UVA Health

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PLACE LABEL HERE.

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

DOWNTIME VIOLENT RESTRAINT FLOWSHEET

Date of Episode: _____ **This is:** ☐ **Continuation of restraints**

☐ **Initiation/ time initiated** _____

Type of Restraint (Check all that apply)

☐ Limb restraints x _____ ☐ Locking ☐ Not locking ☐ Side rails upx 4 ☐ Elbow extender x _____

☐ Roll belt ☐ Physical holds ☐ Medication

☐ Seclusion ☐ Other: _____

Current order? ☐ Yes ☐ No

Length of order: _____ 4 hours (age >18) 2 hours (age 9-17) 1 hour (age <8)

Complete upon initiation

Clinical justification of restraint (Check all that apply)

☐ Attempting to harm self ☐ Attempting to harm staff ☐ Attempting to harm others

Less restrictive alternatives to restraints attempted (Check all that apply)

☐ 1:1 Time ☐ Coach coping/relaxation ☐ Active listening ☐ Diversionary activities
☐ Negotiation ☐ Medication ☐ Time out
☐ Consider underlying clinical factor

Response to alternatives: ☐ Ineffective – patient remains at risk ☐ Other: _____

Education (to be completed upon initiation of restraints; check all that apply)

Patient/family intervention and criteria for discontinuation of restraint explained **Time:** _____

☐ Expressed understanding ☐ Needs reinforcement ☐ Patient condition precludes teaching
☐ Refused teaching ☐ No evidence of learning

Discontinuation criteria met: Absence of behavior requiring restraints.

Comments: _____

Time Discontinued: _____

RN Name/Signature: _____

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Date of Episode: ____________________

INSTRUCTIONS:

- RN restraint assessment completed every 2 hours. Includes: need for continued restraint, physical status, level of distress
- Care needs completed every 2 hours. Includes: Food/fluid reposition/range of motion, toileting needs, personal hygiene, safety/comfort, nutrition/hydration and elimination.
- Monitor patient every 15 minutes. Includes: Skin/circulation, and proper restraint application

Time	Staff Instructions	RN Criteria for Discontinuation Met	Staff Initials
	☐ Restraint monitoring (q 15 min) ☐ Care needs addressed (q2h) ☐ RN assessment completed (q2h)	☐ Yes ☐ No	
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	☐ Restraint monitoring (q 15 min) ☐ Care needs addressed (q2h) ☐ RN assessment completed (q2h)	☐ Yes ☐ No	

**** Print another form for each calendar day & with each order.***

Printed Name/Initials ____________________ Printed Name/Initials ____________________

Printed Name/Initials ____________________ Printed Name/Initials ____________________

Printed Name/Initials ____________________ Printed Name/Initials ____________________