Purpose

To describe the process to safely apply restraint techniques for:

- Walking restraint
- Emergency walking relocation of patient (one and two members of staff)
- Seated restraint
- Bed/trolley restraint

Who should read this document?

All staff working within the Trust who have already received formal face to face training.

Key Messages

This document is intended for use as an aid memoir for the Trust taught restraint techniques. All staff using restraining therapies must always do so whilst working within Legal and Human Rights Frameworks for the use of restrictive interventions.

Core accountabilities

Owner: Sophie King: Physical Interventions Lead
Review: Safeguarding Steering Committee
Ratification: Lenny Byrne – Chief Nurse
Dissemination: Safeguarding Steering Committee
Compliance: Safeguarding Steering Committee

Links to other policies and procedures

- UHPNT Plymouth Hospitals NHS Trust Paediatric Physical Intervention Policy
- UHPNT Management of Physical Intervention (Restraint) for Adults in an Acute Hospital Setting Policy
- UHPNT Mental Capacity Act (MCA 2005), including Deprivations of Liberty (DoLS, 2007) Policy
- UHPNT Standard Operating Procedure Individuals who are Violent or Aggressive
- UHPNT Moving and Handling People and Objects Policy

Version History

1 June 2020 Final Document

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.
Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Definitions</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Procedures to Follow</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4a Walking Restraint (with figure of four hold)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4b Bed/Trolley Restraint</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>4c Seated Restraint</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>4d Relocation of Patient (double forearm hold one staff member)</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>4e Emergency Relocation of Patient (double forearm hold two staff members)</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>Document Ratification Process</td>
<td>19</td>
</tr>
<tr>
<td>6</td>
<td>Dissemination and Implementation</td>
<td>19</td>
</tr>
<tr>
<td>7</td>
<td>Monitoring and Assurance</td>
<td>19</td>
</tr>
<tr>
<td>8</td>
<td>Reference Material</td>
<td>19</td>
</tr>
</tbody>
</table>
1 Introduction

This Standard Operating Procedure (SOP) describes UHPNT’s taught restraint techniques for the walking restraint of a patient, seated restraint of a patient, bed/trolley restraint of a patient, and the emergency relocation of a patient.

This SOP links to:

- UHPNT Plymouth Hospitals NHS Trust (UHPNT) Paediatric Physical Intervention Policy
- UHPNT Management of Physical Intervention (Restraint) for Adults in an Acute Hospital Setting Policy
- UHPNT Incident Management Policy
- UHPNT Mental Capacity Act (MCA 2005), including Deprivations of Liberty (DoLS, 2007) Policy
- UHPNT Standard Operating Procedure Individuals who are Violent or Aggressive
- UHPNT Moving and Handling People and Objects Policy

2 Definitions

For the purpose of this SOP, the following is defined as:

**Restraint**: Restraint is an act carried out with the purpose of restraining an individual’s movement, liberty and/or freedom to act independently.

3 Background

All episodes of planned and unplanned restraint must comply with the Human Rights Framework for Restraint (2019) and Equality Act (2010). All episodes of restraint must be reported.

The Patient’s vital signs must be monitored during and for a period of time after restraint episodes to ensure no harm (NPSA 2015, Nice Guidance 10, 2015).

All restraint interventions must be carried out in accordance with the following:

**Key Guidance:**

- DOH (2014) Positive and Proactive Care: reducing the need for restrictive interventions.
- NPSA (2015) the importance of checking vital signs during and after restrictive interventions/manual restraint.

**Key Legislation:**

- Care Act (2015)
- Health and Safety at Work Act (1974)
- Health and Social Care Act (2008)
- Equality Act (2010)
- Human Rights Act (1998): Article 3 (prohibition on torture, inhuman and degrading treatment), Article 5 (protects your right to liberty and security), Article 8 (respective for autonomy, physical and psychological integrity) and Article 14 (non-discrimination) of the European Convention on Human Rights.
- Mental Capacity Act (2005)
- Mental Health Act (2007)
4a  Procedure to follow for Walking Restraint (two staff)

**Step 1: Approach to the patient into Stage 1 Bicep Block**

Approach patient sideways on, at an arm’s length (figure 1).

Placing palm of hand above the patient’s elbow blocking the bicep (remembering to maintain your stable base) (figure 2).

**Step 2: Changing to Stage 2 Control of Wrist**

Outside hand collects patient’s wrist in an underhand hold (your thumb on top), whilst maintaining contact with your inside hand on the patient’s upper arm (figure 3).

