TRAFFORD
COUNCIL

Services for Children, Young People and Families

Children in care

Children's homes

Restrictive Physical Intervention

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Staff and carers have a “duty of care” to children in care. This may involve all staff having to handle children to prevent them harming themselves, others or damaging property

1. Introduction

This policy has been prepared for the support of all staff and carers who come into contact with children and young people.

The policy is intended to explain the arrangements for physical intervention. Its contents are available to parents, carers, staff and other professionals working with children in care.

The policy should be read in conjunction with other Children in Care policies relating to interaction between adults and children and in particular the Behaviour Policy.

“Team-Teach techniques seek to avoid injury to children, but it is possible that bruising or scratching may occur accidentally, and these are not to be seen necessarily as a failure of professional technique, but as a regrettable and infrequent side effect of ensuring that the child remains safe.”

Values and underpinning principles of the policy

2. Purpose of Policy

The Children in Care Service believes that good personal and professional relationships between staff, carers and children are vital to promote positive behaviour. It is recognised that the majority of children respond positively to the discipline and control practised by carers. It is also acknowledged that in exceptional circumstances, staff and carers may need to take action in situations where the use of reasonable force may be required.

Every effort will be made to ensure that all staff and carers:

(i) clearly understand this policy and their responsibilities in the context of their duty of care in taking appropriate measures where reasonable force is necessary and

(ii) are provided with appropriate training to deal with these difficult situations.

Individual members of staff and foster carers cannot be required to use restrictive physical intervention without training. Following training they are required to do so to ensure the safety of the children and others, including themselves.

Such intervention must be in the paramount interests of the child.

The application of any form of physical control places staff and carers in a vulnerable situation. It can only be justified according to the circumstances described in this

policy. Staff and carers therefore, have a responsibility to follow the policy and to seek alternative strategies wherever possible in order to prevent the need for physical intervention.

Physical Intervention will only be used as a last resort when all other behaviour management strategies have failed.

3. Definitions

a) Physical Contact

Situations in which proper physical contact occurs between carers and children, e.g., young children who are upset or ill

b) Physical Intervention Positive Handling

This may be used to divert a child from a destructive or disruptive action, for example guiding or leading a child by the hand, arm or shoulder with little or no force. (Refer to Behaviour Management policy)

c) Restrictive Physical Intervention

This will involve the use of physical intervention/ reasonable force when there is an immediate risk to children, staff, carers or risk of significant damage to property.

4. Underpinning Principles

Children, staff and carers have a right to

- recognition of their unique identity;
- be treated with respect and dignity;
- live and work in a safe environment;
- be protected from harm, violence, assault and acts of verbal abuse.

Children, staff and carers have a right to;

- individual consideration of a child's needs by staff who have a responsibility for their care and protection;
- expect staff and carers to undertake their duties and responsibilities in accordance with the CiC policies;
- be informed about house rules, relevant policies and the expected conduct of all children and staff
- be informed about the CiC complaints procedure.

5. Persons authorised to use Restrictive Physical Intervention

Only staff or foster carers who have undertaken the Team Teach Training can undertake any form of restrictive physical intervention.

Health care staff working within the service will have their own policies regarding physical intervention. Such staff will, whilst on the children's homes premises, be expected to be aware of and operate within the policy of the home.

Some residential staff have completed Advanced Team Teach training which includes the removal of 'weapons'. Staff will inform the police of any serious threat to a child, staff or visitor to the home that involves the use of a 'weapon' and will intervene to remove a 'weapon' if necessary.

6. Training

All staff, and foster carers, will be made aware of this policy and the behaviour management policy. All staff will be provided with training in managing behaviour, including how to diffuse potentially difficult situations and how to avoid confrontation. Such training will include advice about physically intervening with children.

Where risk assessment indicates a need for regular restrictive physical intervention a Physical Intervention Plan for an individual child is necessary.

Preventative and pro-active strategies to deal with challenging behaviour

Please refer to Behaviour Management Policy which includes, Promoting Positive Behaviour, Rewards and Sanctions and Positive Handling

7. Escalating Situations

Reasonable force may be used to prevent a child from doing, or continuing to do any of the following:

- self-injury or placing him or herself at risk;
- injuring others
- causing significant damage to property, including that belonging to the child
- committing a criminal offence (even if the child is below the age of criminal responsibility)

8. Types of Incidents where physical intervention may be required

(a) where action is necessary in self-defence or because there is an imminent risk of injury;

(b) where there is a developing risk of injury, or significant damage to property that may put themselves or others at risk of injury.

