PERSONAL CARE HOME/ TRANSITIONAL CARE UNIT RESTRAINT CARE PLAN

ADDRESSOGRAPH

Restraint type and method of application: _____

Date & time restraint initiated: _____

Concern for Resident (check applicable concerns)

- ☐ Risk for falling when ambulating
- ☐ Risk for falling out of chair
- ☐ Risk of falling out of bed
- ☐ Risk of sliding down in chair
- ☐ Unsteady gait
- ☐ Unable to maintain position independently
- ☐ Seating discomfort
- ☐ Resident/family requesting restraint to be used
- ☐ Behaviour creates a significant safety risk for self/others
- ☐ Other:

Expected Outcome

Resident will remain safe, comfortable, free from abuse, and have their needs met when restraint is being used.

Other:

It is to be used (length of time at each application):

- ☐ continuously when: _____
- ☐ occasionally when (state specifically): _____

The resident and the restraint are to be **checked for safety and well-being every _____ hours/minutes** when the restraint is being used.

A check involves removing a restraint a minimum of 10 minutes every 2 hours with care, ambulation and hydration.

If the restraint is to be removed more frequently, state the time frame for removal here: _____.

Restraint Reassessment/Review

This restraint will be reassessed for its effectiveness and need for continued use **every three (3) months with the quarterly care plan review** by the interdisciplinary team and recorded on the Interdisciplinary Quarterly Care Plan & Restraint Review Form (CLI.6410.PL.002.FORM.09). If reassessment is required at more frequent intervals, state here:

Date:	
Signature & Designation:	