot sides, bumpers, Grab handles

Appendix 1 – Decision aid

Bed and Trolley Rails Assessment Decision Aid

All Patients Must Be Assessed Prior To bed Or Trolley Rail Use.

Bed or trolley rails should usually be considered:

- ✓ If the patient is considered as being at risk from falling from the bed or trolley due to a cognitive, physiological, or physical condition, the benefits and risks of using rails should be balanced against the risks of using an alternative.
- ✓ In areas where patients are recovering from an anaesthetic, sedation and are under constant observation.
- ✓ If the patient requests bed or trolley rails and has capacity
- ✓ The patient lacks capacity, MCA undertaken, best interest decision applied and documented.

Bed or trolley rails should not usually be considered:

- ✗ If the patient is at risk of climbing over the bed or trolley rails, injuring themselves or incurring entrapment.
- ✗ If the patient would be independent if the bed or trolley rails were not in place.
- ✗ Patient has capacity and declines.
- ✗ For restraint purposes

Bed or Trolley Rails must be in place whilst transferring a patient between areas.

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Bed Rails Assessment in the Community Setting

To be completed at initial assessment, every 12 months or if the patient's condition changes / deteriorates

Unit Number:	NHS No:	
Surname:	Gender:	DOB:
First Name:	Address:	
GP details:		Postcode:

Step 1: Is the patient at risk of slipping/rolling/falling/sliding out of bed (NOT including climbing)

Yes? - Continue with the below

No - Provision is not suitable

If yes continue to Step 2: use bed rail risk matrix tool below to consider the risks and benefits for provision:

- The colour codes should be used as guidance only
- If patient is independent, has capacity and wants the bed rails up, advice should be given re risks
- Step 3 should be completed at each assessment that takes place.

DO NOT use bed rails if the following apply:

- **If the patient has the potential to climb out of bed due to their confused state**
- **To restrain a patient e.g., to keep an agitated patient in bed or if there is risk of entrapment**
- **If the patient has atypical anatomy i.e. If the patient weighs less than 40kg and / or is less than 1.46m in height.**

Step 2: Bed Rails Decision Aid

		Mobility		
		Patient is immobile (Bed rest or hoist dependant)	Patient has reduced mobility. Requires assistance to mobilise / transfer	Patient can mobilise without help from staff
Mental State	Patient is significantly confused/agitated	Bed rails NOT recommended. Ensure appropriate bed height.		
	Patient is mildly confused/drowsy	Bed rails recommended	Use bed rails with care. Ensure appropriate bed height	Bed rails NOT recommended Ensure appropriate bed height
	Patient is orientated and alert	Bed rails NOT recommended - Ensure appropriate bed height Clinical judgment needed if prescribing		
	Patient is unconscious	Bed rails NOT recommended		

Additional Strategies - for patients considered to be at risk of falls

1. Ensure suitability of environment and level of supervision	3. Discuss with the patient / carer on strategies used pre assessment
2. Bed left at most appropriate height for patient after care delivery	4. Consider - Body positioning and alerting devices e.g. pillows / bed wedges / pendant alarms.

Appendix 3b – Bed Rails Assessment – Community

Bed Rails Assessment in the Community Setting

(WHC10474814_10.08.22_V0.1)



The Royal Wolverhampton
NHS Trust

Surname: M O U S E NHS No.: 9 9 9 0 0 2 7 7 1 4 Unit No.: N 4 3 4 2 6 4

Forename: M i n n i e DOB: 0 1 - 0 2 - 1 9 3 3

Date: 1 5 1 2 2 0 2 3 Time: 0 9 3 5

Please ensure, that is patient has their own grab rail, this is also taken in to account with regards to entrapment and ill use. These are to be removed in order for bed rails to be put in place, safely

Bed rails assessment to be completed at point of initial assessment, weekly assessment in line with patient allocation and visit and subsequently if patients condition changes/deteriorates; if patient has had a fall

Do not use bed rails if the following apply:
 If the patient has the potential to climb out of bed due to their confused state
 To restrain a patient e.g. to keep an agitated patient in bed or if there is a risk of entrapment.
 Do not use if the patient has atypical anatomy, is under 40kgs in weight or under 1.46 m height
 As routine where there is no risk of falls

Step 1
 Use the bed rail matrix below, to consider the risks and benefits for individual patients. The colour codes should be used as guidance only.
 If the patient is independent and has capacity and wants the bed rails up advice should be given to the patient on risks and step 3 should be completed at each assessment that takes place

Mental State	Mobility		
	Patient is immobile (bed rest or hoist dependent)	Patient has reduced mobility. Requires assistance to mobilise	Patient can mobilise without help from staff
Patient is confused / agitated	Use bed rails with care Ensure appropriate bed height	Bed rails NOT recommended Ensure appropriate bed height	Bed rails NOT recommended Ensure appropriate bed height
Patient is drowsy	Bed rails recommended	Use bed rails with care Ensure appropriate bed height	Bed rails NOT recommended Ensure appropriate bed height
Patient is orientated and alert	Bed rails recommended	Bed rails recommended	Bed rails NOT recommended
Patient is unconscious	Bed rails recommended	N / A	N / A

Step 2 Additional Strategies - for patients considered to be at risk of falls

Ensure suitability of environment and level of supervision Discuss with the patient / carer on strategies used pre assessment

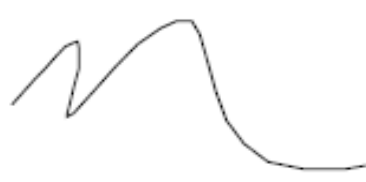
Bed left at most appropriate height for patient after care delivery Consider - Body positioning and alerting devices e.g. pillows / bed wedges / pendant alarms.

Step 3 Bed Rail Risk Assessment Outcome Documentation of Level of Risk

Red Amber Green

Additional Strategies in Place

Signature



Date: 1 5 1 2 2 0 2 3 Time: 0 9 3 5

Staff Name: M Y R A B O N E L L A

Designation: T e s t e r

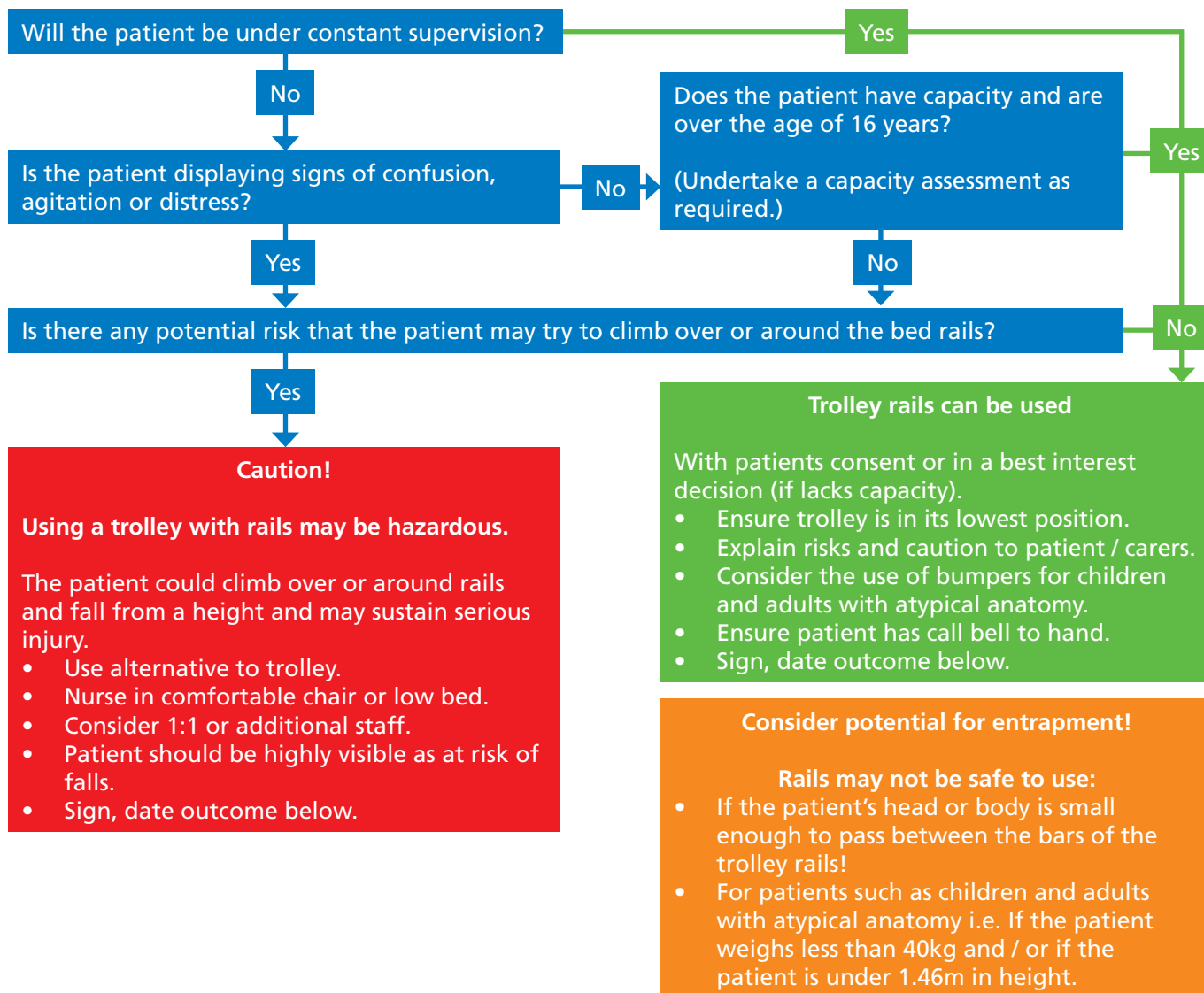
Registration No.: Q W E R T Y

Trolley Rail Risk Assessment

To be used on ALL areas using trollies

Assess patient on arrival and on every shift.

