(Name of RCHD)

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 RCHD 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 dugs ☐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	
☐seeking medical advice to find out the possible cause(s) leading to the emotion problem or confusion and handling accordingly		☐	☐	
☐discussing with medical practitioners for treatment or medication adjustment		☐	☐	
☐seeking intervention from physiotherapists/occupational therapists/clinical psychologists/social workers		☐	☐	
☐improving furniture: using more appropriate chairs, cushions or other accessories		☐	☐	
☐improving environment: to facilitate the resident to feel secure, comfortable and be familiar with the environment		☐	☐	
☐providing leisure and diversionary activities to the resident		☐	☐	
☐spending more time to talk to the resident for building up harmonious and mutual trust relationship		☐	☐	
☐observing and inspecting regularly by home staff		☐	☐	
☐adjusting daily care procedures to meet the special need of the resident		☐	☐	
☐requesting visits and assistance from the resident's family/friends		☐	☐	
☐others, please specify _____		☐	☐	

(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
☐safety vests	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others _____
☐safety belts	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others _____

☐wrist restraints	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others ____
☐gloves/mittens	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others ____
☐non-slippery trousers/stripes	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others ____
☐lap trays	☐sitting on chair/wheelchair	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others ____
☐others ____	☐sitting on chair ☐lying in bed ☐sitting on chair & lying in bed	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐others ____

Seclusion

Period of Seclusion	☐daytime (from ____ to ____) ☐whole day ☐at night (from ____ to ____) ☐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)

I, ____ (resident's name), after being clearly explained by *staff/medical practitioner of the RCHD 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 ____ Date ____	**If the resident has cognitive impairment, please complete this part only** 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. Name of witness ____ Relationship ____ Signature ____ Date ____

(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. Condition of the resident should be reviewed at least once every 15 minutes during the period of seclusion.
3. 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.
4. A resident's bones may become brittle and liable to fracture due to the reduction of weight-bearing activities.
5. Swelling of the resident's lower limbs may occur due to reduced blood circulation.
6. Residents under restraint may have negative emotions, such as anger, shame, fear, helplessness, distress, etc.
7. Residents may become bad-tempered and anxious or even have depressive mood as a result of long term use of restraint.
8. Residents under restraint may become more frail and apathetic. They may fall and hurt themselves more easily.
9. Some residents resist restraint very much and may harm themselves or fall when they try to get rid of the physical restraints.
10. As residents' mobility is restricted, they have fewer chances to talk to or get along with others, thus affecting their social well-being.