Restrictive Physical Intervention Policy

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1. Scope

The headteacher has the responsibility to maintain the safety and wellbeing of the students and staff. This policy focuses on how we may use physical intervention with students, what processes we have in place to ensure we are recording and reporting all instances of restrictive physical intervention (RPI) and how we are working to reduce its use in our educational settings.

This policy has been written considering the need to comply with the requirements of the Manual Handling Operations Regulations, 1992 (revised 1998 edition), and the Health and Safety at Work Act, 1974. It takes full account of the Equality Act 2010, the Children and Families Act 2014, the European Convention for the Protection of Human Rights and Fundamental Freedoms and the EU Charter of Fundamental Rights. It also complies with and supplements the relevant provisions of the Education Act 1996, Education and Inspections Act 2006 and the Government's directives to reduce school exclusions.

This policy must be read in conjunction with the following policies:

- Anti-bullying Policy
- Child Protection and Safeguarding Policy
- Behaviour Policy
- Exclusion Policy
- Health & Safety Policy
- Staff Code of Conduct
- Confidential Reporting/Whistleblowing Policy

2. Context

Young people with social, emotional, and mental health difficulties sometimes behave in ways that others can find challenging and which, on some occasions, may be dangerous; potentially resulting in harm to the person displaying the behaviour, peers, staff, or the public. Such behaviours may initially appear to be unpredictable and can be frightening for all concerned including the person displaying the behaviour.

Across the United Kingdom, the primary duty of Horizon Care and Education Group, as a care and education provider are to ensure the people, we support are safe from harm. The fundamental but complex need to balance the right to freedom, dignity, and respect, with ensuring safety from harm is at the heart of this policy and guidance (The Restraint Reduction Network (RRN) Key Strategy 1)

There are a variety of approaches and strategies that can be used to prevent situations from developing into incidents likely to cause harm such as: de-escalation, low arousal techniques and other examples of Positive Behaviour Support. However, on some occasions it may be necessary to use, as a last resort, a strategy that includes a restrictive practice. Any form of restrictive practice will only be used in order to maintain the welfare and safety of the young people we support and others.

Staff will be trained in approved techniques and any unplanned interventions outside of an individual's behaviour support plan will be investigated to ensure that action taken was proportionate and applicable at the time to prevent harm to the individual or others.

3. Legal context

British Institute of Learning Disabilities define a restrictive practice as:

'The implementation of any practice or practices that restrict an individual's movement, liberty, and freedom to act independently without coercion or consequence. Restrictive practices are highly coercive actions that are deliberately enacted to prevent a person from pursuing a particular course of action" - BILD Code of practice 4th edition.

Regarding physical intervention, the crux of common law (both criminal and civil) is that:

- Any threat of non-consensual touching is an assault.
- Any actual touching is battery.
- Any wrongful hindrance to mobility is false imprisonment.

The law recognises that there are situations where some restrictive practice is necessary as an act of care. For example, if someone has a learning disability, mental illness, or related disorder, which puts someone at risk, staff may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the staff member must do what is reasonable to protect the person from reasonably foreseeable harm. If someone's actions could put other people at risk, staff have a duty of care to respond positively, which might include as a last resort restraining the person to prevent harm.

To ensure that we follow best practice when managing signs of stress and physically challenging behaviour, we follow and adhere to the guidance within the BILD codes of Practice and the RRN guidance, the guidelines include the 6 key strategies to the reduction of the use of restraint.

1. Leadership
   The organisation develops a mission, philosophy and guiding values which promote non-coercion and the avoidance of restraint. Leaders commit to developing a restraint reduction plan which is implemented and measured for continuous improvement.

2. Performance Measurement
   The organisation takes a 'systems' approach and identifies performance measures which determine the effectiveness of its restraint reduction plan.

3. Learning and Development
   The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence, and acute behavioural disturbance.

4. Providing Personalised Support
   The organisation uses restraint reduction tools which inform staff and shape personalised care and support to students.

5. Communication and Student Focus.
   The organisation fully involves students in the management of their own behaviour, identifies the needs of students and uses these to inform provision and development.

6. Continuous Improvement
   The principle of post-incident support and learning is embedded into organisational culture.

A restrictive practice is only justified in law if there is the presence of a clear and immediate danger. The term 'immediate' in this context refers to seconds as opposed to minutes. It does not justify action taken to prevent a possible danger unless incident data clearly shows that a given behaviour or cue quickly results in escalation to a dangerous level, in which case a planned intervention may be justified in the short term, whilst furthermore positive and proactive strategies are developed (See British Institute of Learning Disabilities Code of Practice).

As well as the presence of a clear and immediate danger staff must also be able to demonstrate that all other available less restrictive options have been tried and failed before the use of a restrictive practice. A useful acronym in this situation is 'TINA' - There Is No Alternative.