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)



Clinically safe to use trolley rails ? Yes No

During transportation of patients' trolley rails MUST always be in the upright position.

Signature: Designation:

Date:..... Time: Stamp

Reassessment

Clinically safe to use trolley rails ? Yes No

During transportation of patients' trolley rails MUST always be in the upright position.

Signature: Designation:

Date:..... Time: Stamp

BLANK PAGE NOT FOR COMPLETION

Paediatric Nursing Assessment Booklet

Nursing Risk Assessments and if required nursing management / care plans, to be completed on admission, on transfer to another ward on change of clinical condition or otherwise weekly.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	Postcode:
GP details:	

	On Admission (Date)	Transfer 1 (Date)
Location e.g. Ward name / number		

	Date	Date	Date
Weekly reassessment due:			
	<input type="checkbox"/> Completed	<input type="checkbox"/> Completed	<input type="checkbox"/> Completed

- A registered nurse must complete the initial risk assessment contained in this booklet within 6 hours of admission or transfer to a ward / unit / department
- Reassessment to take place weekly as a minimum, on transfer to another ward / unit on change of condition of the patient according to Trust policies
- Subsequent assessments can be completed by both Registered Nurses and Nursing Associates
- Do not start a new booklet if a patient is transferred to another ward or department

Contents

	Page
Bedrail assessment	2
Transfer risk assessment	3
Manual Handling screening	4-6
Activities of Daily Living	7-8
Purpose T assessment and care plans	9-17
Mouthcare assessment	18-19
Stamp Tool	20-21
PEWS Care plan	22
Discharge Care plan	23

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

S ituation	Working Diagnosis:
B ackground	Background: Past Medical History: Safeguarding: CPIS checked: Yes <input type="checkbox"/> No <input type="checkbox"/> Known to Social Services: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes > Social services contacted: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> EH <input type="checkbox"/> CIN Plan <input type="checkbox"/> CP Plan <input type="checkbox"/> MARF: Yes <input type="checkbox"/> No <input type="checkbox"/> Attached: <input type="checkbox"/> Reference Number: Infection Control: Immunisations up to date: Yes <input type="checkbox"/> No <input type="checkbox"/> Recent Travel within last 3 months: Yes <input type="checkbox"/> No <input type="checkbox"/>
A ssessment	PEWS score on handover:.....PEWS escalation requires ≥ 3 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (Full PEWS on transfer checklist) Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> Allergy band: Yes <input type="checkbox"/> No <input type="checkbox"/> State Reaction Sepsis Bundle: Triggered Sepsis: Yes <input type="checkbox"/> No <input type="checkbox"/> Time: De-escalated: Yes <input type="checkbox"/> No <input type="checkbox"/> Time: If escalated: Bundle completed: Yes <input type="checkbox"/> No <input type="checkbox"/> All medications given: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Next medication due at:..... Cannula <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Site: VIP score chart commenced <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> VIP Score:..... NG <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes> Insertion log attached Yes <input type="checkbox"/> No <input type="checkbox"/> IGROW completed: Yes <input type="checkbox"/> No <input type="checkbox"/>
R ecommendation	Frequency of observations required Outstanding investigations required Other relevant information:..... Doctors Plan documented in notes: Yes <input type="checkbox"/> No <input type="checkbox"/>
Timely Transfer	
Initial contact time with Ward 21: Time handed over to Ward 21:	
Transfer time to Ward 21: Delay: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for delay:.....	

Name:..... Signature: Designation:

Date:..... Time: Stamp

Paediatric Transfer Risk Assessment

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	Postcode:
GP details:	

Score	Low	Medium	High	Critical
PEWS	0	1-2	3-4	>5
Assessment	Ensure the patient is assessed by NIC prior to transfer	Ensure the patient is assessed by NIC prior to transfer	Ensure the patient is assessed by a senior Nurse or medical staff prior to transfer.	Keep patient in department until stabilised and PEWS has decreased.
Patient Condition	Stable Saturations >94% in air Mild WOB (PEWS 0-1) Respiratory rate stable AVPU= Alert No infusions Cannula – No infusions NG – Feed off	O ₂ Therapy <40% Saturations >92% AVPU = A-V Cannula with infusions	O ₂ therapy IV infusion – Aminophylline, Salbutamol High flow O ₂ >40% Bubble CPAP – stable to have time off	GCS <8 O ₂ therapy Requiring
Monitoring Requirement	No monitoring required	Continuous O ₂ saturations monitoring	Continuous cardiovascular & O ₂ saturation, respiratory and BP monitoring	Continuous cardiovascular & O ₂ saturation, respiratory and BP monitoring
MRI/CT/XRAY	Not sedated	Sedated	Sedated	Sedated
Minimal Escort required	One of the following: Parent/carer CSW* Required for child protection. Registered Nurse/NA Student Nurse	One of the following: Registered Nurse NA *1 escort must be trained in BLS	Two of the following: Medical staff – Ward 21 Registrar Registered Nurse/NA CSW alongside RN *1 escort must be trained in BLS & have Advanced Life support skills. +/- Anaesthetic team	At least 2 of the following must remain present: Medical staff – Ward 21 Registrar Registered Nurse/NA CSW *2 escorts must be trained in BLS & have Advanced Life support skills. +/- Anaesthetic team
Equipment Required	None	O ₂ cylinder (at least ½ full) Oxygen Mask Sats Monitor	O ₂ cylinder (at least ½ full) Paediatric transfer Bag Suction	Resus Trolley in close proximity or Critical care bag O ₂ cylinder (at least ½ full) Suction
Documentation	Wristband in situ Patient notes (if staff escorting)	Wristband in situ Patient notes	Wristband in situ Patient notes	Wristband in situ Patient notes

Consultant: Diagnosis: Allergies:

Wristband in situ All equipment present and working

Transferred from	Destination	Date	Time	Parent/Carer aware	Baseline observations	Risk Assessment score	Infection control / Safeguarding?
				Yes / No / NA Staff present on transfer:	HR: WOB:	Low	
					O ₂ Sats: in	Medium	
					Temp: BP:	High	
					AVPU: PEWS:	Critical	

Name: Signature: Designation:

Date: Time: Stamp

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Transferred from	Destination	Date	Time	Parent/Carer aware	Baseline observations	Risk Assessment score	Infection control / Safeguarding?
				Yes / No / NA Staff present on transfer:	HR: WOB:	Low	
					O ₂ Sats: in	Medium	
					Temp: BP:	High	
					AVPU: PEWS:	Critical	

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Transferred from	Destination	Date	Time	Parent/Carer aware	Baseline observations	Risk Assessment score	Infection control / Safeguarding?
				Yes / No / NA Staff present on transfer:	HR: WOB:	Low	
					O ₂ Sats: in	Medium	
					Temp: BP:	High	
					AVPU: PEWS:	Critical	

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Transferred from	Destination	Date	Time	Parent/Carer aware	Baseline observations	Risk Assessment score	Infection control / Safeguarding?
				Yes / No / NA Staff present on transfer:	HR: WOB:	Low	
					O ₂ Sats: in	Medium	
					Temp: BP:	High	
					AVPU: PEWS:	Critical	

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Paediatric Bed and Cot Allocation Risk Assessment

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	Postcode:
GP details:	

This risk assessment must be undertaken each shift to select the most appropriate bed or cot for the child based on their risk of falls, impact injury or entrapment risk.

Ensure to go through questions below to determine bed / cot allocation and discuss potential risks and importance of appropriate bed / cot with parents / carers. Refer to Bed Rails Key Messages.

Consider Your Clinical Judgement.

Children under 3 years		Applicable	
Is the child younger than 3 years?	➔	<ul style="list-style-type: none"> Place in cot with rails placed in highest position Pillows are advised against being used in cots, however if parents request a pillow, they must be made aware of all risks involved and given the Safer Sleep leaflet 	Using a Cot? <input type="checkbox"/> Yes <input type="checkbox"/> No
**Has the parent declined a cot for a child aged 2-3 years?	➔	Use clinical judgement and discuss with parents / carers In the absence of a paediatric bed, use adult bed at lowest height. Ensure all risks of falls, impact injury and entrapment are explained to parents / carers **	Using a Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Over 3 years			
Does the child weigh under 40kg, and is under 146 cm tall?	➔	<ul style="list-style-type: none"> In the absence of a paediatric bed (appropriate bed), use adult bed at lowest height and all risks of falls, impact injury and entrapment are explained to parents / carers 	Using an appropriate Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child weigh over 40kg, and/ or is over 146 cm tall?	➔	<ul style="list-style-type: none"> Adult bed (appropriate bed) 	Using an appropriate Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other considerations			
Does the child / young person have involuntary movements, seizures, agitation or confusion, reduce level of consciousness, confusion?	➔	<ul style="list-style-type: none"> Use the appropriate bed for weight and height (as above) There is a risk of falls There is a risk of impact injury due to agitation – Consider bed rails up with bumpers, and all risks of entrapment including suffocation explained to parents / carers. (document reason for use of bed rails and bumpers) Consider the need for 1:1 supervision (parent supervision) 	Bumpers Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No 1:1 supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No
	➔	<ul style="list-style-type: none"> Child with mental health concerns can be cared for within the anti-ligature room (if available) Consider removal of bed and a mattress on the floor for safety 	CAHMS concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
In addition to the above Is the child / young person at risk of impact injury and or entrapment?	➔	<ul style="list-style-type: none"> If bed rail protectors / bumpers are to be used, then this must be documented why they are being used, for example, medical condition / requested by parents / carers 	1:1? <input type="checkbox"/> Yes <input type="checkbox"/> No Bumper? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child / young person likely to climb over the bed rails?	➔	In the absence of a paediatric bed, use adult bed at lowest height with bed rails available to use if required. The risks of falls, impact injury and entrapment explained are to parents / carers .	Likely to climb over bed rails? <input type="checkbox"/> Yes <input type="checkbox"/> No

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Is a 'special' mattress required (for example, pressure relieving)?	➔	Please use clinical judgment to assess risk of injury and/ or entrapment of head / neck / torso / limbs from bed rails when using additional mattress due to height increase. Please ensure all risks of entrapment have been explained to parents / carers	Special Mattress? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--	--

**** Children 2 – 3 years** are at risk of climbing and falling out of bed despite bed rails being up or down. Discuss required supervision level and the use of bed rails with the parents / carers to determine each child's safety needs.