Bring feet, hips and shoulders in to ensure there is no gap between the patient and staff, your inside hand (on the patient’s upper arm) slides around the back of their arm to cup above the elbow (figure 4).

Figure 1  
Figure 2  
Figure 3  
Figure 4
Step 3: Changing from Stage 2 to Figure of Four Hold (FOF)

Using your inside hand (the hand cupping the back of patient's elbow), bring your hand over patient's forearm (figure 5).

The inside hand comes over the patient’s forearm and takes hold of your own wrist (your outside arm) in an overhand hold (figure 5), coming into the figure of four hold. To ensure a secure hold tuck the patient’s arm under your own arm (figure 6).

Both staff members will be side on to the patient hip and shoulders in tight to the patient (figure 7).

![Figure 5](image1.png) ![Figure 6](image2.png) ![Figure 7](image3.png)

Step 4: Changing from Figure of Four Hold to Forearm Hold

With your inside hand that is holding your own wrist (figure 6) rotate your hand over the patient’s wrist (figure 8) to take hold of their forearm in an underhand hold (figure 9).

Once you have gone from the figure of four hold to the forearm hold this frees up both staff members outside hands to enable you to open doors, move obstacles or have a hand free to deflect any potential head butts. When using the forearm hold you will need to tuck the patient’s arm further under your own arm to keep control of the patient’s arm.

![Figure 8](image4.png) ![Figure 9](image5.png)
Safety considerations for Walking Restraint

When applying the Figure of Four hold it is important to tuck the patient's arm under your own inner arm, to ensure safe control of the patient’s elbow.

For the most aggressive patient the further you tuck the patient’s arm under your own inner arm the more control of the patient’s arm/elbow you will have, however there is potential to hyper extend the patient’s shoulder, so you must be mindful of this.

It is important to have your inside leg very close to the patient’s legs when applying walking restraint (as in figures 5, 7, 8, and 9), however from your waist upward you should slightly fan outward from the patient to avoid the potential to constrict the patient's breathing, and minimise the risks to yourself of potential head butt/biting.

If the patient deliberately lifts both feet off the floor you must not attempt to carry them in either the Figure of Four or Forearm restraint holds due to potential injury to you/the patient. In this instance you must release the patient, guiding them to the floor/protecting their head if it is safe for you to do so.

### 4b Procedure to Follow for Bed Restraint (minimum two staff)

#### Step 1: Control of Arms (N.B. The arms must be under control, before any attempt is made at leg restraint).

Ensure that bed rails are down and that you and your colleague approach the patient sideways on, from each side of the bed, with arms raised (to deflect potential kicks and strikes) simultaneously (arriving at the same time). Take care to avoid approaching at the patient’s leg area.

With hands in the over hand position cup the arms above the wrist above the elbow, to gain control of the elbows and wrists. Do not grip, but guide the patient’s arms down onto the bed alongside the patient (see figures 1, 2 and 3 below).

Adopt a sideways safety stance keeping the spine neutral, adopting the moving and handling body weight transfer position.

![Figure 1](image1.png) ![Figure 2](image2.png) ![Figure 3](image3.png)
Step 2: Transferring to Underhand Hold (lowest level arm restraint)

To enable safe holding of arms, move to the underhand hold on both arms (figure 4).

For this to be safe and effective the force used to keep the patient’s arm secure must go through your knuckles into the mattress and not through your thumbs into the patient’s arm. You may brace your own elbow/s against own body for additional support/strength (if required).

Step 3: Moving into the Elevated Arm Position

If the patient draws their arms up the bed, or you need to make them more secure to keep patient and yourselves safe, move with your patient, keeping your hands in same position (figure 5). Sit on the bed (facing upwards to the patient) blocking downward movement of patient’s arm/s with your inside thigh (figure 6). If patient’s elbow protrudes over edge of bed you may block patient’s arm with inner thigh from standing position (figure 7).

It is acceptable for the arms to be held safely in different positions on each side of the patient for example one side in straight arm hold (figure 4), and one in the elevated hold. It is important to adopt the principle of the least amount of restraint for the least amount of time, so do not move to the Elevated Arm Position if you do not need to.
Step 4: Transferring into the Figure of Four (highest level of arm restraint)

Only one staff member at a time to undertake this transfer to the Figure of Four (FOF). First staff member must have secure FOF hold before second staff member transfers into FOF (if applicable).

From the Elevated Arm Position turn inward toward the patient so you are looking at the patient’s feet (keeping hands in same position), either sitting (if chair is available) or kneeling in wide stable stance on floor (figures 9 and 10).

