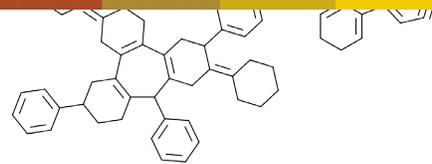


# Individualized Restraint Reduction Planning Form



Directions: Complete this form with your restraint reduction team; enter the appropriate information and/or date(s) for each item.

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_

|  |  |
|--|--|
| 1. What type of restraint is currently being used?   | Type:  |
| 2. When was the restraint ordered?   | Date:  |
| 3. Is the precipitating medical symptom a current concern?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Can a restraint alternative be trialed? (If no, skip to Question 5.)                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Type of restraint alternative to be trialed.  | Type:  |
| b. Date to trial the restraint alternative.  | Date:  |
| c. Staff are aware of the trial period for the restraint alternative.                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Date to assess the resident's response  | Date:  |
| e. Describe resident's response/the effect of the restraint alternative.                         |  |
| f. Proceed with restraint alternative?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. If yes, when is the care plan updated?  | Date:  |
| ii. If yes, when is the staff updated to changes in care plan?                                   | Date:  |
| iii. If no, repeat Question 4 until no additional alternatives can be identified.                |  |
| 5. Can a less-restrictive restraint be used? (If no, skip to Question 6.)                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Type of less-restrictive restraint to be trialed.   | Type:  |
| b. Date to trial the less-restrictive restraint.   | Date:  |
| c. Staff are aware of the trial period for the less restrictive-restraint.                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Date to assess the resident's response.   | Date:  |
| e. Describe resident's response/the effect on the less-restrictive restraint.                    |  |
| f. Proceed with less-restrictive restraint?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. If yes, when is the care plan updated.  | Date:  |
| ii. If yes, when is the staff updated to changes in care plan.                                   | Date:  |
| iii. If no, repeat Question 5 until no additional less-restrictive restraints can be identified. |  |
| 6. Can the current restraint be removed for periods of time?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Time period to trial the removal.   | Time:  |
| b. Dates to trial the times for restraint removal.   | Date:  |
| c. Staff are updated to changes in care plan.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Date to assess the resident's response.   | Date:  |
| e. Describe resident's response/the effect of the restraint removal.                             |  |
| f. Proceed with restraint removal for specified times?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. If yes, care plan is updated.   | Date:  |
| ii. If yes, the staff is updated to changes in care plan.  | Date:  |