Following assessment, the child / young person will be nursed in: (please circle)

* Bassinet * Cot * Paediatric bed * Adult bed

Following identification that a bed is required, please identify the following:
Have the bed and rails been inspected and are in good condition? Yes No

Please circle answers for each box if applicable to obtain risk level	Is the patient on the correct bed for their height and weight?	
	Yes	No
The CYP is at risk of climbing over the bed rails	Bed rails NOT recommended Position bed at lowest level	Bed rails NOT recommended Consider low rise bed, or bed at lowest level
The CYP is NOT at risk of climbing over the bed rails	Bed rails Recommended Use Clinical Judgement	Bed Rails Recommended. Consider risk of entrapment and Impact Injury Use Clinical Judgement
Is there a risk of involuntary movement and risk of falling from the bed?	Bed rails recommended Consider the use of bumpers due to risk of impact injury Bumpers increase risk of entrapment and suffocation Use Clinical Judgement	Use Clinical Judgement Bed rails recommended Consider the use of bumpers due to risk of impact injury. However, consider entrapment and suffocation. Use Clinical Judgement
Is a special mattress in situ?	Bed rails Recommended Use Clinical Judgement	Bed Rails Recommended. Consider risk of entrapment and Impact Injury Use Clinical Judgement

Additional strategies to be used – to be considered for patients at risk of falls, impact injury and entrapment.

1. Bed left at the most appropriate height for patient after care delivery	2. 1:1 supervision delivered by nursing team
3. Use of low-rise bed	4. Use of bumpers
5. Parental supervision	6. Mattress on the floor (CAMHS only)

Manual Handling Screening / Assessment and Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	Postcode:
GP details:	

Weight	Height	BMI
---------------	---------------	------------

Diagnosed Condition	Specify	Improving	Stable	Deteriorating
		(Please circle)		

Global Development Delay Diagnosed	Yes	No
---	-----	----

Communication	Verbal	Spoken language	Non-verbal
Comprehension	Able to understand them – Yes / No		Able to understand them – Yes / No

Postural stability / tone	Head control Yes / No	Trunk control Yes / No	Sitting ability Yes / No	Hypotonic Yes / No	Hypertonic Yes / No
---------------------------	--------------------------	---------------------------	-----------------------------	-----------------------	------------------------

Unpredictability and/or behavioural concerns that may affect safe handling e.g. seizures, involuntary movements	Yes	No
Handling constraints e.g., pressure ulcers, brace callipers splints plasters prosthesis	Yes	No
Restriction of movement e.g., fragile bones, deformity pain joint contracture	Yes	No
Attachments e.g., IV, catheters, monitors, traction	Yes	No

Patient has a normal BMI rating, low level of disability, good comprehension & low level of handling constraints can be handled without risk when employing safe moving and handling principles	Green Score 1-2
Patient has specific needs identified in screening and must be handled in a defined manner check assessment and movement plan	Yellow / Orange Score 3-4
Patients are heavy, high BMI rating, high level of disability, poor comprehension with a high level of handling constraints – check assessment DO NOT HANDLE MANUALLY	Red Score 5-7

The Patients Moving and handling assessment must be updated if conditions change. You only need to amend the details that have changed, and hazard code as required.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Movement Assessment Key		Patient Movement Score
Independent	Complete Independence The young person moves independently, and does not need equipment.	1
	Modified Independence The young person moves independently and needs extra time or equipment.	2
Supervision or set up	Supervision or set up Staff are present but do not need to give physical help. Help by reassuring touch; cueing; coaxing or setting up required items e.g. walking / standing frame. Staff may be present because of safety (risk) considerations.	3
Requires physical assistance from staff	Minimal Physical Assistance The young person requires physical assistance with 1 -2 staff to move. The young person may use a frame or walking aid. The young person can sit / stand / walk / transfer / move self reliably.	4
	Moderate Assistance This young person requires more help than physical assistance from staff; equipment may be needed to move the patient. (May not be reliable in movement or not able to take enough steps to transfer safely) e.g., standing and raising aid hoist.	5
	Maximal Assistance This young person is physically demanding but may be able to roll. They can sit up in bed or sit out in chair e.g., passive hoist; slide sheets; electric bed; chair	6
Name: Date:	Total Assistance This young person is nursed in bed most of the time, all care, complex handling, passive e.g., passive hoist; slide sheets; electric bed	7

Step 1 Movement Assessment and Care Plan

Unit Number: _____ NHS No: _____
 Surname: _____
 First Name: _____ Gender: _____ DOB: _____
 Address: _____
 Postcode: _____
 GP details: _____

Activity		Assessment and Plan	Admission	1st Review
Walking / mobility	Movement level	Independent 1-2	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Supervision or set up to walk 3-4	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Requires physical assistance 5-7	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Circle number of staff required: 0 / 1 / 2 / 3 / 4	0 1 2 3 4	0 1 2 3 4
	Equipment / Additional information	Help with drips / attachments	<input type="checkbox"/>	<input type="checkbox"/>
		Walking aid – specify type:	Specify	Specify
<input type="checkbox"/> Wheelchair / Mobile / Bedside / Chair / Own		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Own clothing / Footwear / Slipper socks		<input type="checkbox"/>	<input type="checkbox"/>	
	Other	Specify	Specify	
Bed mobility	Movement level	Independent 1-2	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Supervision or set up to walk 3-4		
		Requires physical assistance 5-7		
	Staff required	Circle number of staff required: 0 / 1 / 2 / 3 / 4	0 1 2 3 4	0 1 2 3 4
	Specialist mattress	Specify	Specify	
	Slide sheets assigned: <input type="checkbox"/> Yes			
Transfers	Movement level	Independent 1-2	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Supervision or set up to walk 3-4		
		Requires physical assistance 5-7		
	Staff required	Circle number of staff required: 0 / 1 / 2 / 3 / 4	0 1 2 3 4	0 1 2 3 4
	Equipment / Additional information	Passive Hoist:	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Sling size: Small / Med / Large / L/L / X-Large		
		<input type="checkbox"/> Patients own sling	<input type="checkbox"/>	<input type="checkbox"/>
		Loop / clip (please select)	Loop / Clip	Loop / Clip
Safety Check completed for spreader bar change				
<input type="checkbox"/> Sara steady transfer aid	<input type="checkbox"/>	<input type="checkbox"/>		
Sitting transfer board (Banana Board)	<input type="checkbox"/>	<input type="checkbox"/>		
Pat slide and slide sheets	<input type="checkbox"/>	<input type="checkbox"/>		
	Other	Specify	Specify	
Supporting bladder and bowel functions	Movement level	Independent 1-2	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Supervision or set up to walk 3-4	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Requires physical assistance 5-7	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Circle number of staff required: 0 / 1 / 2 / 3 / 4	0 1 2 3 4	0 1 2 3 4
		Independent without supervision	<input type="checkbox"/>	<input type="checkbox"/>
	Equipment / Additional information	Mobile to bathroom with assistant	<input type="checkbox"/>	<input type="checkbox"/>
		Wheelchair to toilet	<input type="checkbox"/>	<input type="checkbox"/>
Commode by bed		<input type="checkbox"/>	<input type="checkbox"/>	
	Manage in bed	Specify	Specify	
	Other	Specify	Specify	
Bathing / Personal Care	Movement level	Independent 1-2	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Supervision or set up to walk 3-4	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Requires physical assistance 5-7	<input type="checkbox"/> Score	<input type="checkbox"/> Score
		Circle number of staff required: 0 / 1 / 2 / 3 / 4	0 1 2 3 4	0 1 2 3 4
	Equipment / Additional information	Bedside wash	<input type="checkbox"/>	<input type="checkbox"/>
		Shower chair	<input type="checkbox"/>	<input type="checkbox"/>
	Bed bath	<input type="checkbox"/>	<input type="checkbox"/>	
	Other	Specify	Specify	
		Name / Signature		
		Designation / Stamp		
		Date / Time		

Activities of Daily Living Assessment

Date of assessment:.....

Time:

Unit Number:	NHS No:
Surname:	Gender: DOB:
First Name:	Address:
	Postcode:
GP details:	

Assessment must be within four hours of admission to Ward 21 or if admitted as an in-patient to a PAU bed. Patient must be reassessed if any significant changes in their condition or every 7 days.