Examples of situations which fall into one of the first two categories are:

- a child attacks a member of staff, carers or another child;
- children are fighting;
- a child is engaged in, or is on the verge of committing, deliberate damage or vandalism to property;
- a child is causing, or is at risk of causing, injury or damage by accident, by rough play, or by mis-use of dangerous materials or objects;
- a child is behaving in a way which he or she might cause an accident or injury to himself, herself or to others;

Children who harm themselves

Children in care who regularly seek to harm themselves should have a referral made for an appropriate health service. A clear risk assessment must be written which identifies the level of risk, increasing risk factors and control measures identified to reduce the level of risk placed to reduce any identified risk.

In cases where Physical Intervention is considered a necessary control measure the Head of Service must agree to this being written as a control measure to be used.

As with other P.I. plans, this should make clear to carers and staff exactly what steps will be taken to prevent or minimise what aspects of self-harming behaviour. This may include, with the consent of parents and child where applicable, restraint.

Staff and carers regularly dealing with children who are likely to be needed to be physically restricted must be trained in P.I.

Behaviour of this kind is sometimes a feature of children with ASD/ PMLD/ SLD and children with significant emotional and mental health issues.

Staff and carers must be aware of triggers to such behaviour and situations where household equipment may be used by children to harm themselves or others.

Staff and carers should also be alert to things brought into the home from outside (especially sharp objects) that may also be used to harm. These should be removed from children or if this proves difficult or hazardous, the police called to assist. Where there is suspicion of a harmful article in a child's possession and child refuses to co-operate, the police should be called upon to assist.

Children who harm members of staff or carers

A few children seek to scratch or bite members of staff or their carers. Where this is predictable staff and carers should ideally be "Team Teach" trained. Such training

teaches staff and carers to avoid (as far as is possible) putting themselves in a situation where they can be harmed.

Incidents in which people are harmed must be reported and recorded appropriately. It is advised injections against tetanus and hepatitis B must be kept up to date. Staff and carers must have access to protective gloves and aprons where blood or bodily fluids are involved

9. Sanctions and rewards as an alternative to physical intervention

Guidance for carers on how positive behaviour can be promoted, the use of rewards and sanctions, prohibited sanctions and positive handling are written into the Promoting Positive Behaviour and Behaviour Management Policy. All carers must have a copy of this policy and receive appropriate training and support of understanding children and behaviour management

Positive behaviour is to be promoted by the use of:

- Praise and encouragement
- Awarding of points
- Choice of activities
- Star charts
- Appropriate rewards
- Certificates
- Privileges
- Points systems

10. Acceptable measures of physical intervention

The use of any degree of force can only be deemed reasonable if:

(a) it is warranted by the particular circumstances of the incident;

(b) it is delivered in accordance with the seriousness of the incident and the consequences which it is intended to prevent;

(c) it is carried out as the minimum to achieve the desired result;

(d) the age, level of understanding and gender of the child are taken into account

(e) it is likely to achieve the desired result;

Wherever possible assistance should be sought from another member of staff or another foster carer before intervening.

Physical intervention uses the minimum degree of force necessary for the shortest period of time to prevent a child harming himself, herself, others or property

Physical Intervention will stop immediately if the child has;

- difficulty in breathing
- vomits
- has a fit or seizure
- experiences swelling or change of hue of skin.

If it is not possible to use physical restraint due to the staff/carer being unable to apply a hold or in certain cases of extreme personal danger or threat, staff/carer must retreat from any danger and ensure the safety of any other children or staff.

In these situations or if a dangerous situation escalates it may be necessary to involve the police.

The form of restraint should only “be reasonable in the circumstances” as likely to be judged by an independent third party i.e. socially acceptable

Restraint techniques should only be used by staff/carers trained to use them

Restraint should not:

- Endanger airways and breathing (e.g. block mouth, nose, throat or pressurise chest)
- Touch or damage eyes, ears, sexual areas
- Injure someone. Consider restraining by holding clothing safely
- Inflict pain; particularly avoid gripping a person by the head or fingers

The following principles apply to the use of physical restraint:

- The objective of physical intervention is to assist a child to regain control and begin the process of discussing what is causing the distress.
- Be aware of the child’s history, age and level of understanding
- Be sensitive to the child: make the experience as dignified as possible
- Only use the holds you have been trained to use
- Always use the minimum force necessary
- Communicate in a calm and reassuring manner

- If the child drops to the floor or a prone position gently relax the hold; **do not use physical restraint on a child on the floor or a prone position**. Check the child's comfort

- The restraint must be relaxed gradually and as soon as possible to allow the child to regain control.