Then slide hand off elbow and snake your arm under the patient’s bicep/triceps area, over the patient’s forearm, taking hold of your own wrist. This is the FOF. When going into the FOF you must spike your inside elbow into the mattress to minimise compromising the patient’s shoulder by accidental hyperextension, and spiking the mattress will also help secure the arm safely. You should dynamically risk assess the appropriateness of this most secure arm hold for bed restraint against any known conditions of your patient (for example chest stenosis /shoulder injury) i.e. the potential risks of using the FOF must not outweigh the potential risks of not restraining the patient to this level.

Remember it is acceptable to have a different hold on either arm, i.e. straight arm hold, elevated arm hold, FOF hold (figure 10a).

When seated next to the patient in bed and applying the FOF remember to have your legs spread to provide you with a stable base (figure 10), and keep you head away from the vicinity of the patient’s face.

It is important for one staff member to continually reassure and communicate with the patient during the restraint episode.
Step 5: Leg Restraint (third staff member required)

If it is at all possible to avoid restraining the legs please do so, to preserve both patient dignity and staff safety. If however the legs have to be restrained to keep either the patient safe or others safe, it is vital that both arms are securely restrained in the first instance for the safety of the staff member restraining the legs.

A pillow is required for this technique to ensure both staff and patient safety and comfort.

Once you are sure that the arms are secure, hold the pillow up like a shield (figure 11).

Approach the legs of patient in a protective stance (narrowest part of your body to the patient in case of kick to body, presenting smaller target area).

Place on knee and lower thigh area of patient (figure 12).

![Figure 11](image1.png) ![Figure 12](image2.png) ![Figure 13](image3.png)

As pillow is placed over patient’s knees/lower thighs bring your inside leg up onto the bed to block the patient’s nearest leg (figure 13).

Lean over pillow just above the knees, and rest your arm down flat, distributing all of your weight through the far edge of the pillow and into the mattress (figures 14, 15 and 16).

It is vital for staff (your) safety that you face up toward the patient when performing leg restraint, so that the person restraining the legs is fully aware of the status of the arm restraint. Do not stare at the patient as this may not be helpful for the de-escalation phase, and be mindful that you will be in direct line of any potential projectile vomit/saliva from the patient.

![Figure 14](image4.png) ![Figure 15](image5.png) ![Figure 16](image6.png)
When exiting the leg restraint for your safety you must exit prior to the staff exiting the arm restraint. Once the legs have exited the staff on arms may then exit together at the same time, blocking the elbow as they leave in case of strike.

**Bed Restraint options:**

Option 1 – **Applying Head Block to stop patient building upward momentum (third staff member needed if only arms restrained, fourth member if legs are also restrained).**

An additional staff member may stand at patient’s head (head of bed), and holds crossed hands above the patient’s forehead to prevent the patient rocking their head up and down to build momentum to break out of the arm restraints, (figure 16).

This is a block and contact should only be made with the patient’s forehead if the patient rocks upward. Hands must be kept flat to avoid fingers accidentally going into patient’s eyes or ending up in patient’s mouth. The block will stop the patient from gaining upward movement/momentum as this may enable the patient to create enough energy to break out of the arm restraint if allowed to continue.

**Figure 17**

Option 2 – **Emergency cannulation back of hand**

From the FOF the hand that is cupping the patient’s wrist releases the patient’s wrist and sweeps the patient’s fingers away from patient (figure 18). Keep the inside arm still hooked over the patient’s arm, as this will keep the arm secure and protect you, should the patient attempt to strike out. Keep your thumb and fingers clear of patient’s grasp.

**Figure 18**
Safety considerations for Bed Restraint:

It is only possible to apply bed restraint safely and effectively with the bed rails lowered. Please be aware not to lean on the chest area/apply pressure to the patient’s airway, or occlude the patient’s mouth when undertaking bed restraint (do not interfere with the mechanics of breathing).

Only restrain the legs if there is no other option.

Staff member restraining legs is the last one in and first one to exit.

Staff members’ on arms must exit together.

<table>
<thead>
<tr>
<th>4c</th>
<th>Procedure to follow for Seated Restraint (two staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One staff member should take control of communication and should lead the restraint, communicating with the patient and the other staff member during the restraint episode. This procedure would be following on from walking restraint.</td>
</tr>
</tbody>
</table>

**Step 1: Approaching the patient’s bed space**

Ensure the patient’s bed space is clear before approaching. The bed must be at its lowest point and bed rails down, ask a colleague that is not involved in the restraint to assist in doing this if necessary.

