PERSONAL CARE HOME/ TRANSITIONAL CARE UNIT
INTERIM RESTRAINT ASSESSMENT TOOL
Admissions with pre-existing restraints

ADDRESSOGRAPH

Complete this tool when a resident is admitted with a restraint already in use. This form must be signed with designation, dated and kept in the health record.

1. Check those restraints already in use:

- ☐ Chair tray
- ☐ Hand mitts
- ☐ Mobility restricting chairs
- ☐ Removal of mobility aid
- ☐ Side rails greater than ½
- ☐ Chemical
- ☐ Isolation
- ☐ Seat belt ☐ Front closing ☐ Rear closing
- ☐ Other (specify):

2. Document admission information regarding history/rationale for restraint use:

_____
_____
_____
_____
_____

3. RESTRAINT ORDER: The LPN, RN/RPN or physician may give and write the order for continuation of restraint(s).

	Type/Method of Restraint	Frequency of Checks Required	Suggested Minimum Frequency of Checks
☐	Chair tray		Q1h
☐	Hand mitts		Q1h
☐	Mobility restricting chair		Q1h
☐	Removal of mobility aid		Q15-30 mins.
☐	Seat and/or lap belt ☐ Rear closing ☐ Front closing		Q1h
☐	Side rails greater than ½		Q1h
☐	Isolation		Q15 mins.
☐	Chemical – see physician, physician assistant or nurse practitioner order (include discontinuation date)		Q15 mins.
☐	Other (specify) :		

Restraint order written by :	**Name :**
	Signature and Designation:

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4. CONSENT FOR CONTINUED USE OF RESTRAINT

The following type(s) of restraint(s) have been recommended:

CONSENT FOR RESTRAINT

I have been fully informed of the potential benefits and burdens/risks of this restraint and have had the opportunity to fully discuss restraint use with the health care team. All of my questions have been answered to my full satisfaction. I understand that I have the right to alter my decisions concerning the restraint at any time.

☐ **I do not consent** to the continued use of the afore-mentioned restraint(s) OR ☐ **I consent** to the continued use of the afore-mentioned restraint(s).

Name (please print)	Signature	Date
Resident:		
Alternate Decision-maker		
Relationship to Resident:	Check if consent given by phone ☐	

Staff member obtaining consent:	**Name:**	**Date & Time:**
	Signature & Designation:	
Second staff member obtaining consent (by phone):	**Name:**	**Date:**
	Signature & Designation (if applicable):	

5. DOCUMENTATION

☐ Document in the **Integrated Progress Notes** (IPN) (CLI.4510.PR.002.FORM.01) that the restraint is in place.

☐ Document in the IPN, the resident's response to initial application of restraints for a minimum of every shift for 48 hours and then as necessary.

☐ **Update the Personal Care Home/Transitional Care Unit Restraint Care Plan** (CLI.6410.PL.004.FORM.04) **with the restraint order, use & frequency of checks, & reassessment and the discontinuation date, if it is a chemical restraint.** Initiate documentation of monitoring of restraint and care provided.

☐ **Update the Personal Care Home/Transitional Care Unit Delivery of Care Record** (CLI.6410.PL.002.FORM.05) to include the restraint, the frequency of assessments, and removal of restraints.

Reassessment of interim restraint: Within eight (8) weeks of admission using the Personal Care Home/Transitional Care Unit Restraint Assessment Tool (CLI.6410.PL.004.FORM.01**).**

Completed by:	**Name:**	**Date:**
	Signature/Designation:	