Restraint Assessment

Resident Name _____ Assessment Date: _____

Physician _____ Contact: _____

Legal Representative _____ Contact: _____

Emergency Contact _____ Contact: _____

Assessment

Does this person use or need restraints? Yes [ ] No [ ]

Has this person previously required the use of a physical restraint? Yes [ ] No [ ]

If yes, when was a physical restraint last used?

What types of restraint(s) is currently or has been used?

When was the restraint ordered?

Who ordered the restraint?

What behavior(s) require or have required restraints to be used?

How is the restraint used?

When should the restraint be terminated?

How often should you evaluate the restraint when in use?

Are there any less restrictive alternatives other than restraint that can be used?

What supports might help this resident to minimize the use of time outs or physical restraint?

Is this outlined in the resident's current Plan of Care or Assisted Living Plan that is agreed upon and signed by the resident's team? Yes [ ] No [ ]

Person Completing this Assessment Signature:_____

Resident/Resident Representatives Signature:_____

Attention: Attach doctors' orders and special instructions for the restraints to this form.

Common Type of Restraints

Self-release safety belts
Lap-top trays
Wedge chair cushions
Concave mattresses.
Bedside rails