

RESTRAINT MONITORING SHEET

Reason for Restraint:

 Self Harm Harm to Others Potential for Removing lines Others :

Type of Restraint : Physical = P (Left Wrist = LW; Right Wrist = RW; Left Ankle = LA; Right Ankle = RA; Chest = C)

Chemical Restraints (Drugs =D)

Type of Device : Extremity restraint (ER) Mitten Restraint (MR) Others :

Restraint education provided to : Patient : Yes No Family : Yes No

Ordered By : Dr. Athar

Treating Doctor : Dr. Athar On : 8/10/2023 Time (from) : 8 AM (Valid Upto) : 8 PM Signature : Aar

ON GOING ASSESSMENT
Type of Restraint : Physan **Type of Device :** ER **Date :** 8/10/2023

Date of 1st Application 7/10

On Going Monitoring

Time	8a	10a	12p	2p	4p	6p	8p	10p	12m	2am	4am	6am
Position	/	/	/	/	/	/	/	/	/	/	/	/
Circulation	/	/	/	/	/	/	/	/	/	/	/	/
Skin Integrity	/	/	/	/	/	/	/	/	/	/	/	/
Skin Cleaned & Massaged	/	/	/	/	/	/	/	/	/	/	/	/
Fluid Needs	/	/	/	/	/	/	/	/	/	/	/	/
Toileting Needs	/	/	/	/	/	/	/	/	/	/	/	/
Nutrition Offered	X	X	X	X	X	X	X	X	X	X	X	X
Evaluate Restraint Removal	/	/	/	/	/	/	/	/	/	/	/	/
Temperature	/	/	/	/	/	/	/	/	/	/	/	/
Deformity of Site	X	X	X	X	X	X	X	X	V	S	S	X
Care Giver Initials EMP ID	Aar											

DOCUMENTATION STANDARDS

Documentation of assessment /care /monitoring is completed by (✓) mark when the following criteria are met. If criteria not met, a (X) mark to be entered and a note is written. Assessment is ongoing; documentation is required at least every 2 hours

POSITION: Proper alignment of the restrained limb is maintained

CIRCULATION: Nail bed blanches in less than 3 seconds and pulse present above and below restraint

SKIN INTEGRITY: Skin integrity around / under the device and all bony prominence indicates no pressure or reddened areas developed

SKIN CLEANED & MASSAGED skin care provided by cleaning massaging and positioning.

FLUID NEEDS: Fluids administer as per physician order (oral or parenteral) . If patient is not on restriction fluid offered every hourly

TOILETING NEEDS: Elimination Need Attended to, either by Foleys catheter(only if ordered for other medical necessity) or by offering bed pan or assistance to bathroom / commode chair

NUTRITION OFFERED: Nutrition needs met as per physician order. If oral intake allowed, patient offered and assisted with meal

TEMPERATURE : Patient skin comfortable to touch, patient temperature checked as per physician order and room temperature maintained as per patient condition

EVALUATION FOR REDUCTION OR REMOVAL: The use of restraint is evaluated frequently (at least every 2 hours)and ends at the earliest possible time

DEFORMITY OF SITE state of deformed no injuries or trauma due to restraint device.

 Any observation

 Restraint Order Discontinued: Yes No Discontinued On: _____ at _____

 Name of Nurse: Rumy Signature & Emp. ID: MOM Date: 8/10 Time: 8:00