Yes, You Can Use Side Rails. But . . .
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Health Facilities Surveyor

Many skilled nursing facilities have chosen to become restraint free, but continue to use side rails for various reasons, such as allowing the resident to maintain independence in bed mobility. Side rails pose a significant risk for entrapment, and care must be taken to ensure resident safety. The potential for injury is greater when a fall occurs from a bed with elevated side rails when the resident attempts to climb over, around or between the rails, than from a bed without side rails.

Many factors need to be considered before making the decision to use side rails. The process starts with assessment. Use of side rails should be based on the resident’s medical needs and be reassessed on a regular basis and with any change in condition. All side rails, including those used to aid mobility, transferring, and repositioning, should be addressed on the resident’s care plan. Documentation should include education of the resident or responsible party regarding the risks versus benefits of side rail use. Attempts should be made to use the least restrictive device necessary to meet the resident’s needs. Immediately reassess the safety if an episode of entrapment or near entrapment occurs, with or without injury.

In the past 21 years, the US Food and Drug Administration (FDA) received 691 entrapment reports, 413 of which resulted in death. Entrapment is most likely to occur with a frail, elderly resident. Residents may attempt to exit the bed due to confusion, pain, hunger, thirst and/or the need for repositioning or toileting.

The FDA has identified zones that present a risk for entrapment. The FDA provides dimensional recommendations for zones 1 through 4 since 80 percent of entrapment cases have occurred in these areas.

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Zone 1: Within the rail – any open space between the perimeters of the rail can present a risk for head entrapment. Recommended space: less than 4 ¾ inches.

Zone 2: Under the rail, between rail supports, or next to a single rail support – the gap under the rail between the mattress and the bottom edge of the rail may allow for head entrapment. Recommended space: less than 4 ¾ inches.

Zone 3: Between the rail and the mattress – if too large it can create a risk for head entrapment. Recommended space: less than 4 ¾ inches.

Zone 4: Under the rail at the ends of the bed – a gap between the mattress and the lower portion of the rail poses a risk of neck entrapment. Recommended space: less than 2 3/8 inches.

Zone 5: Between split rails – when partial or split rails are used on the same side of the bed, the space between the rails may present a risk for neck or chest entrapment.

Zone 6: Between the end of the rail and the side edge of the head or footboard – a gap between the end of the rail and the side edge of the head or footboard can present the risk of resident entrapment.

Zone 7: Between the head or footboard and the end of the mattress – when there is too large of a space between the inside surface of the head or footboard and the end of the mattress, risk of head entrapment increases.

Creating a safe resident environment does not necessarily rule out the use of side rails. The decision to use side rails should be based on assessment and identification of the resident’s needs and include a risk versus benefit analysis. Detailed information regarding entrapment, resident assessment, care planning, and assessing facility beds may be found at: www.fda.gov/cdrh/beds/guidance/1537.html.

Note: Side rails may also be considered a restraint. In that case, follow your facility policy for restraint use.

References:
Direct Supply, Beds & Entrapment: What You Need to Know to Reduce Your Risk
The goal of resident transfers in long term care facilities is generally to move the resident from one surface to another to accomplish a resident care task in an efficient manner that is safe for the resident and staff. A variety of methods, techniques and equipment may be used. Mechanical assistive devices for transfer may include portable total body sling lifts, sit-to-stand lifts, and transfer or gait belts.

The assistive devices and equipment can help residents move with increased independence, transfer with greater comfort, and feel more physically secure. Training of staff and residents on the proper use of assistive devices, equipment, and safe transfer techniques is important to prevent accidents and injuries.1

The State Operations Manual, Appendix PP, at F323, states “The facility must ensure that (1) the resident environment remains as free from accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents. The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. . . .”1

During the calendar year 2008, the North Dakota Department of Health, Division of Health Facilities, cited long term care facility deficiencies at F323 on 32 occasions. Of those, nine (28.1%) were related to improper transfers or improper use of portable total body sling lifts, sit-to-stand lifts, or transfer and gait belts, which resulted in actual harm or placed residents at risk of actual harm.

This article will provide a brief overview of the use of these assistive devices and key points in their use. Key points with any of these devices are RESIDENT ASSESSMENT for the most appropriate use and STAFF EDUCATION in the equipment use.

TOTAL BODY SLING LIFTS
A variety of manufacturers are available. The sling is placed under the resident while in bed or in a sitting position. The sling is attached to the lift apparatus. Key points include:
- Sling size appropriate to the resident.
- Resident properly positioned in the sling.
- Securely fastened sling attachments to the lift apparatus.
- Appropriate numbers of staff for the resident’s needs.
- Avoid using the lift as a transport device.
- Documented preventive maintenance of the sling and lift according to manufacturer’s recommendations.

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SIT-TO-STAND LIFTS
A variety of manufacturers are available. The resident must bear weight on at least one lower extremity. If weight bearing is restricted on the remaining extremity, an approach must be developed, care planned, and FOLLOWED to accommodate this restriction. The resident’s feet are placed on a foot plate or platform and the resident’s knees placed against a padded knee board. The resident grasps a set of handle bars and a sling apparatus is placed around the upper back and under the resident’s arms and attached to the lift. The lift apparatus lifts the sling, bringing the resident to a partial standing position, and the resident is wheeled to a wheelchair, commode, toilet, bed or other surface.