- Make sure another member of staff/carer is present

- Remove any other children away from the situation

After an incident of physical restraint the child should be released in a planned and calm manner. The child will need reassurance and support; this is not the time to deal with any recriminations.

Children should be reminded of their rights, including their right to complain.

Wherever physical intervention is used staff/carers will keep talking to the child in a reassuring and positive manner unless risk assessment has indicated that this is likely to inflame the situation.

Children will not be taken to the ground. In circumstances where the child takes staff to the ground every attempt will be made to hold them in a seated position and not either prone or supine position.

Following any incident of restrictive physical intervention the child must be offered medical attention either through their GP or attendance at A&E.

Unplanned physical intervention will trigger a risk assessment that may lead to a Physical Intervention Plan/Positive Handling Plan being developed.

Length of individual restraint

- Staff and carers involved in a lengthy Team Teach restraint should be changed to ensure the issue is not (simply) with the member of staff involved

- A restraint lasting 20 minutes or more should trigger the involvement of the police

- Staff are vulnerable if involved in over-lengthy restraint

Frequency of individual restraint

- Details of risk assessed frequency should be in a child's P.I plan

- Frequent P.I is deemed to be 2/3 times each week

- There needs to be a significant reduction in the frequency of restraint over a short period of time (2/3 weeks)

- If frequent use of P.I is required over a longer period of time (5/6 weeks) CAMHS should be involved as a matter of urgency

- If there is no reduction in frequency then a planning meeting should be arranged

Children for whom frequent and prolonged P.I. is required

Where such a child is known to be considered for placement to a children's home or less likely a foster placement a P.I plan must be in place and agreed with parents and carers before placement.

Advanced Team Teach techniques may be required for such a child and should be discussed with our Team Teach trained staff or Team Teach consultant. Such training for key staff should also be in place before any placement.

11. Planned Physical Intervention and Risk Assessment

- Planned physical intervention will arise from a child's individual risk assessment
- Such assessments will be written and signed by the social worker, staff/carer, parents/guardians and (where appropriate) the child
- Planned physical intervention will be agreed in advance
- Implemented only by trained staff/carer
- Must be a written and signed Physical Intervention plan. Those who sign the plan will be the social worker, parent and child if appropriate and staff/carer
- Recorded as planned intervention
- Be part of a holistic care/individual plan
- Shortest time/minimum force

12. Unacceptable measures of physical intervention

- Locking a child in a room. Seclusion of a child (forcing them to spend time alone against their wishes) in this way requires statutory powers other than in an emergency. Seclusion is different from 'time out' which is restricting positive reinforcement as part of a planned behaviour programme and requires an agreed written plan. Often time out to an agreed safe place within the building is nominated by and agreed with the child in advance. Withdrawal is removing a child from a situation but they are observed and supported until they are ready to resume normal activities. With 'time out' and 'withdrawal' the child may be alone in an unlocked room with a member of staff/carer continually observing the child or staff/carer being present in the room along with the child. Such provision will be part of an agreed plan
- Physical punishment including slapping, pushing and rough handling
- Deprivation of food, drink, medical attention or sleep

- Making a child wear distinctive clothing
- Restriction to breathing/circulation (see below)
- Pressure on joints
- Use of a mechanical or therapeutic device unless agreed as part of a physical intervention plan

Physical Interventions – Positional Asphyxia

Deaths in and following restraint continue to occur in the UK in a variety of workplace settings. It is essential that all staff are made aware of the potential dangers associated with restraints, understand their mechanisms and can recognise their early signs.

Background

A number of adverse effects (including some deaths) have been reported following the application of restraints. These deaths have been attributed to positional asphyxia (asphyxiation resulting from an individual's body position). Adverse effects of restraint include being unable to breathe, feeling sick or vomiting, developing swelling to the face and neck and development of petechiae (small blood-spots associated with asphyxiation) to the head, neck and chest. This advice sheet serves to remind staff of the dangers of restraint and signs of impending asphyxiation.