ADL	Child's usual activity	Alteration due to illness	
Breathing			Name:..... Signature: Designation: Date:..... Time: Stamp:
Eating and drinking			Name:..... Signature: Designation: Date:..... Time: Stamp:
Elimination			Name:..... Signature: Designation: Date:..... Time: Stamp:
Communication			Name:..... Signature: Designation: Date:..... Time: Stamp:
Sleeping			Name:..... Signature: Designation: Date:..... Time: Stamp:
Controlling of temperature			Name:..... Signature: Designation: Date:..... Time: Stamp:

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

ADL	Child's usual activity	Alteration due to illness	
Washing and dressing			Name:..... Signature: Designation: Date:..... Time: Stamp:
Mobilisation			Name:..... Signature: Designation: Date:..... Time: Stamp:
Maintain a safe environment			Name:..... Signature: Designation: Date:..... Time: Stamp:
Working and playing			Name:..... Signature: Designation: Date:..... Time: Stamp:
Parental / carer involvement			Name:..... Signature: Designation: Date:..... Time: Stamp:

Pressure Ulcer Risk Assessment

Paediatric assessment adapted from PURPOSE T (V2)

Unit Number:	NHS No:
Surname:	Gender:
First Name:	DOB:
Address:	Postcode:
GP details:	

Step 1 – Screening

Mobility Status – tick all applicable Needs the help of another person to walk <input type="checkbox"/> Spends all or the majority of time in bed or chair <input type="checkbox"/> Remains in the same position for long periods <input type="checkbox"/> Moves independently with or without aids <input type="checkbox"/> If ANY yellow boxes are ticked, go to Step 2	Skin Status – tick all applicable Current PU category 1 or above? <input type="checkbox"/> Reported history of previous PU? <input type="checkbox"/> Vulnerable skin <input type="checkbox"/> Medical device causing pressure/shear at skin site e.g. O ₂ , mask, NG tube <input type="checkbox"/> Normal skin <input type="checkbox"/> If ONLY blue box is ticked If ANY yellow boxes are ticked, go to Step 2	Clinical Judgement – tick as applicable Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids, poor nutrition <input type="checkbox"/> No problem <input type="checkbox"/> If ANY yellow boxes are ticked, go to Step 2 If ONLY blue box is ticked	No pressure ulcer, not currently at risk Tick if applicable <input type="checkbox"/> Not currently at risk pathway
--	---	--	--

Step 2 – Full assessment

Complete ALL sections

Analysis of independent movement Tick the applicable box (where frequency and extent categories meet) <table border="1"> <tr> <th colspan="2"></th> <th colspan="3">Extent of all independent movement Relief of all pressure areas</th> </tr> <tr> <th colspan="2"></th> <th>Doesn't move</th> <th>Slight position changes</th> <th>Major position changes</th> </tr> <tr> <th rowspan="3">Frequency of position changes</th> <th>Doesn't move</th> <td><input type="checkbox"/></td> <td>N/A</td> <td>N/A</td> </tr> <tr> <th>Moves occasionally</th> <td>N/A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <th>Moves frequently</th> <td>N/A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Extent of all independent movement Relief of all pressure areas					Doesn't move	Slight position changes	Major position changes	Frequency of position changes	Doesn't move	<input type="checkbox"/>	N/A	N/A	Moves occasionally	N/A	<input type="checkbox"/>	<input type="checkbox"/>	Moves frequently	N/A	<input type="checkbox"/>	<input type="checkbox"/>	Sensory perception and response – tick all applicable No problem <input type="checkbox"/> Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. paralysis, neuropathy, epidural <input type="checkbox"/>	Moisture due to perspiration, urine, faeces or exudate – tick all applicable No problem / Occasional <input type="checkbox"/> Frequent (2– 4 times a day) <input type="checkbox"/> Constant / nappies <input type="checkbox"/> Diabetes – tick all applicable Not diabetic <input type="checkbox"/> Diabetic <input type="checkbox"/>
		Extent of all independent movement Relief of all pressure areas																							
		Doesn't move	Slight position changes	Major position changes																					
Frequency of position changes	Doesn't move	<input type="checkbox"/>	N/A	N/A																					
	Moves occasionally	N/A	<input type="checkbox"/>	<input type="checkbox"/>																					
	Moves frequently	N/A	<input type="checkbox"/>	<input type="checkbox"/>																					
Perfusion – tick all applicable No problem – Capillary refill <2 secs <input type="checkbox"/> Conditions affecting central circulation e.g. shock, heart failure, hypotension <input type="checkbox"/> Conditions affecting peripheral circulation e.g. meningitis, medication, inotropes <input type="checkbox"/>	Nutrition – tick all applicable No problem <input type="checkbox"/> Unplanned weight loss <input type="checkbox"/> Poor nutritional intake <input type="checkbox"/> <2 centiles below weight <input type="checkbox"/> >2 centiles over weight <input type="checkbox"/>	Medical device – tick all applicable No problem <input type="checkbox"/> Medical device causing pressure / shear at skin site e.g. O ₂ , mask, NG tube <input type="checkbox"/>																							

Vulnerable skin (precursor two PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
 NPUAP / EPUAP Pressure Ulcer Classification System (2009)
 Cat 1 Non-blanchable redness of intact skin
 Cat 2 Partial thickness skin loss or clear blister
 Cat 3 Full thickness skin loss (fat visible / slough present)
 Cat 4 Full thickness tissue loss (muscle / bone visible)
 Cat U (Unstageable / Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment –

tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin	
Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical device skin site					
L Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occipital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
R Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Heel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
L Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
R Ischial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
L Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Step 3 – Assessment decision

If ANY pink boxes are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer. PU Category 1 or above or scarring from previous pressure ulcers Tick if applicable <input type="checkbox"/> Secondary prevention and treatment pathway	If ANY orange boxes are ticked (but no pink boxes), the patient is at risk. No pressure ulcer but at risk Tick if applicable <input type="checkbox"/> Primary prevention pathway	If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk. No pressure ulcer not currently at risk Tick if applicable <input type="checkbox"/> Not currently at risk pathway
--	--	--

Name: Signature: Designation:

Date: Time: Stamp

Step 4 - Pathway

Use Assessment to identify level of risk and pathway required.

Review pathway on transfer, change of condition, or otherwise weekly. Enter Yes / No / N/A to interventions below.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Secondary prevention and treatment pathway Tick which interventions apply		Pathway review	Pathway review
a	Reassess Purpose T on transfer, change of condition / post-surgery / otherwise weekly		
S	Reassess skin twice a day and record (State rationale if reduced to once daily)		
	Check fit and position of any head and neck medical devices or hair devices to reduce risk of skin damage. If high risk of moisture from the device apply 1ml skin protection film. Monitor skin and revise plan if early signs of skin damage.		
	Inform the patient and report pressure ulcers or MASD on datix / safeguard. Check the diagnosis is correct.		
	Complete wound assessment and follow wound assessment guide		
	Refer to wound assessment pathway and care plan and evaluate treatment weekly. Plan wound care using formulary items and evaluate at least weekly		
S	If child sleeps in a cot, check the cot mattress is suitable for the risks / needs		
	If child is nursed on a standard hospital bed – Mattress on hi/lo mode from admission for at least 2 days (unless has an unstable spine refer to spinal pathway or mobile)		
	Record mattress function / type on intervention plan		
	If child is nursed in hospital bed – Use profile of bed for pressure relief to heels / float with device e.g., pillows.		
	Correct seating posture with cushion / bespoke chair. If sitting in chair / wheelchair encourage an upright sitting position and check specification of cushion/ seat is suitable for the needs and risks of the child		
K	Prevent device related skin damage by careful positioning / fit / management		
	Specialist therapy mattress – consult with TVN / Matron		
	Repositioning – a starting point is 2 hourly if any pressure point is damaged. Assess skin tolerance and plan a schedule between 2 - 4 hours. For sacral UN / C3 / C4 Pu's limit the supine / sitting position at meal times for 1 hour until mobility or wound improves. Record if the patient is too unwell to move or has limited positions due to medical needs		
I	Prevent contractures with limb stretching exercises during personal care and refer to a physiotherapist if at risk		
	Moisture associated skin damage prevention commenced		
	Toilet first approach		
	Correct use of containment products (such as pads, sheaths, stoma bags or catheters if deemed necessary)		
	Manage the temperature of the patient to prevent sweat related skin changes.		
N	Wash and dry skin folds		
	Apply skin protection		
	Encourage diet and fluids		
g	Complete food and hydration / fluid balance chart if identified at risk		
	Refer to dietician as per policy		
g	Issue and discuss the pressure ulcer prevention leaflet and verbal duty of candour.		
	Advise patient to inform a nurse of any changes to their skin or management of activities of daily living		
	Name / Signature		
	Designation / Stamp		
	Date / Time		

Step 4 - Pathway

Use Assessment to identify level of risk and pathway required.

Review pathway on transfer, change of condition, or otherwise weekly. Enter Yes / No / N/A to interventions below.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Primary prevention and treatment pathway Tick which interventions apply		Pathway review	Pathway review
a	Reassess Purpose T on transfer, change of condition / post-surgery / otherwise weekly		
S	Reassess skin twice a day and record (State rationale if reduced to once daily)		
	Check fit and position of any head and neck medical devices or hair devices to reduce risk of skin damage. If high risk of moisture from the device apply 1ml skin protection film. Monitor skin and revise plan if early signs of skin damage.		
S	If child sleeps in a cot, check the cot mattress is suitable for the risks / needs		
	If child is nursed on a standard hospital bed – Mattress on hi/lo mode from admission for at least 2 days (unless has an unstable spine refer to spinal pathway or mobile)		
	Record mattress function / type on intervention plan		
	If child is nursed in hospital bed – Use profile of bed for pressure relief to heels / float with device e.g., pillows.		
	Correct seating posture with cushion / bespoke chair. If sitting in chair / wheelchair encourage an upright sitting position and check specification of cushion/ seat is suitable for the needs and risks of the child		
	Specialist therapy mattress – consult with TVN / Matron		
K	Repositioning frequency 4 hourly - increase to 2 hourly in the day if skin becomes red / be aware of darker skin tones		
	Prevent contractures with limb stretching exercises during personal care		
I	Moisture associated skin damage prevention guide commenced		
	Toilet first approach		
	Correct use of containment products (such as pads, sheaths, stoma bags or catheters if deemed necessary)		
	Manage the temperature of the patient to prevent sweat related skin changes.		
	Wash and dry skin folds		
	Apply skin protection		
N	Encourage diet and fluids		
	Complete food and hydration / fluid balance chart if identified at risk		
	Refer to dietician as per policy		
g	Issue and discuss the pressure ulcer prevention leaflet and advise patient to inform a nurse of any changes to their skin or management of activities of daily living		
	Name / Signature		
	Designation / Stamp		
	Date / Time		

Step 4 - Pathway**Use Assessment to identify level of risk and pathway required.**

Review pathway on transfer, change of condition, or otherwise weekly. Enter Yes / No / N/A to interventions below.

