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. Athale

Treating Doctor : Dr. Athale On : 7/10 Time (from) : 8am (Valid Upto) : 8a Signature : Kn

ON GOING ASSESSMENT

Type of Restraint : Physical Type of Device : Extremity restraint Date : 7/10/25

Date of 1st Application 7/10/25

On Going Monitoring

Time	8am	10a	12p	2pm	4pm	6p	8p	10p	12a	2a	3a	6a
Position	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Circulation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Integrity	✓	✓	✓	✓	✓	–	✓	✓	✓	–	✓	✓
Skin Cleaned & Massaged	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓
Fluid Needs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Toileting Needs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutrition Offered	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evaluate Restraint Removal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Temperature	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Deformity of Site	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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: _____ at _____

Name of Nurse: [illegible] Signature &Emp.ID: [illegible] Date : 8/10 Time: 6a