- The resident must be in a sitting position.
- The resident must be weight bearing on at least one lower extremity.
- The resident’s hip, knee and ankle range of motion must be sufficient to allow a partial standing position.
- The resident’s feet must be positioned appropriately on the foot plate or platform.
- If the resident cannot or will not grasp the handle bars, the resident may feel as if they are “hanging” in space, creating apprehension and possible shoulder discomfort and injury. Some degree of resident participation is necessary.
- The resident’s upper extremity range of motion must be sufficient to allow reaching to the handle bars.
- The resident’s knees and the knee board must be appropriately positioned.

- Securely fastened sling attachments to the lift apparatus.
- Appropriate numbers of staff for the resident’s needs.
- Avoid using the lift as a transport device.
- Documented preventive maintenance of the sling and lift according to manufacturer’s recommendations.

GAIT OR TRANSFER BELTS
A variety of styles, manufacturers and suppliers are available. The belts are generally of heavy web construction with a buckle or quick-releasing attachment. The belts are used to assist residents for standing transfers and during ambulation.

Begin with the resident in a sitting position. To keep the belt securely in place, the belt should be snugly placed low over the waist, below the abdomen. Let the resident know what the caregiver will be doing and what is expected or desired of the resident. The caregiver should grasp the belt at the resident’s side or back for a lifting motion and assist the resident to a standing position. DO NOT PULL OR LIFT ON THE RESIDENT’S ARMS OR SHOULDERS. This may cause pain or even shoulder dislocation.

During ambulation, the purpose of the belt is to provide the resident with support and a means to lower the resident to a sitting position without pulling or lifting on the arm or shoulder. The intent of the belt is not to be the sole point of support.

- The belt must be snugly fastened, but not cause the resident pain.
The belt should be low at the waist. As an individual stands from a sitting position, the trunk lengthens, the waist becomes smaller, and, if too low, the belt will slide up under the resident’s arms.

Let the resident know what is going on.

Ask the resident to help as much as he or she can.

Use a firm underhand grasp at the back or the side of the belt for the most support in a “lifting” motion rather than in the front in a “pulling” motion.

DO NOT PULL OR LIFT ON THE RESIDENT’S ARMS OR SHOULDERS.

The belt is not intended to be the caregiver’s sole point of support for the resident. The resident must be able to provide some support by weight bearing.

Appropriate number of staff for the resident’s needs.

Documented preventive maintenance of the belt according to manufacturer’s recommendations. The belts do become frayed and worn.

The belt on the resident’s bathroom door or around the caregiver’s waist does not benefit the resident unless it is used on the resident.

Accomplishing resident transfers in a safe, efficient manner can be a challenging task in any long-term care facility. Residents are not always cooperative and situations are not perfect. Each facility establishes its own policies, procedures and criteria to accomplish these tasks. This article is meant to provide a limited overview of key points that facilities and staff should consider in this process.

1 State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, 483.25(h) Accidents, 08/17/07.

On March 9, 2009, Bruce sent via email a small “word” table to each NH administrator. The table can be used in lieu of a phone call for the initial abuse allegation report. Send the table back to Bruce via email. Your final investigation report still should be sent or faxed to Bruce.

Call if you have any questions regarding allegation and/or need to report.

Written Investigation Report (within five working days).

Mail to: Bruce Pritschet
North Dakota Department of Health
Division of Health Facilities
600 E Boulevard Avenue Dept 301
Bismarck, ND 58505-0200
Fax: 701.328.1890 Attn: Bruce Pritschet
Must be followed by mailing of a signed “Hard copy” of the report.
RAI UPDATE
By Joan Coleman
State RAI Coordinator
It is important to not take any directions about how to complete the MDS from the assessment form. The MDS assessment form has not been updated for many years and contains directions that are no longer applicable. The correct coding directions and explanations are found only in the RAI User’s Manual and the succeeding updates that have been published since December 2002.


CERTIFIED NURSE AIDE REGISTRY UPDATE
By Cindy Kupfer and Rocksanne Peterson
The North Dakota Department of Health Nurse Aide Registry website www.ndhealth.gov/HF/ is an official verification method. This is the same information you would receive verbally from the registry.

If you are a candidate for testing, please call either the North Dakota Board of Nursing at 701.328.9777 or Headmaster at 800.393.8664. Both testing vendors are comparable in price and tests.

QUOTES:
You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You are able to say to yourself, ‘I have lived through this horror. I can take the next thing that comes along.’ You must do the thing you think you cannot do.

By Eleanor Roosevelt

The Centers for Medicare and Medicaid Services (CMS) released the latest revisions to the Long-Term Care Facility RAI User’s Manual with a date of December 2008. Although dated December 2008, CMS did not post these updates until February 2009. These latest revisions and the Long-Term Care Facility RAI User’s Manual can be found at this CMS website: www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp

MDS 3.0 Implementation
CMS planned to implement MDS 3.0 on Oct. 1, 2009. Due to concerns voiced by states, providers, and other stakeholders about this implementation date, CMS has officially decided to revise the MDS 3.0 implementation date to Oct. 1, 2010. The State RAI Coordinators were informed of this in March. In the coming days, CMS plans to begin announcing this to states, providers and other stakeholders.