PERSONAL CARE HOME/TRANSITIONAL CARE UNIT RESTRAINT ASSESSMENT TOOL

ADDRESSOGRAPH

Complete this tool when considering a restraint to address a significant concern (e.g. frequent falls, sliding down in chair/wheelchair, climbing out of bed, positioning, behaviour endangering the resident or others, etc.)

All sections must be reviewed, signed with designation, and dated and kept in the permanent health record.

SECTION 1 – ASSESSMENT

1.1 ☐ **DOCUMENT in the IPN that an assessment for restraint has been initiated.**

1.2 CHECK all reasons for considering a restraint:

- ☐ Admitted with restraint in use
- ☐ Danger to others
- ☐ Danger to self
- ☐ Fall risk
- ☐ /Resident request/Alternate Decision-maker (note reason in IPN)
- ☐ Hallucinations, paranoia, delusions, agitation, restlessness
- ☐ Inability to maintain positioning independently
- ☐ Other (specify):

DESCRIBE the behaviour, environment in which it occurs, and when it happens, i.e. time of day **(NOTE: this section MUST be completed)**

1.3 REVIEW OF ENVIRONMENT - Check all contributing factors OR ☐ Not applicable

- ☐ Clutter (e.g. furniture, people)
- ☐ Flooring (e.g. distortion due to glare or pattern)
- ☐ Lighting conditions (e.g. dim or bright)
- ☐ Noise (e.g. loud TV/music, shift change, meal time, etc)
- ☐ No safe area to wander
- ☐ Recent changes to immediate environment (e.g. renovations, continuity of staff in resident care)
- ☐ Reflections (e.g. mirrors)
- ☐ Temperature (e.g. too hot/cold)
- ☐ Other (specify):

1.4 EMOTIONAL/MENTAL/PSYCHOSOCIAL – Check all that apply

- ☐ Agreeable
- ☐ Anxious
- ☐ Content
- ☐ Delusions
- ☐ Fear
- ☐ History of psychiatric illness (specify):
- ☐ Hallucinations
- ☐ Happy
- ☐ Paranoid thinking
- ☐ Poor insight /judgement
- ☐ Other (specify):
- ☐ Sadness
- ☐ Sleep disturbance
- ☐ Tearfulness
- ☐ Withdrawn

☐ Current psychiatric symptoms (specify):

☐ Accumulation of losses (specify):

☐ Past experiences that influence current behaviour (specify): (e.g. post traumatic stress, prisoner of war, addiction (alcohol, nicotine, illegal substances)

Current MMSE Score (if appropriate): Is this a change from previous score? ☐ No ☐ Yes

Comments:

1.5 NUTRITION – Check all that apply or

- ☐ Change in appetite
- ☐ Feeding/swallowing issues
- ☐ Dehydration
- ☐ Other (specify):

☐ Not applicable

☐ Documented weight loss or gain (See Identification of Significant Weight Change CLI.6110.SG.001)

1.6 REVIEW OF CURRENT MEDICATIONS

- ☐ Medication change in last week OR
- ☐ There are concerns/issues for follow-up (specify):

☐ There are no concerns/issues

1.7 CURRENT/PHYSICAL SYSTEMS ASSESSMENT – Check all that apply or ☐ No changes noted in systems

☐	Deterioration in health status	Specify:
☐	New diagnosis	Specify:
☐	Pain	Specify:
☐	Sensory changes	Specify:
☐	Bowel habits changed	Specify:
☐	Infection	Specify:

Current Falls Risk Assessment Completed Y ☐ N ☐ N/A ☐

Change/concern in any systems:

☐	Neurological	Specify:
☐	Vision	Specify:
☐	Hearing	Specify:
☐	Skin/Mucous membranes	Specify:
☐	Throat/Mouth	Specify:
☐	Respiratory	Specify:
☐	Cardiovascular	Specify:
☐	Gastrointestinal	Specify:
☐	Genitourinary	Specify:
☐	Musculoskeletal	Specify:
☐	Reproductive	Specify:
☐	Sleep	Specify:

Information provided by:	Relationship to Resident:	
Section 1 completed by:	**Name(s):**	**Date:**
	Signature and Designation:	
	Name(s):	**Date:**
	Signature and Designation:	

SECTION TWO – ACTIONS TAKEN & ALTERNATIVES TRIED

2.1 ACTIONS TAKEN TO ADDRESS ISSUES IDENTIFIED IN ASSESSMENT – Check all that apply or ☐ N/A

- ☐ Dental (e.g. dentures fitted) ☐ Hearing (e.g. hearing aid) ☐ Vision check
- ☐ Repeat meal observation screening (Test of Texture Modified Diet Form, Part 1): _____
- ☐ P.I.E.C.E.S.™ assessments (e.g. DOS)
- ☐ Other (specify): _____
- ☐ Lab and diagnostic testing (specify date and type): _____
- ☐ Pain assessment

Consults	Referral Date	Comments
☐ Dietitian		
☐ Occupational Therapy/Physiotherapy		
☐ Seating assessment completed		
☐ Palliative Care		
☐ Pharmacy		
☐ Physician		
☐ Seniors Consultation Team		
☐ Speech Language Pathologist		
☐ Other (specify):		

