STANDARDS

This protocol specifies the conditions / situations in which enablers (equipment, devices or furniture, voluntarily used by a patient following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence, comfort and / or safety *RMSP NZS 8134.0:2008*) are used and ensures compliance with the Bay of Plenty District Health Board (BOPDHB) policy 1.2.4 Restraint Minimisation and Safe Practice.

Enablers may be used when required to facilitate treatment delivery / investigations where movement may increase the risk of injury to the patient or impede the recording of investigations necessary to improve health state. Verbal agreement by the patient or representative is required and any risks explained. Use of enabler should be documented within the patient's care plan and observations carried out as described for each enabler. If required a Falls Risk Care Plan should be completed.

Examples:

1. A patient voluntarily uses bed rails to assist their mobility in bed, to aid in the positioning of pillows for comfort or to prevent them falling from bed (*RMSP NZS 8134.0:2008*)
2. A patient voluntarily uses a fixed tray in front of their chair to assist them to have a meal independently (*RMSP NZS 8134.0:2008*)
3. Equipment, devices or furniture is used, following appropriate assessment, to assist in the physical positioning of a patient without limiting their normal freedom of movement. These interventions are not considered a form of restraint, but rather a normal component of the patient's day to day life (*RMSP NZS 8134.0:2008*)

APPROVED ENABLERS IN BOPDHB – refer to Appendix 1

- Splints (Adult / Paediatric)
- Limb Enabler
- Bedrails / Cot Sides (Paediatrics)
- Personal Safe Hold (Child)
- Lap Belts
- Mittens / Boxing Glove bandaging
- Specialist Chairs
- Personal Safe Hold (Adult)
- Paediatric Pigg-0-stat Device

STANDARDS TO BE MET

1. The techniques used are to be carried out in a safe and controlled manner, with emphasis on maintaining patient safety and not causing any additional harm. An explanation of the personal hold will be given to the patient at the outset where possible.
2. Assessment should be completed in partnership with patient, family / whānau, and significant others. This shall ensure cultural considerations, respect for dignity, patients privacy and choices are met. This shall also assist to identify triggers and alternative options.
3. Obtain related assessments from the multidisciplinary team into factors such as pain, which may be exacerbating the patient's agitation or restlessness.
4. Ensure there is a documented comprehensive Care Plan that includes rationale and monitoring to prevent injury or discomfort.
5. Check and monitor patient for any negative effects such as increased incontinence, pressure areas, muscle atrophy, decreased muscle tone and strength, contractures, loss of ability to walk and loss of autonomy.
6. Psychological, cultural and spiritual factors also need to be considered.
7. Any signs of agitation, stress or discomfort must be reported to the nurse in charge immediately.

8. Wherever possible continue to work in partnership with patient, family / whānau, and significant others.
9 If unsure whether Personal hold is an enabler or restraint always complete an Incident Management Form.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Restraint Minimisation & Safe Practice controlled documents
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.D1.1 Delirium, Dementia and Depression in Older Adults – Care Guidelines
- Bay of Plenty District Health Board policy 0.0 Glossary of Terms / Definitions
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 2.1.1 Risk Management
- Bay of Plenty District Health Board policy 2.1.2 protocol 2 Controlled Document Development Standards
- Bay of Plenty District Health Board policy 2.1.2 protocol 6 Controlled Document Review Standards
- Bay of Plenty District Health Board policy 2.1.3 Hazard Management
- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 5.4.7 Threatening Behaviour, Bullying, Harassment and Violence in the Workplace - Management
- Bay of Plenty District Health Board policy 7.104.1 protocol 3 Care Delivery – Observing Patients
- Bay of Plenty District Health Board Practice of Restraint Advisory Group (PRAG) Terms of Reference
- Bay of Plenty District Health Board Incident Management Form

