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 : _____

Treating Doctor : Dr Prashant On : 9/10/24 Time (from) : 8 am (Valid Upto) : 8c Signature : _____

ON GOING ASSESSMENT _____

Type of Restraint : Physical restr Type of Device : Extremity restraint Date : 9/10/24

Date of 1st Application _____

On Going Monitoring

Time	8a	10a	12p	2p	4pm	6pm	8pm	10pm	12am	2am	4am	6a
Position	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Circulation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Integrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Cleaned & Massaged	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fluid Needs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Toileting Needs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutrition Offered	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X
Evaluate Restraint Removal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Temperature	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Deformity of Site	P	∞	∞	∞	∞	∞	∞	∞	X	X	X	X
Care Giver Initials EMP ID	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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: 10/10/24 at 8AM

Name of Nurse: [illegible] Signature &Emp.ID: [illegible] Date : 10/10/24 Time: 8A