2.2 ALTERNATIVES TO RESTRAINT USE TRIED: (This is not a comprehensive list)

CHECK all interventions attempted:	History of intervention(s) with dates noted and outcome(s):
☐ Approach (calming, re-approaching later)	
☐ Appropriate clothing/footwear	
☐ Bathroom routine according to resident cues	
☐ Bed/chair alarm	
☐ Call bell easily accessible	
☐ Caregiver (consistent staff, same gender)	
☐ Companion involvement	
☐ Dietitian assessment	
☐ Emotional/spiritual support	
☐ Fall mat	
☐ Family involvement	
☐ Hip protectors	
☐ Immediate environment has familiar items	

CHECK all interventions attempted:	History of intervention(s) with dates noted and outcome(s):
☐ Improved lighting	
☐ Increased level of observation	
☐ Locked or secured unit	
☐ Low bed	
☐ Medication review	
☐ Motion sensor	
☐ Music/massage/therapeutic touch	
☐ Offer food/hydration	
☐ OT assessment	
☐ Pain assessment & management program	
☐ Personal articles within reach	
☐ Redirection	
☐ Reduce environmental stimuli	
☐ Regular rest periods	
☐ Remove mirrors	
☐ Remove resident from area or triggers	
☐ Reorientation	
☐ Resident security system	
☐ Room change	
☐ Specific recreation interventions	

DESCRIBE other Alternatives Tried

2.3 ☐ **DOCUMENT successful interventions on Integrated Care Plan/Kardex. Proceed to Section 3: Recommendations.**

Section 2 completed by:	**Name:**	**Date:**
	Signature and Designation:	
	Name:	**Date:**
	Signature and Designation:	

PERSONAL CARE HOME/TRANSITIONAL CARE UNIT RESTRAINT ASSESSMENT TOOL

ADDRESSOGRAPH

SECTION THREE – RECOMMENDATIONS

3.1 RESTRAINT BEING CONSIDERED – Check one only

Type/Method of Restraint :	**Reason :**
☐ Chair tray	
☐ Hand mitts	
☐ Mobility restricting chairs	
☐ Removal of mobility aid	
☐ Seat and/or lap belt ☐ Rear closing ☐ Front closing	
☐ Side rails greater than a ½ side rail	
☐ Chemical	
☐ Isolation	
☐ Other (specify):	

3.2 BENEFITS AND BURDENS (ACTUAL AND POTENTIAL) – Check all that apply :

Benefits	**Burdens**
☐ Enhanced nutritional status	☐ Agitation due to confinement
☐ Enhanced positioning	☐ Immobility complications
☐ Falls Prevention	☐ Loss of dignity
☐ Rest from pacing	☐ Loss of independence
☐ Sense of security	☐ Resignation and defeat
☐ Safety of self and/or others	☐ Risk of serious harm to or death from restraint
☐ Other (specify) :	☐ Skin complications
	☐ Other (specify) :

Ethical considerations (describe):

CHECK one ☐ The restraint will be beneficial. **OR**
☐ The burdens that may/will result from restraint application exceed the benefits that may/will be achieved.

3.3 RECOMMENDATION

☐ Restraint is **not** recommended (specify reason) :

☐ Restraint is **not** recommended **but:** ☐ Resident requests use of restraint ☐ Family requests use of restraint

If family requests use of the restraint then document in the IPN the discussion with the resident/family. Include ethical issues/concerns discussed. Consider using the Framework for Ethical Decision-Making as a guide.

☐ Restraint **is** recommended as described in Section 3.1.

If restraint is recommended provide resident or representative/designate with ***Restraint in Personal Care Homes* /Transitional Care Units h*andout*** (CLI.6410.PL.004.SD.01)

3.4 INTERDISCIPLINARY TEAM MEMBERS CONTRIBUTING TO ASSESSMENT/RECOMMENDATIONS (Must be interdisciplinary i.e. Nurse, HCA, Therapeutic Recreation etc.):

Date	Name	Signature	Designation

Section 3 completed by:	**Name:**	**Date:**
	Signature and Designation:	
	Name:	**Date:**
	Signature and Designation:	

OBTAIN CONSENT FOR RESTRAINT (Section 6)

SECTION 4 – RESTRAINT ORDER

4.1 RESTRAINT ORDER: The LPN, RN, RPN, physician, physician assistant or nurse practitioner may give and write the order.

	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 :**		**Date :**	
	Signature and Designation:			

SECTION 5 – DOCUMENTATION

5.1 DOCUMENTATION REQUIREMENTS

- ☐ Document in the Integrated Progress Notes (IPN) the discussion with the resident or alternate decision-maker about restraint use, including benefits and burdens and plan of care.
- ☐ Document in the IPN, the date and time of initial restraint application.
- ☐ Document in the IPN, the resident's reaction 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) to include restraint order, when and how long the restraint is to be used for each application, frequency of checks while the restraint is in use, and when regular removal is to occur. Initiate documentation of monitoring of the restraint and care provided.
- ☐ **Update the Personal Care Home Delivery of Care Record Form** (CLI.6410.PL.002.FORM.05) to include the restraint, the frequency of assessments, removal. of restraints, behavior of the resident, skin integrity, toileting regime, behavior interventions trialed, and resident's response to the restraint

Section 5 completed by:	**Name:**		**Date:**	
	Signature and Designation:			
	Name:		**Date:**	
	Signature and Designation:			

SECTION 6: CONSENT FOR RESTRAINT

6.1 The following restraint has been recommended:

Method of 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.

☐ **YES,** I **consent** to the use of the method of restraint listed above.

OR

☐ **NO,** I **do not** consent to the use of the method of restraint listed above (see IPN).

	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):	

Note : Consent by telephone requires that a second staff member must hear the verbal consent either via speakerphone or by speaking with the representative/designate. The second staff member does not need to be a registered professional.