Restraints: Assessment and Evaluation

Key Steps	Key Elements
Examination and Evaluation	**Basic assessment to rule out acute illness** • Physical examination and medical history • Observation • Interview resident and/or family
Assessment and Treatment	**Validation tools, tests, measures** • Assessment log • ADL scales • Functional capacity tests • Functional simulations • Fall scales • Barriers checklist **Explore underlying medical and environmental conditions** • **Unstable Gait** – Stability, strength, range of motion, balance, hearing/vision, assistive devices, fall risk, fractures/precautions, shoes/clothing • **Cognition** – Delirium, confusion, depression, hallucinations, agitation, wandering, aggressive behaviors, psychoactive medications • **Impaired Communication** – Difficulty making needs/wishes understood or understanding others • **Environment** – Access to call light/television/telephone, lighting, access to bathroom, availability of nutrition/hydration, noise level, adaptive equipment • **Medications** – Multiple medications/dosages, side effects, new medications • **Cardiovascular Insufficiency** – Syncope, oxygen saturation, fluctuations in blood pressure, shortness of breath, TIA • **Infections** – Urinary tract infection, upper respiratory infection, delirium, fever • **Hyperglycemia/Hypoglycemia** – Blood sugar levels • **Dehydration/Constipation** – Change in mental status, amount of fluid intake, bowel sounds, abdominal distension • **Sleep Problems** – Sleep/wake patterns • **Pain** – History of pain, location, intensity, onset, duration, ability to express pain, barriers to pain management, effectiveness of pain management • **Wandering** – Cognition, medication, physical surroundings
Documentation	**Basic assessment to rule out acute illness** • Tests, performance, functional capacity • Response to activity • Safety awareness • Education provided • Family, caregiver involvement • Plan of care • Interventions, frequency, duration • Referrals

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