Hospital Authority

United Christian Hospital

Use of Physical Restraint Observation Record Form

Please Use Block Letters or Affix Label without I.D. No.

HN:_____ **MRN:**_____

Name:_____

Sex:_____ **Age:**_____

Dept:_____ **Ward/Bed:**_____

Please ✓ at the appropriate box.

The commence date and time of the use of physical restraint : _____ (Date) _____ (Time)

Intended Duration: _____

Reason(s) for physical restraint

- ☐ Prevention of patient / other injury
- ☐ High risk of fall
- ☐ Prevention of patient tampering with medical device
- ☐ Other : _____

Type of physical restraint device used

- ☐ Shoulder restraint / strap
- ☐ Waist / Abdominal belt
- ☐ Safety vest
- ☐ Limb(s) restraint / Boxing glove
  - ○ Left hand ○ Right hand
  - ○ Left foot ○ Right foot
- ☐ Other : _____

Nursing intervention(s) taken

- Physical restraint is prescribed by doctor: _____ (Name) on _____ (Date)
- Relative _____ (Relationship) is informed and explained on _____ (Date)

Secondary Review Daily by doctor / senior nurse (Name / Date & time)		
By _____ on _____	By _____ on _____	By _____ on _____

Frequency of observation																					
Date																					
Time																					
Mental status	Confusion																				
	Restless																				
	Aggressive																				
	Conscious																				
	Other: _____																				
Respiration	Rate (per min)																				
	Normal																				
	Dysponea																				
Status of circulation	**Hands**		L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R
		Warm																				
		Pink																				
		Skin Intact																				
		Normal sensation																				
		Cold																				
		Pale																				
		Cyanotic																				
		Oedema																				
		Abrasion																				
		Bruise																				
		Numbness																				
			L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R
	Feet	Warm																				
		Pink																				
		Skin Intact																				
		Normal sensation																				
		Cold																				
		Pale																				
		Cyanotic																				
		Oedema																				
		Abrasion																				
		Bruise																				
		Numbness																				
Continue to use physical restraint?			Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No	
Name of assessor (Nurse)																						

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