

(Name of RCHE)

Assessment and Consent Form for Applying Restraint

(re-assessment shall be made at least once every 6 months or when there is any change in the resident's condition)

Name of Resident _____ Sex/Age _____ HKIC No. _____

Room and/or Bed No. _____ Last Assessment Date _____

(Principle: Restraint refers to a means of limiting a resident's movement so as to minimise harm to himself/herself and/or other residents. An RCHE should adopt measures with least restraint. The use of restraint should only be considered when all other alternative attempts are ineffective or in case of emergency and when the well-being of the resident and/or other residents is jeopardised.)

(I) Conditions of Resident/Risk Factors (please tick as appropriate, may choose more than one item) **Abnormal mental condition and/or abnormal behaviour** emotion problem/confusion wandering self-injurious behaviour, please specify: _____ injuring/harassing others, please specify: _____ **Inability to maintain a proper seating posture** weak in back and loin muscles paralysis joint degeneration others, please specify: _____ **Risk of fall** unsteady gait fall during hospitalisation visual/hearing impairment under influence of drugs other risks of fall, please specify: _____ **History of removing therapeutic medical supplies and/or personal items** feeding tube oxygen tubing or mask urinary catheter stoma appliances diaper or clothes others, please specify: _____ **Others, please specify:** _____**(II) Alternatives**

Other attempted alternatives (please tick as appropriate, may choose more than one item)	Assessment Date	Assessment Result		Remarks
		Effective	Ineffective	
<input type="checkbox"/> seeking medical advice to find out the possible cause(s) leading to the emotion problem or confusion and handling accordingly		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> discussing with medical practitioners for treatment or medication adjustment		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> seeking intervention from physiotherapists/occupational therapists/clinical psychologists/social workers		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> improving furniture: using more appropriate chairs, cushions or other accessories		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> improving environment: to facilitate the resident to feel secure, comfortable and be familiar with the environment		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> providing leisure and diversionary activities to the resident		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> spending more time to talk to the resident for building up harmonious and mutual trust relationship		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> observing and inspecting regularly by home staff		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> adjusting daily care procedures to meet the special need of the resident		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> requesting visits and assistance from the resident's family/friends		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> others, please specify: _____		<input type="checkbox"/>	<input type="checkbox"/>	

(III) Recommendations on Restraint (please tick as appropriate, may choose more than one item)

Physical restraints		
Type	Condition for applying restraints	Period of applying restraints
<input type="checkbox"/> safety vests	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day
	<input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____
<input type="checkbox"/> safety belts	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day
	<input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____

<input type="checkbox"/> wrist restraints	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed <input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day <input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____
<input type="checkbox"/> gloves/mittens	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed <input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day <input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____
<input type="checkbox"/> non-slippery trousers/stripes	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed <input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day <input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____
<input type="checkbox"/> lap trays	<input type="checkbox"/> sitting on chair/wheelchair	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day <input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____
<input type="checkbox"/> others _____	<input type="checkbox"/> sitting on chair <input type="checkbox"/> lying in bed <input type="checkbox"/> sitting on chair & lying in bed	<input type="checkbox"/> daytime (from _____ to _____) <input type="checkbox"/> whole day <input type="checkbox"/> at night (from _____ to _____) <input type="checkbox"/> others _____

Next assessment date _____

Name of nurse/health worker _____ Signature of nurse/health worker _____ Date _____

Name of home manager _____ Signature of home manager _____ Date _____

(IV) Medical Practitioner's Comment (please tick as appropriate)

- Agree** to apply restraint on the above resident as suggested in part (III)
- Disagree** to apply restraint on the above resident

Remarks: _____

Name of medical practitioner _____ Signature of medical practitioner _____ Date _____

(V) Resident's Intention (please tick the appropriate box and delete * as appropriate)

<p>I, _____ (resident's name), after being clearly explained by *staff/medical practitioner of the RCHE the reasons for using restraint, type and period for the restraint to be used, the short-term and long-term impacts that may be caused by the use of restraint [see part (VII) below] and other alternatives that have been exhausted and their effectiveness, hereby <input type="checkbox"/> agree/<input type="checkbox"/> disagree to the use of restraint as suggested in part (III).</p> <p>Signature _____ Date _____</p>	<p>If the resident has cognitive impairment, please complete this part only</p> <p>I, *guardian/guarantor/family member/relative / visiting medical practitioner of _____ (resident's name), hereby witness that the resident cannot sign the consent due to cognitive impairment.</p> <p>Name of witness _____ Relationship _____</p> <p>Signature _____ Date _____</p>
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(VI) Guardian's/Guarantor's/Family Member's/Relative's intention

(please tick the appropriate box and delete * as appropriate)

I, _____ * guardian/guarantor/family member/relative of _____ (resident's name), after being clearly explained by *staff/medical practitioner of the home the reasons for using restraint, type and period for the restraint to be used, the short-term and long-term impacts that may be caused by the use of restraint [see part (VII) below] and other alternatives that have been exhausted and their effectiveness, hereby **agree**/ **disagree** to the use of restraint as suggested in part (III).

Signature _____ Relationship with the resident _____ Date _____

(VII) Special Notes

1. Condition of the resident should be reviewed at least once every 2 hours while under physical restraints.
2. The use of restraint will confine a resident to a seating or lying down position for a long period of time, thus reducing the resident's mobility and joint movement and resulting in muscle contracture.
3. A resident's bones may become brittle and liable to fracture due to the reduction of weight-bearing activities.
4. Swelling of the resident's lower limbs may occur due to reduced blood circulation.
5. Residents under restraint may have negative emotions, such as anger, shame, fear, helplessness, distress, etc.
6. Residents may become bad-tempered and anxious or even have depressive mood as a result of long term use of restraint.
7. Residents under restraint may become more frail and apathetic. They may fall and hurt themselves more easily.
8. Some residents resist restraint very much and may harm themselves or fall when they try to get rid of the physical restraints.
9. As residents' mobility is restricted, they have fewer chances to talk to or get along with others, thus affecting their social well-being.