Mechanics of Breathing

In order to breathe effectively, an individual must not only have a clear airway but they must also be able to expand their chest, since it is this that draws air into the lungs. At rest, only minimal chest wall movement is required and this is largely achieved by the diaphragm and the intercostals muscles between the ribs. Following exertion, or when an individual is upset or anxious, the oxygen demands of the body increase greatly. The rate and depth of breathing are increased to supply these additional oxygen demands. Additional muscles in the shoulders, neck, chest wall and abdomen are essential in increasing lung inflation. Failure to supply the body with the additional oxygen demand (particularly during or following a physical struggle) is dangerous and may lead to death within a few minutes, even if the individual is conscious and talking.

Positional Asphyxia

Any position that compromises the airway or expansion of the lungs may seriously impair a subject's ability to breathe and lead to asphyxiation. This includes pressure to the neck region, restriction of the chest wall and impairment of the diaphragm (which may be caused by the abdomen being compressed in a seated kneeling or prone position). Some individuals who are struggling to breathe will 'brace themselves' with their arms: this allows them to recruit additional muscles to increase

the depth of breathing. Any restriction of this bracing may also disable effective breathing in an aroused physiological state.

There is a common misconception that, if an individual can talk, they are able to breath. This is not the case. Only a small amount of air is required to generate sound in the voice box, a much larger volume is required to maintain adequate oxygen levels around the body, particularly over the course of several minutes during a restraint. A person dying of positional asphyxia may well be able to speak prior to collapse.

When the head is forced below the level of the heart, drainage of blood from the head is reduced. Swelling and blood spots to the head and neck are signs of increased pressure in the head and neck which is often seen in asphyxiation. A degree of positional asphyxia can result from any restraint position in which there is restriction of the neck, chest wall or diaphragm, particularly in those where the head is forced downwards towards the knees. Restraints where the subject is seated require particular caution, since the angle between the chest wall and the lower limbs is already partially decreased. Compression of the torso against or towards the thighs restricts the diaphragm and further compromises lung inflation. This also applies to prone restraints, where the body weight of the individual acts to restrict the chest wall and the abdomen, restricting diaphragm movement.

13. Recording

Where restrictive physical intervention as defined in 3c) has been used to manage and safeguard a child, a record of the incident must be kept. This record will be made in the homes Serious Incident Book and Physical Intervention Log or for foster carers recording sheets, the report must include:

- the name of the child
- the date, time and place of the incident
- a brief description of the incident and any actions taken.

The Incident Book will be completed as soon as possible after the incident by the staff member, normally prior to staff going home. It will be countersigned by the Registered Manager.

A copy of this is to be forwarded to the child's social worker and a copy held on the child's file. A copy must also be sent to the Placements Manager for children's homes or the Team Manager of Family Placement Team for children in foster placements.

Parents (where appropriate) are also entitled to a copy of the Record of Restraint on request. They should be informed of the incident by the child's social worker.

In addition, specific details of the use of planned or unplanned physical intervention will be recorded on a Record of Physical Intervention form (Appendix 1) which will include:

- how the incident developed
- attempts made to calm the situation

- names of any person who witnessed the incident
- the outcome of the incident including any injuries sustained by any child, member of staff or carer
- any damage to property which had resulted
- whether/how parents have been informed
- (where possible) child's view of the incident and whether they wish to make a complaint
- and, after investigation, a summary of actions taken

A Health and Safety Accident/Incident Form (HS1) will be completed and returned to the Authority when an injury has occurred during Physical Intervention.

The Service will review such records at least every half term to ensure that:

- Records are being appropriately kept
- Patterns of behaviour in individual children
- Training issues arising from the above are being identified and addressed

14. Action after an incident

See also Section 17

The Registered Manager or Child's Social Worker will ensure that each incident falling into 3c) above is reviewed and investigated further as required. In the case of planned intervention a meeting will be held if it is agreed to be necessary. In the case of unplanned intervention a meeting will always be held. Meetings of this type will be arranged within 5 working days of the physical intervention incident.

If further action is required in relation to a member of staff, carer or child, this will be pursued through the appropriate procedure

- Child Protection Procedure
- Staff Disciplinary Procedure
- Behaviour Policy

The member of staff will be kept informed of any action taken.

In the case of action concerning a member of staff, he/she will be advised to seek advice from his/her professional association/union.