Unit Number:	NHS No:
Surname:	Gender: DOB:
First Name:	Postcode:
Address:	
GP details:	

Not currently at risk pathway all interventions apply		Pathway review	Pathway review
a	Reassess Purpose T on transfer, change of condition / post-surgery / otherwise weekly		
S	Reassess skin when Purpose T is completed		
S	Ensure devices fit well		
	Encourage good lying and seating posture		
	Mattress in foam mode		
K	Encourage regular exercise e.g. walking, limb stretching		
I	Assess for moisture associated skin damage when Purpose T is completed		
N	Encourage diet and fluids		
g	Advise patient or primary care giver to inform a nurse of any changes to their skin or management of activities of daily living		
Name / Signature			
Designation / Stamp			
Date / Time			

Mouth Care Risk Assessment

To be completed for every patient on admission and reviewed weekly.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

<p>Mouth care is everybody's responsibility</p> <p>Has the patient got: Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No?</p> <p>Has the patients got a Toothbrush: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provided?</p> <p>Has the patient got Toothpaste: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provided?</p> <p>Denture / Orthodontic appliance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Storage pot? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provided?</p>	<p>Who will be providing the mouth care?</p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Parent / Carer</p> <p><input type="checkbox"/> Staff</p> <p><input type="checkbox"/> Shared care</p>
--	---

2. Mouth assessment				Admission	Reassessment	Reassessment
Enter Low risk (L) Medium risk (M) or High risk (H) in the columns on the right-hand side <input type="checkbox"/>						
The highest score identified on any section will be the overall level of risk for the patient						
	Low Risk (L)	Medium Risk (M)	High Risk (H)			
Lips	Normal colour / moist	Dry / cracked	Swollen / Ulcerated / Bleeding			
Tongue	Pink / moist / clean	Coated / cracked / dry / Red / inflamed	Blistered / ulcerated / swollen / bleeding			
Cheeks / palate gums	Saliva present / clean Looks healthy / moist	Thick / sticky secretions Food debris	Very dry / ulcerated / bleeding Inflamed gums / looks abnormal			
Teeth	Clean	Unclean / generalised plaque	Broken teeth			
Dysphagia (Swallowing)	No difficulties / normal diet and fluids	Some difficulties / Requires assistance to eat and drink	Nil by mouth (excluding pre-procedure) NG or peg fed Dysphagia with any diet and fluid modification.			
Nutritional Intake	Low risk on Nutrition / hydration assessments	Medium risk identified for nutrition / hydration assessment	High risk identified on Nutrition / hydration assessment			
Mucositis	None	Steroid therapy / Oxygen therapy / Diabetes	Chemotherapy Radiotherapy			
Level of support	Independent, fully alert / fully conscious	Some assistance required / mild cognitive impairment	Fully dependent / severe cognitive impairment / sedated / tracheostomy ventilated / unable to communicate			
Additional Information:				Record overall level of Risk:		
				Name / Signature		
				Designation / Stamp:		
				Date / Time		

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

3. Level of action Enter Yes (Y) No (N) or Not Applicable (N/A) in the columns on the right-hand side <input type="checkbox"/> . Any other information should be recorded in the patients' notes.		Review	Review	Review
Low Risk	Patient or primary care giver to brush teeth twice daily with toothbrush and paste (prompt patient if necessary)			
Medium Risk	Support patient with mouth care , brushing twice per day with toothbrush and paste,			
	Removal of dentures and to brush with soap and water, dentures to be left out at night in a dry and labelled denture pot with lid.			
High Risk	Remove any debris and build up secretions from the oral cavity with the single use mouthEze oral cleanser and to provide frequent sips of water given unless nil by mouth (ensure correct consistency).			
	To provide mouth care for patient by brushing teeth twice a day with toothbrush and paste			
	Mouth moisturising gel should be applied using the green oral care swab sponge (single use) to any dry areas of the mouth, including the tongue, palate, cheeks, gums and lips.			
	Remove debris or build-up of secretions from oral cavity with single use mouthEze oral cleanser.			
	Use suction when brushing teeth if patient is high aspiration risk.			
	Refer to doctor / dentist if there any of the following are present: Painful lips / teeth or gums / facial swelling / swollen lips / tongue looks abnormal / white coating / wide spread ulceration or mouth ulcer present ≥ 2 weeks / anti-inflammatory or antifungals / mouth spray are required / dysphagia suspected.			
	Name / Signature			
	Designation / Stamp			
	Date / Time			

Additional Information:

.....

.....

.....

.....

.....

.....

.....

.....

Screening Tool for the Assessment of Malnutrition in Paediatrics

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Step 1 – Diagnosis	
Does the child have a diagnosis that has any nutritional implications?	Score
Definitely	3
Possibly	2
No	0
Note: Please see diagnosis table below for assistance.	

Step 2 – Nutritional intake	
What is the child's nutritional intake?	Score
None	3
Recently decreased / poor	2
No change / good	0

Step 3 – Weight and height	
Use a growth chart or the centile quick reference tables to determine the child's measurements	Score
> 3 centiles / columns apart (or weight < 2nd centile)	3
> 2 centiles / columns apart	1
Similar centiles / columns	0

Step 4 – Overall risk of malnutrition	
Add the scores from Steps 1 to 3 together to calculate the overall risk of malnutrition	Score
High risk	≥4
Medium risk	2-3
Low risk	0-1

Step 5 – Care Plan		
Develop a care plan based on the child's overall risk of malnutrition		
High risk	Medium risk	Low risk
<ul style="list-style-type: none"> Refer to a Dietitian, nutritional support team or consultant Monitor and review care plan weekly 	<ul style="list-style-type: none"> Monitor nutritional intake for 3 days Repeat STAMP screening after 3 days Amend care plan as required 	<ul style="list-style-type: none"> Continue routine clinical care Repeat STAMP screening weekly while child is an inpatient Amend care plan as required

Risk Identified

	Admission	Review	Review	Review
Record overall level of Risk:				
Name / Signature				
Designation / Stamp				
Date / Time				

Please use 'Diagnosis Table' on following page to assist with scoring.

Diagnosis Table

To be used to assign a score for
step 1 of STAMP

Unit Number:	NHS No:
Surname:	Gender: DOB:
First Name:	Postcode:
Address:	
GP details:	

Define nutritional implications	Possible nutritional implications	No nutritional implications
<ul style="list-style-type: none"> • Bowel failure, intractable diarrhoea • Burns and major trauma • Crohn's disease • Cystic fibrosis • Dysphagia • Liver disease • Major surgery • Multiple food allergies / intolerances • Oncology on active treatment • Renal disease / failure 	<ul style="list-style-type: none"> • Behavioural eating problems • Cardiology • Cerebral palsy • Cleft lip and palate • Coeliac disease • Diabetes • Gastro-oesophageal reflux • Minor surgery • Neuromuscular conditions • Psychiatric conditions • Respiratory syncytial virus (RSV) • Single food allergy / intolerance 	<ul style="list-style-type: none"> • Day case surgery • Investigations

- While every effort has been made to include diagnoses that have nutritional implications, this list is not exhaustive
- If you have any queries, please discuss them with a Dietitian

STAMP should be used in association with Trust referral guidelines and policies

© 2008 Central Manchester and Manchester Children's University Hospitals NHS Trust
Supported by an education grant from Abbott.
Date Reviewed: September 2021 UK-N/A-2000202 (v2)

Care of the Child Who Requires Vital Signs and Observation Using (PEWS)

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem requires vitals signs and observations carried out
Goal	Ensure’s vital signs and observations are carried out using PEWS (Paediatric Early Warning Score) and remain stable without complications.
	Action
1 requires vitals signs and observations carried out using Paediatric Early Warning Score (PEWS) assessment regularly as dictated by Medical professions / condition dictates, and to be documented clearly on correct age appropriate chart.
2	Vital signs to include and document are; heart rate, respiratory rate, blood pressure, oxygen saturations and temperature. Observations require a clinical judgment and to include assessing levels of consciousness, capillary refill time and acting on staff / carers concerns, a non-physiological parameter which must also be scored is oxygen therapy’s observations must be scored using PEWS and appropriate action taken as set out in the escalation guide on the PEWS chart
3	Ensure Oxygen is available at the bedside. If Oxygen therapy is required ensure it is prescribed as per Medicines Management Policy and Guidelines
4	Ensure Suction is available at the bedside. Consideration of upper airway obstruction / airway secretions should be given for a child whom requires Oxygen due to reduced oxygen saturations or respiratory distress.
5	Ensure’s family are involved in all aspects of care and kept informed at all times. Give appropriate advice and support to the family.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Pain Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	Pain has been identified/reported and assessed using the pain assessment tool. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	Ensure necessary nursing and medical interventions are completed to care for their pain. To be pain free, or reduce pain to a level they are comfortable.
Action	
1	An age-appropriate pain assessment tool should be discussed and documented on the pain assessment chart and PEWS chart.
2	Pain should be assessed and documented at the following times: <ul style="list-style-type: none"> • When observations are taken • When patients have complaints of pain • When administering regular pain analgesia • 60 minutes following administration of pain analgesia or other intervention • If pain develops at a different site
3	Professional measurement from the Nursing or the Medical team of the patient's pain, should be used in conjunction with self- report and physiological signs if applicable.
4	If pain scores indicate mild pain, comfort measures should be attempted, these may include, re positioning, toileting, distraction therapy, parents/carers presence or reducing environmental stress before giving analgesia
5	Parents / carers should be encouraged to contribute to the assessment of their child's pain.

Name:..... Signature:..... Designation:.....

