



1000000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

NON-BEHAVIORAL RESTRAINT FLOWSHEET

Date of Episode: _____

Type of Restraint (Check all that apply)

- Mitt x _____
- Side rails up x 4
- Roll belt
- Limb restraints x _____
- Elbow extender x _____
- Enclosure bed
- Other: _____

Note: Gap protectors are required when patients are at risk for entrapment

Current order? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initiation of restraint	Time Initiated: _____
Date and Time order expires _____	<input type="checkbox"/> Continuation of restraint	

Clinical justification for restraint (Check all that apply)	
<input type="checkbox"/> Pulling essential lines <input type="checkbox"/> Pulling essential tubes <input type="checkbox"/> Engaging in unsafe behavior	<input type="checkbox"/> Removing essential equipment <input type="checkbox"/> Removing essential dressings <input type="checkbox"/> Other: _____

Less restrictive alternatives to restraints attempted (Check all that apply)	
<input type="checkbox"/> 1:1 Observation <input type="checkbox"/> Family/Care Partner involvement <input type="checkbox"/> Decreased stimulation <input type="checkbox"/> Review of labs/meds <input type="checkbox"/> Use of assistive devices <input type="checkbox"/> Pain management <input type="checkbox"/> Activity/ambulation	<input type="checkbox"/> Explain need for tubes/lines <input type="checkbox"/> Wrap/cover/secure site/tubing <input type="checkbox"/> Regular toileting <input type="checkbox"/> Bed alarm system <input type="checkbox"/> Redirection/Reorientation <input type="checkbox"/> Other: _____

Education (to be completed upon initiation of restraints; check all that apply)			
Patient Intervention and criteria for discontinuation of restraint explained Time: _____			
<input type="checkbox"/> Expressed understanding	<input type="checkbox"/> Needs reinforcement	<input type="checkbox"/> Patient condition precludes teaching	<input type="checkbox"/> Refused teaching
Family Intervention and criteria for discontinuation of restraint explained Time: _____			
<input type="checkbox"/> Expressed understanding	<input type="checkbox"/> Needs reinforcement	<input type="checkbox"/> No evidence of learning	<input type="checkbox"/> Unable to contact

Discontinuation criteria met (Check all that apply)		
<input type="checkbox"/> Absence of behavior requiring restraints	<input type="checkbox"/> D/C of essential therapies	<input type="checkbox"/> Appropriate sedation (ICU)
Comments: _____		
Time Discontinued: _____		
RN Name/Signature: _____		

Instructions:

- **Monitor patient every hour, with more frequent monitoring based on patient condition.**
- **Even Hours: RN Assessment required. Complete and initial.**
- **Odd hours: RN or PCA patient safety check required. Complete and initial.**
- **Patient Safety Check includes: Skin/Circulation/Position, Nutrition/Hydration, Elimination and Proper Restraint Application.**

Time	Patient Response (Check all that apply)	Staff Interventions	RN Assessment/ Criteria for Removal Met	Initials
00:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
01:00		<input type="checkbox"/> Patient Safety Check		_____
02:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
03:00		<input type="checkbox"/> Patient Safety Check		_____
04:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
05:00		<input type="checkbox"/> Patient Safety Check		_____
06:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
07:00		<input type="checkbox"/> Patient Safety Check		_____
08:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
09:00		<input type="checkbox"/> Patient Safety Check		_____
10:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
11:00		<input type="checkbox"/> Patient Safety Check		_____
12:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
13:00		<input type="checkbox"/> Patient Safety Check		_____
14:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
15:00		<input type="checkbox"/> Patient Safety Check		_____
16:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
17:00		<input type="checkbox"/> Patient Safety Check		_____
18:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
19:00		<input type="checkbox"/> Patient Safety Check		_____
20:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
21:00		<input type="checkbox"/> Patient Safety Check		_____
22:00	<input type="checkbox"/> Unable to follow direction <input type="checkbox"/> Calm <input type="checkbox"/> Drowsy <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Restless <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient Safety Check <input type="checkbox"/> Emotional Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
23:00		<input type="checkbox"/> Patient Safety Check		_____

Comments:

Name/Signature/Initials/Shift _____ Name/Signature/Initials/Shift _____
 Name/Signature/Initials/Shift _____ Name/Signature/Initials/Shift _____
 Name/Signature/Initials/Shift _____ Name/Signature/Initials/Shift _____