Communicate with the patient throughout and prompt the patient to walk towards their bed. Stop at a legs length distance from the bed, to allow space for turning.

![Figure 1](image1.jpg)

**Step 2: Rotate right and approach the patient’s bed space backwards**

Once at a suitable distance from the bed space (to allow for adequate space for turning around in restraint position), the person on the right will start to rotate anti clockwise until both staff members and the patient have their backs to the bed (figure 2).

Staff member leading the communication will communicate for all to walk backwards until you all feel the bed edge on the backs of your legs (figure 3).

![Figure 2](image2.jpg) ![Figure 3](image3.jpg)
**Step 3: Sit on the bed**

The staff member communicating will ask the patient and other staff member if they can feel the bed on the back of their legs. The other staff member must respond positively even if the patient does not, prior to sitting down (to ensure patient and staff safety).

The staff member communicating will prompt all involved to sit.

On the word sit both staff members will exaggerate a seated position (figure 4) then sit on the bed.

![Figure 4](image)

**Step 4: Positioning of the legs (main positioning)**

Your inside leg will be alongside the patient’s leg so that the patient’s legs are together-this maintains patient dignity and braces the patient’s legs (figure 5).

Your outside leg will be positioned into a stable and comfortable angle for stability.

![Figure 5](image)  ![Figure 6](image)

**Step 5: Patient attempting to push back with legs**

If the patient attempts to push back with their legs, your inside leg will come under that leg and raise their foot off the floor (figure 6). Lower the foot as soon as you can back to main positioning of the legs.

**Step 6: Patient attempting to kick forward with legs**

If the patient attempts to kick the leg that you are bracing, your inside leg will come over the kicking leg to block, your knee and ankle should be positioned over the patient’s lower leg and not placed over the thigh (figure 7).

Slide the patient’s leg back as far as it will naturally go, ensuring that the patient’s leg is positioned with their foot facing forward.
Your foot should be planted firmly on the floor.

Your leg should be aligned from the hip, foot positioned straight in front of you (not at an angle, to avoid potential groin injury).

Ensure you maintain your outside leg in a stable and comfortable angle for stability. Resume main positioning of the legs as soon as possible.

**Step 7: Compliance of patient- testing before release**

Ask the patient to place their own hands onto their own thighs.

**Step 8: Change hand and arm position-preparing to release**

Rotate your underhand hold at wrist to an overhand block. Maintaining skin to skin (glove) contact with the patient at all times (see Figure 8).

Release your own wrist (inside hand) bringing this hand to block the patient’s bicep. Whilst doing this slightly slide yourself away from the patient, maintaining skin to skin (glove) contact with the patient at all times (see Figure 9 and 10). This is completed one staff member at a time. It is crucial to communicate with your colleague, both staff ending in the position of figure 11.
Step 9: Disengaging from Hold

Both staff need to shuffle to the edge of the bed, maintaining hand positions at all times (figure 12).

![Figure 12](image1.png)  ![Figure 13](image2.png)

Together both staff members will stand but maintaining hand positions and tilting heads away from the patient (figure 13).

Both staff are to move away at a 45° angle from the patient, maintaining vigilance at all times for both patient safety and your safety.

Safety Considerations

Check that the patient is safe to leave before exiting from hold. Ensure if leaving them on the edge of the bed their feet reach the floor to avoid them slipping off bed onto floor.

Both staff members to exit at the same time (figure 13), ensuring containment of patient’s elbow until safe to release, as this will protect against any potential re-escalation of aggression in the patient leading to a strike out against the staff releasing the hold.

<table>
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<tr>
<th>4d</th>
<th>Procedure to follow for the emergency relocation of patient (Double Forearm Hold one staff member)</th>
</tr>
</thead>
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The emergency relocation of a patient should only ever be used on a person that is slighter in stature than yourself (i.e. you must be able to easily reach your arm around the patient without constricting the patient’s breathing).

This technique should not be attempted by a lone member of staff if it is known or suspected that the patient is aggressive or has the potential to be aggressive. This technique should only be used as a last resort in an emergency (unless used for a child/young person and deemed more proportionate by staff caring for the young patient than the standard two person approach (section 4e)).
Step 1: Approach of the patient

Approach patient sideways on, at an arm’s length (figure1), placing palm of hand above the patient’s elbow blocking the bicep (remembering to maintain your stable base).

Step 2: First stage of the Single Person Double Forearm Hold

Your outside hand collects patient’s wrist in an underhand hold (your thumb on top), whilst maintaining contact with your inside hand just above the patient’s elbow to block the power from the patient’s bicep, and protect yourself (figure 2).