Date:..... Time: Stamp

Breathing Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	A change to normal breathing has been identified. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	Ensure necessary nursing and medical interventions are completed to care for their breathing problem
Action	
1	Assess their vital signs and observations using Paediatric Early Warning Score (PEWS) at regular intervals as dictated by medical professionals / condition, and document clearly on an ageappropriate chart. Escalating deterioration or abnormal PEWS in line with policy.
2	Ensure oxygen and suction is available at bedside. If oxygen is required ensure this is prescribed as per Medicines Management Policy and Guidelines.
3	Nurse in a more upright position when possible. Nurse with cot tilted for babies. For children encourage sitting upright in bed to aid effort of breathing.
4	Administer medication as prescribed as per Medicines Management Policy and monitor for effectiveness of treatment.
5	Assist with medical investigations. All children attending with respiratory symptoms should have viral swabs in line with trust policy / IPC guidelines.
6	Children who have a suspected or confirmed infectious respiratory illness should be isolated or cohort nursed in line with trust policy. Personal Protective equipment (PPE) should be used as advised in trust policy. Additional cleaning following discharge/transfer should be completed in line with trust policy.
7	Ensure and family are involved in all aspects of care and kept informed at all times. Give appropriate advice and support to the family.

Name:..... Signature: Designation:.....

Date:..... Time: Stamp

Eating and Drinking Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	A change has been identified with’s intake. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	Ensure their nutritional needs are met.
	Action
1	Ensure their height and weight is documented. Complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) assessment on admission for all children aged 2 years and above, (iGROW) is for all ages. Escalate and review care appropriately as outlined in STAMP risk assessment.
2	Document their intake and output on appropriate chart. Ensure that any concerns with a reduced intake are escalated to medical clinicians.
3	Provide an appropriate diet for babies under 6 months old should be exclusively fed on breast or formula milk. Children aged 6 months and above should be offered fluid and diet as appropriate for child.
4	If child has any allergies or cultural dietary requirements, ensure these are clearly documented on All About Me board in bedspace. Any child with a known allergy to have a red allergy wristband. Provide assistance to parents when ordering meals to ensure allergens are avoided and cultural needs are met.
5	In children where enteral feeding is clinically indicated: Ensure naso-gastric tube (NGT) is in correct position before feeds. Ensure feed plan as directed by medical clinician or dietitian is followed and documented.
6	If intravenous (IV) fluids are required ensure correct fluids are given in line with Medicines Management Policy. Strict input output monitoring is documented. Whilst intravenous infusion (IVI) required cannula site is visually inspected hourly and documented on fluid chart. IV fluid bag should be changed every 24 hours and IV fluid administration line to be changed every 72 hours as per infection control policy. Ensure all IV lines are labelled.
7	If deemed necessary by clinicians to remain Nil By Mouth (NBM) ensure this clearly documented in notes and on All About Me board in bedspace. If they need to remain NBM for a prolonged period consider the need for alternate hydration such as IV fluids.
8	Ensure’s family are involved in all aspects of care and kept informed at all times. Give appropriate advice and support to the family.

Name:.....Signature:.....Designation:.....

Date:.....Time: Stamp

Elimination Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	Postcode:
GP details:	

Problem	A change in’s elimination has been identified. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	Ensure a healthy and regular bowel and urinary function is maintained.
Action	
1	Monitor their urine output by weighing nappies / pads; if worn or collecting urine in appropriate container. Aim for them to pass 1ml/kg/hour of urine. Escalate urine output to medical clinician if it is less than or greater than 1ml/kg/hr.
2a	Identify their normal bowel movements. Document on stool chart any motions passed. Identify if their having loose stools. If there has been a new onset of Bristol stool chart type 5-7 to send a stool sample and isolate child in line with infection control policy. If there is any suspicion of infectious diarrhoea to follow infection control procedures, using appropriate personal protective equipment (PPE) and enhanced cleaning of the room following transfer/ discharge.
2b	Identify their normal bowel movements. Escalate to medical clinicians if constipation is identified. Ascertain if constipation is long term or a new onset whilst an inpatient. Following medical clinicians plan, ensure support is offered to them and their family in managing constipation with diet / fluid intake and medical management. Offer advice leaflets and referral to constipation clinic where appropriate.
3	Assess pressure ulcer risk in paediatric risk assessment booklet if child is using continence aids. Ascertain their normal continence needs, escalating any concerns if child has a new continence need. Ensure child is using appropriately sized nappy or pad. Ensure that child is having nappy / pad changed at regular intervals and when soiled.
4	Ensure’s family are involved in all aspects of care and kept informed at all times. Given appropriate advice and support to the family.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Unit Number:

NHS No:

Surname:

First Name:

Gender:

DOB:

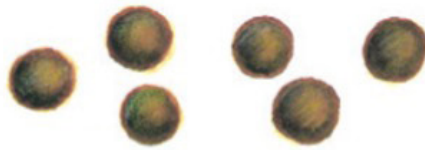
Address:

Postcode:

GP details:

THE BRISTOL STOOL FORM SCALE (for children)
choose your POO!

type **1**



looks like:

rabbit droppings

Separate hard lumps, like nuts (hard to pass)

type **2**



looks like:

bunch of grapes

Sausage-shaped but lumpy

type **3**



looks like:

corn on cob

Like a sausage but with cracks on its surface

type **4**



looks like:

sausage

Like a sausage or snake, smooth and soft

type **5**



looks like:

chicken nuggets

Soft blobs with clear-cut edges (passed easily)

type **6**



looks like:

porridge

Fluffy pieces with ragged edges, a mushy stool

type **7**



looks like:

gravy

Watery, no solid pieces ENTIRELY LIQUID

Communication Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem or their families need support communicating whilst in hospital. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	For and their family to be able to communicate effectively with staff.
Action	
1	Ensure 'All About Me' boards are completed at bed space.
2	Communication aids e.g. Makaton, British Sign Language, Wordskii on wheels (WOW) interpreting system.
3	Identify any neurodiverse needs affecting their communication and involve the Play specialist if required.
4	Provide age-appropriate aids to enable communication.
5	Ensure appropriate referrals made if required to SALT services in a timely manner.

Name:..... Signature:..... Designation:.....

Date:..... Time: Stamp

Care of Child with an Alteration in Sleeping.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem's sleep pattern has altered Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	Encourage normal sleep pattern/environment..
Action	
1	Encourage an environment to induce sleep, changing to a cot/bed if required and safe.
2	Use suitable lighting where appropriate.
3	Encourage visitors to adhere to visiting times.
4	Encourage parents to keep similar routine as to that of home environment.
5	Introduce 'Bring A blanket' initiative

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Control of Temperature Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

ProblemHas a high / low body temperature Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	To stabilise core body temperature to be within normal limits / range.
	Action
1	Record their temperature using age-appropriate thermometer tympanic/axilla.
2	Nurse in cool / minimal clothing in a well-ventilated area with minimal handling.
3	Administer anti pyretics as prescribed per BNFC in line with the medicine management policy, and monitor effects.
4	Encourage oral fluid intake and document on fluid/feed chart.
5	Assist with investigations / collecting specimens and document in the notes.
6	Consider SEPSIS and escalate if necessary, ensuring sepsis bundle is completed.
7	Consider using extra clothing / blankets, cosy therm or transwarmer if cold.

Name:.....Signature:.....Designation:.....

Date:.....Time: Stamp

Washing and Dressing Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem needs assistance with washing and dressing. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	To maintain hygiene and dressing needs.
	Action
1	Support parent / carer in meeting their needs.
2	Use appropriate aids to ensure their safety.
3	Provide appropriate toiletries as required.
4	Encourage to dress in own clothes each day.
5	Ensure the is appropriate access to washing and changing facilities.
6	Appropriate clothing as required.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Mobilisation Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	Assist with.....'s mobilisation. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	To ensure safe mobilisation is maintained.
Action	
1	Encourage safe mobilise as required.
2	Ensure their weight is clearly documented
3	Ensure necessary equipment is available and at the bed side / outside room to assist with their mobility
4	Ensure an assessment by physio and appropriate aids have been identified
5	Ensure safe use appropriate aids prior to discharge.

Name:.....Signature:.....Designation:.....

Date:.....Time: Stamp

Maintaining a Safe Environment Care Plan.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	To maintain a safe environment whilst’s stay in hospital.
Goal	Ensure a safe stay in hospital
	Action
1	Ensure bed rail assessment is completed in risk assessment booklet on arrival to ward. Ensure to follow the “Bedrail decision aid / tool” located in the nursing assessment booklet to consider the risks and benefits for the individual. Bedrail assessment must be reassessed each shift.
2	Ensure RCEM assessment completed on admission if required (Mental Health only).
3	Ensure Safecare is completed and any red flags inputted as appropriate by the nurse in charge.
4	Check Careflow flags for each patient
5	Check CPIS status via the summary care record using a SMART card.
6	Ensure all elements of the nursing documentation is completed for each patient.
7	Encourage 24-hour parental supervision for during their inpatient stay.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Working and Playing Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	To ensure has adequate time and accessibility to the ability to work and play
Goal	To maintain an environment that enables working and playing
	Action
1	Encourage access the outdoor play area, indoor play room with activities and role play and sensory room.
2	Identify the need of play specialist involvement. Including distraction techniques, age-appropriate activities and toys and any learning equipment required.
3	Support with age-appropriate activities and toys.
4	Involve school services where identified.

Name:..... Signature: Designation:.....

Date:..... Time: Stamp

Parental and Carer Involvement Care Plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	Parental / carer involvement to be maintained.
Goal	To ensure.....,s family members and/or carer are kept up to date and involved with their care.
Action	
1	Promote family centred care, to assist with giving cares and medications where required.
2	Ensure 'All About Me' boards are completed on admission.
3	Ensure family and friends feedback is obtained during stay in hospital and any concerns dealt with in a timely manner.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Care of Child with Safeguarding Concerns.