The PACE framework and Sherwood training offers guidance and a series of non-restrictive and non-aversive techniques to avoid/reduce the use of restrictive practices. There is an expectation that alternatives to restrictive practices would increase with staff training, experience, and knowledge of the individual (RRN Key Strategy 4).

If you can find no alternative to using a restrictive practice, then you should use it.

3.1 Duty of Care

Horizon Care and Education Group staff have a duty of care towards the young people

supported, which requires the organisation to take reasonable care to avoid doing something or failing to do something which results in harm to another person. There are situations where some action must be taken, and it is a matter of choosing the course of action that would result in the least harm.

3.2 Best Interest

The principle of best interest applies. A member of staff must demonstrate that in the presence of a clear and immediate danger they have considered all available alternatives, acted in the best interest of the person in their charge, have considered that not acting could result in greater harm, and does not use unreasonable or excessive force, then the action can be defended in law.

3.3 Reasonable & Proportionate

Any force used must be 'reasonable and proportionate', reasonable in that it is the minimum force required to prevent injury and proportionate in that it is not excessive given the seriousness and likely harmful consequences of the person's behaviour. As with all issues to do with caring for, developing, and teaching the children and young people we support, decisions need to be made on the best available knowledge at the time.

A useful concept to bear in mind when carrying out any restrictive practice is that of Social Validity. During any restrictive practice we should be conscious both of how our intervention may look to others not involved in the interaction and how we would like ourselves, family members or friends to be interacted with in similar circumstances.

4. Restrictive physical interventions

All those supported in school and requiring any form of behavioural intervention will have a behaviour support plan and risk assessment that provides detailed information relating to all aspects of a student's behaviour and how to support them.

The plan is person centered in its approach setting out details about the individual's behaviours including hypotheses about the functions of a particular behaviour, known as contributory environmental factors, antecedents, triggers, as well as how known behaviours should be recorded when they occur. Whenever possible the plan ought to be produced in collaboration with the student and/or parents/carers. The plan describes the proactive and reactive strategies that are to be followed by those supporting the student to improve the student's quality of life and reduce the risk of harm to themselves or others (RRN Key Strategy 3 & 4).

Part of this reactive plan may include restrictive practices where necessary and deemed in a student's best interest. Where someone has capacity to consent, then they need to agree and sign their plan. Where someone does not have capacity, the plan must be agreed as in their best interest by the relevant people involved in their care (RRN Key Strategy 5).

Restrictive practices can take several forms and may not always involve direct physical force but also mechanical restraint and environmental restraint, such as the holding of doors or blocking access by use of a person.

Restrictive practices can be categorised as planned or unplanned practices.

4.1 Planned Restrictive Practice - pre-arranged interventions based on risk management and are clearly recorded in behaviour support plans.

These interventions should be Sherwood Positive Behaviour Management sanctioned techniques and staff will be fully trained to carry out these interventions. They will be agreed as in an individual's best interest and as the least restrictive intervention and used for the least amount of time possible (when the present and immediate danger has passed). The time frame for reporting the use of a planned restrictive practice is within 24 hours of the practice/Intervention taking place.

4.2 Unplanned Restrictive practices - an action used in response to unforeseen hazardous events such as a student supported is about to run out in front of a car and There Is No Other Alternative (TINA).

The time frame for reporting the use of an unplanned restrictive practice is within 24 hours of the practice/Intervention taking place.

Wherever possible, an unplanned response should still be a Sherwood Positive Behaviour Management sanctioned and trained technique. However, in an emergency situation if this was not practicable, but an intervention is still urgently needed to prevent harm to self and/or others, staff must follow the legal principles laid out at the start of this policy by providing a reasonable and proportionate response to the situation they are presented with, only when all other options have been explored where and when possible.

Where unplanned or unintentional incidents of restrictive practices occur, they should always be recorded, opportunity given to debrief to ensure learning and continuous safety improvements (RRN Key Strategy 6).

If monitoring shows that an unplanned restrictive practice is required on more than one occasion in a 4-week period the behaviour support plan and risk assessments should be amended to include a planned restrictive practice, along with proactive measures to reduce the need for such interventions over time (RRN Key Strategy 6).

Unacceptable and dangerous intervention - There are a number of interventions that are either unacceptable, dangerous and often both:

- Prone restraint - Chest on floor / other surface
- Supine restraint - Back on floor / other surface
- Any restraint using the locking of joints
- Any restraint using pain to achieve compliance
- Any restraint that involves forcing the head forward onto the chest area.

The above interventions should be avoided even in emergency situations unless the situation is life threatening. Care should be taken with any physical practice involving a person with underlying health problems such as swallowing, obesity or heart problems. When assessing the needs of any individual that requires the use of a restrictive practice as part of their support plan, it is essential that advice is sought from the relevant medical professionals around the use of such practices for the individual when underlying medical conditions are diagnosed and/or apparent.