Appendix 1
Enabler Classification Tool

Type	Usage	Application	Observation and monitoring	Documentation
Bedrails / padded rails. **Cot sides** in paediatrics	• To prevent patient accidentally falling from bed. • Normal practice in Emergency Department, Paediatrics, ICU and Perioperative Care. • **NB. Not to be used solely as the means to prevent patient climbing out of bed.**	• Transporting of patients. • Anaesthetised or sedated patients • Supporting pillows. • Distorted body image	• Minimum ½ hourly visual checks. • Minimum 2 hourly check for food, fluids, toileting, and pressure areas. • Bed placed at its lowest position following any cares or interventions. • **Check appropriateness if patient confused and at risk of climbing out of bed.** • Assess if delirium present and if so refer to Delirium protocol	• Falls Risk Care Plan • Generic Care Plan • Patient's health record • CPM.D1.1
Lap belts	• For patients with poor trunk control to prevent accidental falling / slipping out of chair or wheelchair. • Patients who need to be correctly positioned in wheelchairs	• As part of a falls prevention programme • By prescription of Occupational Therapist only	• Ensure no excess pressure on patient. • Minimum ½ hourly visual checks. • Observe for physical discomfort and offer assistance with personal requirements. • Minimum 2 hourly checks for toileting, offering food, fluids and pressure areas.	• Falls Risk Care Plan • Generic Care Plan • Patient's health record
Limb enablers: • Dressing-soft gamgee padding and soft bandaging • Soft Velcro padded limb enabler	• To prevent paediatric or confused patients from: – Pulling at medical devices (IV, NG etc.) – Pulling off dressings – Grabbing, – hitting or scratching	• Apply firmly without interfering with circulation. • Ensure 2 fingers can be inserted. • Allow as much limb movement as possible.	• Minimum 1 hourly check for skin integrity. • Remove when patient co-operative.	• Generic Care Plan • Patient's health record

Type	Usage	Application	Observation and monitoring	Documentation
Mittens / boxing glove bandaging: • Tubigrip • Gauze or cotton wool padding • Bandages • Tape	• To prevent paediatric or confused patients from: – Pulling at medical devices (IV, NG etc.) – Pulling off dressings – Grabbing, hitting or – Scratching	• Hands to be padded with bulky gauze in "resting" position then firmly but not tightly bandaged to form a 'boxing glove'. Tape in place carefully to ensure it is not too tight.	• Bandage should be removed at least 2 hourly during the day or when awake for inspection of warmth, colour, movement and sensation of hands and to provide hygiene requirements. Finger movement should be encouraged at this time. • While patient is asleep boxing glove bandaging can remain in place. • Remove during meal times if appropriate and while under constant supervision (family or staff) • Report any pain, swelling or impaired circulation to medical staff and complete an Incident Management form.	• Generic Care Plan • Patient's health record
Paediatric Personal Safe Hold for treatment delivery	• To prevent injury to child during procedures / diagnostic interventions and or examinations. • Technical holding for lumbar punctures or cervical spine stabilisation. • Insertion of NG tubes, cannulae, sutures or venepuncture • Administration of medications	• To keep patient still during procedure. • Technical positioning using appropriate technique. • Staff or parents (if appropriate) can hold child. • Blanket may be used if appropriate to wrap child.	• Ensure no excess pressure on patient • Ongoing communication • Monitor for bruising	• Care Plan • Patient's health record
Paediatric Pigg-o-stat Device	• To allow chest x-ray of 0 - 2 year olds.	• **Radiology only.**	• Ensure careful explanation and support given to parents along with information leaflet.	

Type	Usage	Application	Observation and monitoring	Documentation
Personal Safe Hold Treatment delivery for Adults	• To prevent injury to patient during procedures / diagnostic interventions and or examinations. • Technical holding for lumbar punctures or cervical spine stabilisation. • Insertion of NG tubes, cannulae, sutures, venepuncture • Administration of medications.	• To keep patient still during procedure • Technical positioning using appropriate technique	• Ensure no excess pressure on patient • Ongoing communication • Monitor for bruising	• Patient's health record
Specialist Chairs Examples: • Wheel chairs • Lazy-boys • Chairs with a fixed table or pushed under a table for meals or activities	• Used for patients with reduced postural stability	• As part of falls prevention • To prevent patient slipping down / out of chair	• Ensure no excess pressure on patient • Minimum ½ hourly visual checks • Observe for physical discomfort and offer assistance with personal requirements • Minimum 2 hourly checks for toileting, offering food and fluids, mobilising / physiotherapy • Remove patient from specialist chair every 2 hours • Offer alternative activities while patient in chair	• Falls Risk Care Plan • Generic Care Plan • Patient's health record
Splints (Adult or Paediatric) • Velcro fastening band • Tubigrip or similar • Padded wooden splints / plastic splints • Crepe / Elastic Bandage	• For prevention of interfering with lines / wounds • To prevent limb shortening • To be used in conjunction with existing treatment policies to facilitate the safe delivery of clinical intervention and to prevent injury during treatment.	• Select appropriate equipment. • Application under the direction of a registered health professional	• Splints and limbs to be checked on a regular basis, according to the individual care plan and / or health record. • All checks should be performed 2 hourly minimum. • Wherever possible continue to work in partnership with patient, family / whānau, significant others.	• Care Plan • Patient's health record