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	A Safeguarding concern has been identified. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	To identify safeguarding concern. Manage safeguarding concerns appropriately whilst on PAU / Ward and ensure a safe discharge is completed.
	Action
1	Ensure’s demographic details are correct and documented at point of admission, including social worker name and contact numbers.
2	Ensure a verbal referral to social services has been made and documented accordingly.
3	Check CPIS status via Summary Care Record.
4	Contact medical photography if required.
5	Ensure body mapping completed if required.
6	Ensure child Protection medical paperwork completed if required.
7	Liase with Walsall hospital Safeguarding teams.
8	Liase with social services to ensure safe discharge.
9	Ensure documentation is clear, eligible and up to date.

Name:..... Signature: Designation:.....

Date:..... Time: Stamp

Care of the Child Requiring Safe Discharge

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem requires a safe discharge
Goal	Ensure all arrangements for’s discharge from hospital are completed as planned.
	Action
1	Ensure..... is safe for discharge as planned, agreed and documented by medical professionals in medical notes. Ensure safeguarding care plans are completed as required and communication has been made to relevant professionals to agree a safe discharge. Keep clear and accurate records of all communication prior to discharge.
2	Ensure electronic Discharge Summary (EDS) is completed by Medical Professionals and medications are requested in a timely manner at the earliest opportunity from pharmacy as required.
3	Ensure To Take Out medication (TTO) is given with full explanation to include safe administration, duration, possible side effects, storage and disposal
4	Ensure all referrals; out-patient appointments, MDT referrals, HAH referrals are either requested in communication folder to be made or made and sent as requested by medical professionals.
5	Ensure patient information leaflet is given upon discharge as required, to include further treatment plan, symptoms, management, who, when and where to seek medical advice from. Ensure open access to include Paediatric Assessment Unit (PAU) contact number has been given to the parent / carer and duration of open access as agreed by medical professional
6	Ensure nursing discharge summary is completed in full and signed by the health professional and parent / carer upon discharge and placed in medical notes and paediatric liaison folder (ensure consent is obtained for information sharing). Nursing discharge summary should be given in addition to EDS. If discharged by unregistered nurse then primary nurse to oversee discharge.

Name:.....Signature:..... Designation:.....

Date:.....Time: Stamp

Mental Health Care plan

Unit Number:	NHS No:
Surname:	
First Name:	Gender: DOB:
Address:	
	Postcode:
GP details:	

Problem	Mental Health concern has been identified. Yes <input type="checkbox"/> No <input type="checkbox"/>
Goal	To identify any mental health concerns. Ensure safety is maintain whilst on PAU / Ward and ensure a safe discharge
	Action
1	Ensure’s demographic details are correct and documented at point of admission, including social worker / CAMHS worker name and contact numbers.
2	Ensure a verbal referral to social services has been made and documented accordingly.
3	Ensure an EMARF is completed and log number documented, and a copy is filed in medical notes.
4	Check CPIS status via Summary Care Record.
5	Nurse in anti- ligature room where available if applicable
6	Ensure written / verbal referral / contact is made with ICAMHS.
7	Liase with Walsall hospital Safeguarding and Mental Health teams.
8	Liase with social services and ICAMHS to ensure safe discharge.
9	Ensure the ‘Child and Young Person Crisis Pathway’ (RCEM) is completed.
10	Ensure CAMHS referral completed.

Name:..... Signature: Designation:.....

Date:..... Time: Stamp

Ward 21 Nursing Discharge Checklist

Discharge Date:

Discharge Time:

Unit Number:	NHS No:
Surname:	Gender: DOB:
First Name:	Postcode:
Address:	
GP details:	

	Yes	No	N/A
EDS Patient copy and notes copy			
Discharge observations completed			
Cannula removed			
TTO's / Patient own medications checked by 2 nurses and returned to patient			
'Medicines for children' Patient information leaflet given			
'Healthier together' patient information leaflet given			
Asthma bundle in admission pack completed			
Community midwife / Health visitor informed of discharge			
Open access form given			
Patient feedback iPad / QR code given			
Outpatient appointments added to diary			

Name: Signature: Designation:

Date: Time: Stamp

BLANK PAGE NOT FOR COMPLETION

BLANK PAGE NOT FOR COMPLETION

Bed Grab Handles Assessment in the Community Setting

Bed grab handles (including bed levers, bed sticks) assessment to be completed at point of initial assessment, every 12 months and subsequently if patients condition changes / deteriorates e.g. if patient has had a fall.

Unit Number:	NHS No:	
Surname:	Gender:	DOB:
First Name:	Postcode:	
Address:		
GP details:		

DO NOT use bed grab handles if the following apply:

- If the patient has the potential to climb out of bed due to their confused state
- To restrain a patient e.g., to keep an agitated patient in bed or if there is risk of entrapment
- **If the patient has atypical adult anatomy i.e. If the patient weighs less than 40kg and / or is less than 1.46m in height.**

Step 1 Use the bed grab handles risk matrix tool below, to consider the risks and benefits for individual patients. The colour codes should be used as guidance only.

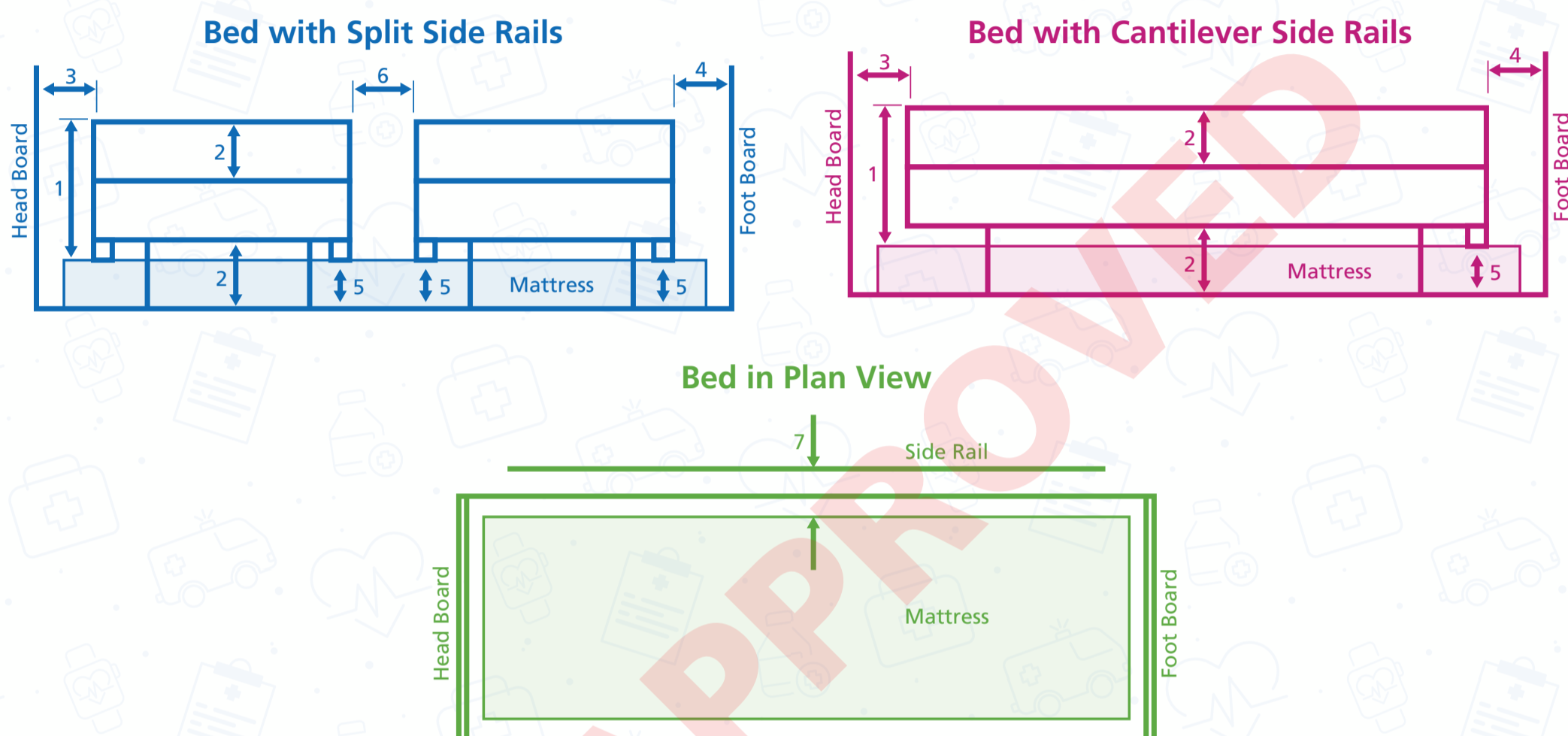
Bed Grab Handles Decision Aid				
		Mobility		
		Patient is immobile (Bed rest or hoist dependant)	Patient has reduced mobility. Requires assistance to mobilise / transfer	Patient can mobilise / transfer without help from staff
Mental State	Patient is confused/ agitated	Bed grab handles NOT recommended. Ensure appropriate bed height.	Use bed grab handles with care. Ensure appropriate bed height.	Bed Grab handles recommended.
	Patient is drowsy	Bed Grab Handles Not recommended		
	Patient is orientated and alert	Use bed grab handles with care to aid with repositioning.	Bed grab handles recommended	Bed grab handles recommended
	Patient is unconscious/sedated	Bed Grab Handles Not recommended		

Step 2 Additional considerations: e.g patients at risk of falls

1. Ensure suitability of environment and level of supervision	3. Discuss with the patient / carer on strategies used pre assessment
2. Ensure bed at suitable height; applicable for all profiling, standard divan and slatted beds	4. Consider other furniture, body positioning and other devices e.g pillows/bed wedges/pendant alarms/falls alarms
5. Medical considerations; e.g. weight bearing status, fluctuated cognition, sensory deficit	6. Placement of bed grab handle re distance from wall/head end of the bed re entrapment risk

Adult Bed Rail Types

- Consider the risk and benefits of using bed or trolley rails
- Consider alternative strategies for patients at risk of impact injury, entrapment, climbing over
- Bed rails must not be used for restraint or to restrict independence



Description	Diagram Reference	BS EN 60601-2-52:2010	Notes
Height of the top edge of the side rail above the mattress without compression	1	≥ 220mm	Where a speciality mattress or mattress overlay is used and the side rail does not meet ≥ 220mm a risk assessment shall be performed to assure equivalent safety
Gaps between elements within the perimeter of the side rail and between the side rail and mattress platform	2	< 120mm	
Gap between headboard and end of side rail	3	< 60mm	Most disadvantageous angle between headboard and side rail
Gap between foot board and end of side rail	4	< 60mm OR > 318mm	Most disadvantageous angle between foot board and side rail
Distance between open end of side rail(s) and mattress platform	5	< 60mm	The gap between the open end of the side rail and headboard is not relevant to this position reference
Gap between split side rails	6	< 60mm OR > 318mm	When in most disadvantageous position
Gap between side rail and mattress in 'plan' elevation	7	Perform test	120mm aluminium cone is positioned between mattress and side rail to determine if gap is acceptable or not.

