Canterbury District Health Board
Te Poari Hauora ō Waitaha
Christchurch Hospital Campus

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Use of Restraint

Date: _____Time: _____ Location of patient: _____

Family/Whānau consulted and informed of restraint?	☐ Yes	☐ No
Consent obtained from Child/Family/Whānau **(Child Health Only)**	☐ Yes	☐ No

Restraint Minimisation and Safe Practice Assessment

Specify any previous history of restraint/evaluation episodes to inform management for this episode?

Specify any underlying causes, triggers or unmet needs thought to be driving or contributing to the relevant behaviour:

Specify restraint free interventions and/or de-escalation attempted prior to the use of restraint?

Specify the rationale for restraint / the harm that restraint is attempting to prevent:

Specify the desired outcome and criteria for restraint to end:

Specify the risks of the restraint chosen and the frequency of monitoring required:
(Note that physical restraint requires the completion of the 'Restraint Monitoring Form' C24033)

Disciplines consulted about this Restraint Minimisation and Safe Practice Assessment:

Restraint details

Category of restraint:	☐ Physical ***Specify***: _____ (Intentional restriction of normal movement by use of equipment, devices or furniture)	☐ Personal (intentional restriction of normal movement by holding)	☐ Environmental (intentional restriction of access to normal environment)

Staff member who initiated restraint: Name…… Designation…….. ….

Commenced: _____ *Date/Time* Finished: _____ *Date/Time* Total Time: _____ *Minutes*
Commenced: _____ *Date/Time* Finished: _____ *Date/Time* Total Time: _____ *Minutes*
Commenced: _____ *Date/Time* Finished: _____ *Date/Time* Total Time: _____ *Minutes*

Outcome

Was debriefing of the patient considered?	☐ Yes	☐ No
Did the patient receive a debrief?	☐ Yes	☐ No*
*Outline why a debrief didn't occur:		
Did the family/whānau receive a debrief?	☐ Yes	☐ No
What impact did the use of restraint have on the patient?		
Did the episode of restraint result in injury to the patient? *If yes complete an Incident Report Form and record number here _____	☐ Yes*	☐ No
Did the episode of restraint result in injury to staff or visitors? *If yes complete a staff accident report form (blue form) _____	☐ Yes*	☐ No

Please fax both sides of this fully completed form to the Dept of Nursing 80844

USE OF RESTRAINT

C240190

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Evaluation of the Episode of Restraint Use

Personnel involved in this evaluation (staff name & designation, patient or family/whānau involved)

Name	Designation	Name	Designation

Was the use of restraint clinically justified?	☐ Yes ☐ No
Was the type of restraint used approved for use? *If no complete an incident form and record the number here _____	☐ Yes ☐ No*
Was the desired outcome achieved?	☐ Yes ☐ No
Was the patient monitored?	☐ Yes ☐ No
Any suggested changes to the patient's treatment/crisis plan/plan of care including the need for advocacy and support?	
Future options to avoid restraint, utilise a less restrictive option, or lessen the amount of time restraint is used?	
Any general ideas on how restraint minimisation should be practised/taught?	

For completion by Line Manager who assisted in evaluation

Comment if the restraint was appropriate and the restraint minimisation policy was followed

_____ _____ _____

Signed (manager) Designation: Date

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