Where staff/carers have been involved in an incident involving physical intervention they should have access to counselling and support. Within the children's home, this is available through the BDMA scheme and for foster carers through Fostertalk.

The Post Incident Support Structure for Children and Staff

Following a serious incident it is the policy to offer support for all involved. People take time to recover from a serious incident. Until the incident has subsided the only priority is to reduce risk and calm the situation down. Staff/carers should avoid saying or doing anything which could inflame the situation during the recovery phase. Immediate action should be taken to ensure medical help is sought if there are any injuries which require more than basic first aid. All injuries should be reported and recorded using the correct systems. It is important to note that injury in itself is not evidence of malpractice. Even when staff/carers attempt to do everything right things can go wrong. Part of the post incident support may involve a reminder of this, as people tend to blame themselves when things go wrong. Time needs to be found to repair relationships. When careful steps are taken to repair relationships a serious incident does not necessarily result in long term damage. This is an opportunity for learning for all concerned. Time needs to be given to following up incidents so that children have an opportunity to express their feelings, suggest alternative courses of action for the future and appreciate other people's perspective. When time and effort are put into a post incident support structure the outcome of a serious incident can be learning, growth and strengthened relationships.

15. Complaints

Any complaints received from parents, staff or any other persons regarding alleged ill treatment of children or injuries received by a child during the course of physical intervention must be fully investigated in accordance with procedures

16. Monitoring of Incidents

Whenever a member of staff/carer has occasion to use physical intervention, this will always be recorded, documented and reported to the child's social worker.

Monitoring of incidents will help to ensure that staff are following the correct procedures and will alert the Registered Manager of the Children's Home, Team Manager of Family Placement Team and the child's social worker to the needs of any child whose behaviour can only be contained by the use of Physical Intervention. Monitoring of incidents will assist managers to identify any patterns of incidents and assess training needs of carers and staff.

17. Support

Children must be offered appropriate support following any incident of physical intervention. The child's social worker must undertake a visit to a child following an incident of Restrictive Personal Intervention.

18. The Removal of Weapons

Staff working at the children's homes are trained in the removal of weapons. Weapons are not permitted in the children's homes and zero tolerance will be implemented. The staff will only attempt to remove a weapon in circumstances where by not attempting to remove the weapon will seriously endanger the child, young person, staff or others. The staff will request police assistance if a weapon is not handed in or the staff cannot remove safely.

Only staff that have completed the Team Teach Advanced Weapons course are qualified to remove weapons.

Physical Intervention Risk Management Assessment

Name of Child/Young Person:	**D.O.B:**	**Date:**

Description of Behaviour Causing Concern:

1. Risk Area	**2. Risk Consequences**
1.1 Physical Environment:	2.1 Injury to self:
1.2 Interaction with others:	2.2 Injury to others/property/environment:

3. Risk Outcome Level:

Low	High	Very High

4. Risk Probability

Low	High	Very High

5. Risk Management:

If physical intervention/restraint is identified as a means of managing the risk then an individual intervention plan **must** be completed.

Specific Risks (Please Number)
How to manage the risk (Please Number)

6. Signatures of Multi-disciplinary Team:

Name

Designation

Organisation

Signature

Date

7. Date of Review:

INDIVIDUAL PHYSICAL INTERVENTION PLAN

This must be completed for any child where physical intervention is used in conjunction with the individual risk assessment. The purpose of this plan is to identify the appropriate action to prev

CHILD'S NAME:

DATE OF BIRTH:

1. Description of behaviours:

2. Indicators/known triggers of behaviours:

3. Proactive measures taken to decrease behaviours – where applicable refer to individual guidelines/strategies. Indicate clearly if these differ in different settings:

4. Reactive measures taken - indicate clearly the strategies for physical intervention agreed. Indicate clearly if these differ in different settings:

5. Describe any approaches or methods previously used with the child that have not been successful:

6. Give details of any specific techniques which should not be used (for example, this may be as a result of the child experiencing abuse in the past, Medical information):

7. Details of GP or Paediatrician consulted

   Name:

   Address

   Tel:

8. State, as appropriate, any medical/health implications of the planned intervention

9. State any other significant factors e.g. life events, history of abuse

10. This plan has been agreed by:

Name	Designation	Organisation	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Date form completed:

12. Review dates:

13. Attach Risk Assessment to this plan