For more information, visit:

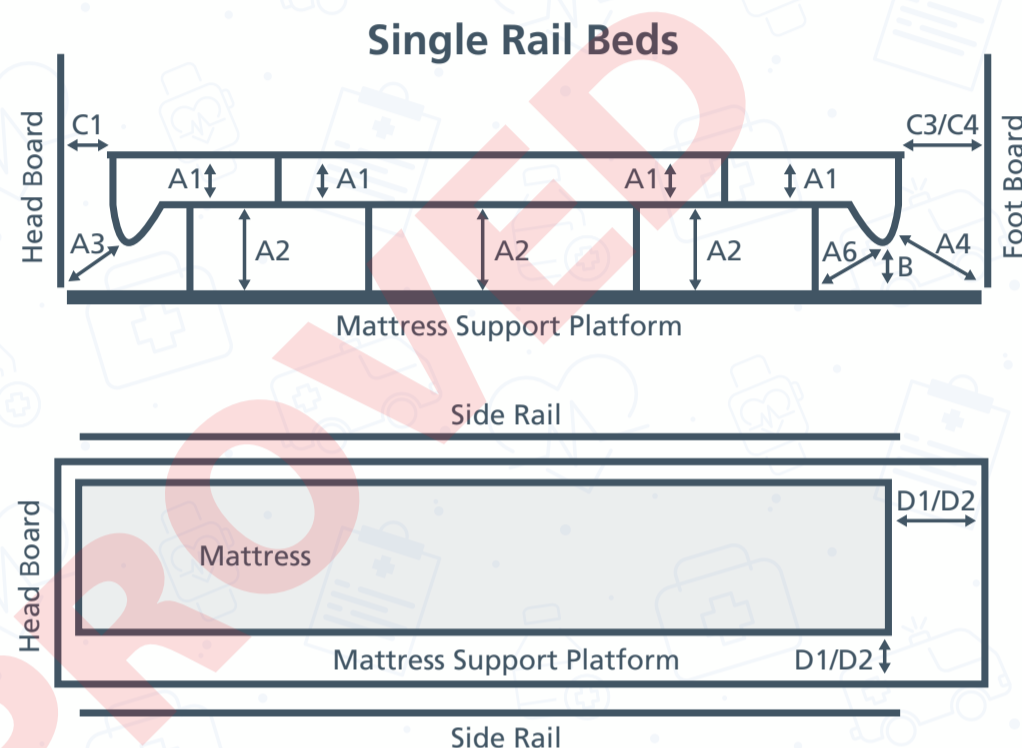
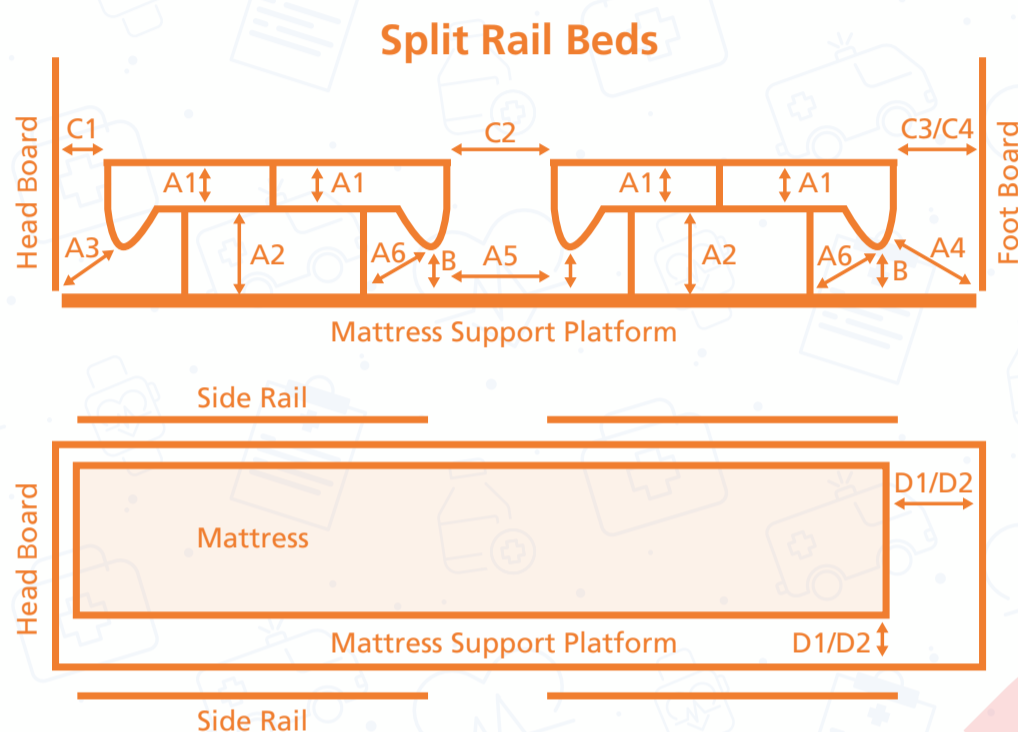
<https://www.gov.uk/guidance/bed-rails-management-and-safe-use>



Paediatric Bed Rail Types

This will also apply to patients under 40kg or less than 1.46 metres

- Consider the risk and benefits of using bed or trolley rails
- Consider alternative strategies for patients at risk of impact injury, entrapment, climbing over
- Bed rails must not be used for restraint or to restrict independence



Description	Diagram Reference	BS EN 50637:2017	Notes
Fully enclosed openings within a side rail, head/foot board, mattress support platform	A1	<60mm	
Fully enclosed opening defined by the side rail, its supports and the mattress support platform	A2	<60mm ⁷	
Partially enclosed opening defined by the head board, mattress support platform and side rail	A3	<60mm	
Partially enclosed opening defined by the foot board, mattress support platform and side rail	A4	<60mm	Except when gap between side rail and foot board is >300mm
Partially enclosed opening between segmented or split side rail and the mattress support	A5	<60mm	Except when gap between side rails is >300mm
Partially enclosed opening defined by lowest point of a side rail, the adjacent side rail support and mattress support platform, to the outside of the side rail supports	A6	<60mm	
Other openings defined by accessories (e.g. IV poles, fracture frames) and side rails, head or foot boards and or mattress support platform. Not shown in figures.	A	<60mm	
Distance between mattress support platform and the lowest point of the side rail outside the side rail support AND The angle between the side rail and mattress support platform at the range of the mattress height defined by the manufacturer ± 2 cm	B	<40mm AND Angle between mattress support platform and side rail interface >75° over the entire range of mattress heights from minimum recommended height minus 2 cm to the maximum recommended mattress height plus 2 cm.	
Gap between head board and adjacent side rail	C1	<40mm	
Gap between segmented or split side rails with both side rails raised	C2	<40mm OR >300mm	For a gap >300mm: the gap shall be >300mm or <400mm for the entire vertical distance
For all medical beds except junior beds: gap between side rail and foot board. Other openings defined by accessories (e.g. IV poles, fracture frames etc.) and side rails, head board, foot board, and or mattress platform	C3	<40mm	
For junior beds: gap between side rail and foot board. Other openings defined by accessories (e.g. IV poles, fracture frames etc.) and side rails, head board, foot board, and or mattress platform	C4	<40mm OR >300mm	For a gap >300mm: the gap shall be >300mm or <400mm for the entire vertical distance
Region defined by side rail/head board/foot board and the mattress for cribs and cots	D1	Perform test	Cone tool does not sink below the mattress surface by 50% or more of its 60mm diameter.
Region defined by the side rail/head/foot board and the mattress for junior beds and oversize cots	D2	Perform test OR Gap between side rail/head/foot board and mattress <30mm	Cone tool does not sink below the mattress surface by 50% or more of its 60mm diameter.

For more information, visit:

<https://www.gov.uk/guidance/bed-rails-management-and-safe-use>




Our Safe and Effective Use of Bed Rails Policy

1  Assess all patients in all areas

2  Assess on admission, transfer, change in condition, each shift, post fall.

3  Every 28 days as a minimum in the community.

4  The risk assessment must focus on the individual patient.


5  Consider height and weight. Less than 1.46 metres and/or 40kg – adult bed or trolley rails are not appropriate.

6  Consider mitigation and alternatives, low rise bed, crash mats, bumpers, supervision.

7  Discuss the decision for rails with the patient, carer, relatives.

8  Document decision and action in the patient record.

9  Communicate the risks, plan and actions at handover and during safety huddles.

10  Document need for bed rails on SBART. Escalate any unmitigated risk, document and incident report.

11  Use bed or trolley rails when transporting a patient to another department.