Step 3: Collecting the Patient’s Outside Forearm

Bring yourself in closer to the patient, maintain your side on stance; at this point you release your inside hand from the patient’s upper arm and guide your hand around the back of the patient with your palm facing outwards, this ensures your hand/fingers do not snag in clothing but also to protect yourself from allegations of inappropriate touching. Figure 3 illustrates this step of the technique from the posterior demonstrating position of your palm facing away from the patient.

Step 4: Final step of single person double forearm hold.

Using your inside hand that has come around the back of the patient, move your hand over the patient’s forearm (figure 4). Collect the patient’s forearm in an overhand hold. At this point tuck the patient’s arms back, keeping the gap between you and the patient closed.
Safety considerations for Double Forearm Hold one staff member

Relative size of the patient and size of staff member must be considered (staff arms must be able to go around patient’s width without causing constriction to the patient).

Assess if single person approach is appropriate- will assistance be required (two person Double Forearm Hold, see below)?

Ensure that your thumb is positioned on the patient’s forearm next to your own fingers and not under the patient’s forearm because this can cause pain and trauma to the patient (will dig into their side/ribs).

Be mindful not to pull in on the patient’s arms, as this may restrict the patient’s breathing.

### 4e Procedure to Follow for Emergency Relocation of Patient (Double Forearm Hold two staff)

Whilst undertaking the one person double forearm hold described in section 4d (above), in circumstances whereby the patient becomes increasingly agitated/confused/aggressive, to maintain both patient and staff safety it will be necessary to transfer into the two person double forearm hold.

The emergency relocation of a patient carried out by a single member of staff is only to be used in an emergency situation, therefore if the patient is still requiring restraint another member of staff should come to assist for the safety of both the patient and staff member as soon as possible.

The first member of staff maintains the same hold of the patient until the second staff member has a secure hold of the patient. Both staff members need to remain present until the restraint is no longer required or other measures put in place to maintain the safety of both the patient and others.

**Step 1: Approach of second staff member**

From the single staff member Double Forearm Hold (figure 1), the second member of staff would approach the patient side on, using their outside hand to collect the patient’s wrist in an underhand hold (figure 2).

**Step 2: Second staff member locates patient’s outer forearm**

Using their inside hand the second member of staff taps the shoulder of the first member of staff to prompt first staff member to create a gap under the patient’s arm for the second staff member to bring their hand through the gap and collect the patient’s forearm in a underhand hold (figure 3).
The second staff member guides their hand around the back of the patient with their palm facing outwards, this ensuring their hand/fingers do not snag in clothing but also to protect themselves from allegations of inappropriate touching (figure 4).

Figure 3  Figure 4

Step 3: The Double Forearm Hold with two staff

Both staff members would bring their hips in close to the patient whilst ensuring their upper bodies are not leaning inward, which may cause constriction to the patient’s breathing. From the waist upward staff should fan outward from the patient, both to allow ease of breathing for the patient, but also to minimise risks to staff of potential head butting/biting (figure 5).

Figure 5  Figure 6

Safety considerations for Double Forearm Hold with two staff

Relative size of the patient and size of staff member must be considered (staffs arms but be able to go around patient’s width without causing constriction to the patient).

By utilising the double forearm hold each staff member may free up their outside hands to shield against any potential head butts /spitting (figure 6).

Staff to ensure their thumbs are on top of patient’s forearm (figure 5) otherwise thumbs will dig into patient’s ribs.

If the patient deliberately lifts both feet off the floor you must not attempt to carry them in either the Figure of Four or Forearm restraint holds due to potential injury to you and the patient. In this instance you must release the patient, guiding them to the floor/protecting their head if it is safe for you to do so.
5 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is one year from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

6 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust’s formal documents library and all staff will be notified through the Trust’s normal notification process, currently the ‘Vital Signs’ electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Chief Nursing Officer and for working with the Trust’s training function, if required, to arrange for the required training to be delivered.

7 Monitoring and Assurance

The Physical Interventions Team will monitor instances of restraint by reviewing reported incidents, and working with the Safeguarding Team, to identify and investigate any concerns surrounding the use of inappropriate patient restraint, or the use of inappropriate restraint techniques.

Staff working in high risk areas will receive annual refresher training on restraint techniques guidelines, and risks in accordance with UHPNT policies and National frameworks.

8 Reference Material


DOH (2019) Reducing the Need for Restraint and Restrictive Intervention Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties.


Mental Health Act (1983) www.legislation.gov.uk

