

WESTERN MARYLAND HEALTH SYSTEM

Physician Orders

REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION
DO NOT USE ABBREVIATIONS

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DOCTORS ORDERS MEDICAL-SURGICAL RESTRAINT ORDERS	CHECK OFF/ INITIALS
PRN ORDERS NOT PERMITTED	
ORDERING PHYSICIAN: _____	
INITIAL / RENEWAL (Circle)	
DATE patient placed in restraints: _____ TIME patient placed in restraints: _____	
INDICATION FOR USE: _____ Prevent walking unassisted _____ Prevent climbing out of bed/chair _____ Prevent interference with treatments, pulling at lines and tubes _____ Prevent movement that is detrimental to healing	
TYPE OF RESTRAINT: _____ Geri-Chair _____ Side Rails X 4 _____ Quick Release Waist Belt _____ Soft Waist Belt _____ Soft Roll Belt _____ Elbow Restraints _____ Mittens _____ Soft Limb Restraint Wrist: _____ Left _____ Right Ankle: _____ Left _____ Right	
DURATION OF RESTRAINT (order not to exceed 24 hours): ___ 1 hour ___ 2 hours ___ 4 hours ___ 6 hours ___ 8 hours ___ 12 hours ___ 24 hours (maximum) ___ ICU/CVU PROTOCOLS: If the patient has invasive lines and tubes required for their care and they are unable to understand and follow commands to not remove them, initiate the least restrictive restraint device. Discontinue the restraints when the lines and tubes are discontinued or the patient is able to understand and follow commands not to remove them.	
MEDICAL CONDITION REQUIRING SPECIAL PRECAUTIONS: ___ No ___ Yes, Specify: _____	
VORV/TORV _____ DATE: _____ TIME: _____	
PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____	
PHYSICIAN FACE-TO-FACE ASSESSMENT (Must be done within 24 hours and must be repeated every day thereafter)	
DATE: _____ TIME: _____ PHYSICIAN ASSESSMENT: _____ _____ _____	
CONTINUE RESTRAINT USE: **Renewal of restraint requires a new Physician's Order** ___ YES (If patient remains at risk for falls, pulling at lines and tubes or has movement detrimental to healing) ___ NO	
Ways/alternative methods identified to help the patient have restraints removed: <input type="checkbox"/> Medication review <input type="checkbox"/> Lower the bed <input type="checkbox"/> Diversional activities <input type="checkbox"/> Remove un-needed lines/tubes <input type="checkbox"/> Lines/tubes disguised <input type="checkbox"/> Family involvement <input type="checkbox"/> Other _____	
* All areas MUST be completed for a valid restraint order. Fax copy of order sheet to Nursing Service MHC (4450) BHC (5207)	
Physician/Date/Time: _____	Nurse/Date/Time: _____
Secretary/Date/Time: _____	

Full page of orders requires only one physician, one nurse and one clerical signature



Original to Patient's Chart

Revised: 2/07; 7/07

Fax to Nursing Service
Form # 1.7-002

MEDICAL-SURGICAL RESTRAINT ALTERNATIVE AND RESTRAINT FLOWSHEET

Date _____

Less Restrictive Measures Attempted: (Check all that apply)

- Providing companionship and / or supervision
- Relaxation techniques (massage, warm bath)
- Attending to physical needs (toileting, glasses, hearing aid)
- Diversionary and physical activities (i.e., TV, radio, ambulation, ADL)
- Disguise lines/tubes
- Encourage family/friends to visit
- Place closer to nurses' station
- Decreasing environmental stimuli
- Schedule position changes
- Reality orientation / psychosocial intervention
- Pain / comfort measures

Restraint Alternative Devices Attempted: (Check all that apply)

- Wrap around belt TABS monitor Wedge/Gel seat Tool box Disguise tube/line Busy vest/apron

Restraints: (REQUIRED DOCUMENTATION)

Indication for application of restraint:

- _____ Prevent walking unassisted _____ Prevent climbing out of bed/chair
 _____ Prevent interference with treatments _____ Prevent movement that is detrimental to healing

Patient/family informed: Yes No **If NO - comment:** _____

Procedure explained to patient: Yes No **If NO - comment:** _____

Results of attempt to remove restraints: _____

Type of Restraint: (Check all that apply) * Order Restraints Through Order Entry *****

- Elbow Restraints Mittens Quick Release Belt Soft Belt Roll Belt Geri Chair
- Side Rails X4 Soft Wrist Left ___ Right ___ Soft ankle Left ___ Right ___

Application:

Initial Application: Date _____ Time: _____ RN/LPN: _____

Vital Signs Upon Initiation: Temp: _____ Pulse: _____ Resp: _____ B/P: _____ Oxygen Sat: _____

Reassessment by healthcare team every shift for continuation of restraint: Time: _____ Time: _____ Time: _____

*****The assessments, monitoring, and physical care according to the two (2) hour time frame must be recorded.***
 Any abnormalities must be documented in the patient care notes.**

Offer or Provide the following:	Time:	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600
1. Skin condition													
2. CMS checks													
3. Early release													
4. Hydration and offer fluids													
5. Nutrition needs and assist w/meals/snacks													
6. Need for elimination & assist with toileting													
7. Re-positioning													
8. Joint Mobility-Release restraints loosen/remove, passive ROM exercise, and reapply													
9. Communication-Call light in reach													
10.*Change in clinical condition/behavior													
11. Restraint reduced/removed**													
12. Personal hygiene. (every 8 hours)													
Initials of assessor													

KEY: Y = Yes, N = No, N/A = Not applicable, R = Restraint removed, S = Sleeping.

*Describe change: _____

**Date, time, description of behavior, and skin assessment when restraints discontinued: _____

Initials Signature/Title:

Initials Signature/Title:

(Reminder: Remove restraints from room; Send restraints to laundry; and Discontinue order through Order Entry)

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To Our Patients and Families:

Sometimes patients may become confused or disoriented in the hospital. This may be due to their condition, illness, medication, procedures, change in environment, or a combination of any of these.

To help keep your family member safe, you may be asked to help with their care. You may be asked to have a family or a friend stay with them. This may keep the patient more oriented, less frightened, and more cooperative. An alternative to family and friends is a sitter. A list of sitters may be obtained from the charge nurse. Sitters are called and paid for by the family.

Sometimes efforts are unsuccessful to relax and calm patients who are at high risk for hurting themselves or others or interrupting their care. To reduce possible injury, as a last resort, it may be necessary to use wrist, arm or belt restraints. The need for restraints is assessed regularly and they will be removed when no longer necessary.

Please discuss any questions you may have about this with the Registered Nurse or Nursing Supervisor.

*Memorial Campus
600 Memorial Avenue
Cumberland, MD 21502
301-723-4000*

*Braddock Campus
900 Seton Drive
Cumberland, MD 21502
301-723-4200*



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