Medical attention should be sought if a Restrictive Practice has been used to support someone with underlying health issues (RRN Key Strategy 5).

5. Seclusion

Seclusion and segregation are recognised terms in mental health inpatient environments and are defined in the Mental Health Act code of practice. The definitions below seek to explain the practice and give examples that might apply in school situations. Seclusion normally takes place as a direct response to manage an incident or episode. Segregation is usually an active decision to care for somebody separately.

Seclusion: Seclusion refers to the supervised confinement and isolation of a person, away from other people, in an area from which the person is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others.

The reason for seclusion might be because the person is highly aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings when other therapeutic interventions have failed to contain the behaviour.

Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his/her own free will, may be deemed a restriction of liberty. Under this Act, restriction of liberty of children is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation.

Advice for staff working in schools is that seclusion should not be used - if it is used as an unplanned response to prevent harm in an emergency, there should be an immediate review and risk assessment and the production of a plan that considers the use of proactive strategies and less restrictive options.

During any period of seclusion, staff must remain in sight of the individual. Staff must be able to observe an individual at all times to ensure the student's health and wellbeing and that their needs are met. This includes access to the toilet, food and drink and activities.

If this is an agreed restrictive practice, follow the guidance in the student's behaviour, support plan and risk assessment. This must be recorded as a restrictive physical intervention within 24 hours of the incident.

Seclusion should only be used:

- As a last resort
- For the shortest possible time

Seclusion should never be used:

- As a punishment or threat
- As part of a behaviour support programme, unless the aim is to introduce a graded restrictive reduction plan where these strategies have been used previously
- Because of a shortage of staff
- Where there is a risk of suicide or self-harm

5.1 Planned Seclusion

Prior to use, planned seclusion must be discussed with the managing director and ratified with an appropriate legal framework.

Any period of seclusion must be agreed and signed by the Headteacher.

Agreed protocols for recording and monitoring planned seclusion must be in place before any period of seclusion.

5.2 Unplanned Seclusion

If seclusion is used as an unplanned response to an extreme situation, monitoring throughout the period (until the present/immediate danger has passed) must be undertaken in line with the guidance above and as soon as is practicable. Within 24 hours, the managing director must be notified of the incident.

6. Segregation

Caring/educating a student in isolation. The isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.

The reasons for the use of segregation are as follows:

- An individual may be displaying high levels of behaviours of concern/challenging behaviour (Frequency, Severity, Duration), that is having an impact on others physical or emotional well-being within a shared environment.
- An individual's personal hygiene or health is having an impact on others' physical or emotional wellbeing, for example smearing faeces.
- To safeguard an individual from potential abuse, bullying from peers, sensory impact, impact to physical or emotional wellbeing.

The segregation must be evidence based and, in the student's, best interest. Where there is 'Staff Withdrawal' as part of a student's behaviour support plan, it needs to be agreed and form part of the student's risk assessment.

6.1 Staff Withdrawal

When Staff withdraw to allow the student to regulate, allow privacy or have been asked to do so by the student. This would be without the use of a locked door acting as a barrier, and the person should have freedom to leave or request staff engagement whenever the person chooses. There must be robust monitoring protocols in place to ensure the correct use of the strategy. Doors must remain unlocked to support the guidance within the strategy and adherence to procedure and staff should be fully trained in the use of this intervention, including when, how and logging and reporting systems.

6.2 Principles for the use of restrictive practices

Physical interventions may be considered necessary in the following situations:

When a student's behaviour is putting other students, staff, or others in danger of physical harm, for example, if a student is attacking another person.

- When a student is at risk of harming themselves or putting themselves in danger, for example, running into the road or when two students are fighting, causing the risk of injury.

- When a student's behaviour is causing disruption to the extent that good order and discipline is being seriously affected, for example, if a student is causing or is at risk of causing injury or damage, by accident, by rough play, or by the misuse of dangerous materials or objects.
- When a student is causing or is on the verge of causing deliberate damage to property.
- When it is beneficial for staff to establish firm and consistent boundaries with younger students in order to reinforce student safety and the necessary behaviours and attitudes to sustain the students' school placement.
- When it is necessary to prevent a student from leaving the classroom, allowing the student to leave would risk their safety or lead to behaviour that disrupts others.
- When a student is behaving in a way that seriously disrupts a school sporting event or school visit. (As part of the preparation for off-site visits risk assessments are undertaken. It may be deemed unsafe or inappropriate to take a child on an activity where there is a significant likelihood of a need for physical intervention).
- When a student persistently refuses to follow an instruction to leave a classroom. (It is recognised that in this instance the refusal of a student to remain in a particular place is not enough on its own to justify the use of force.) However, it may be justifiable where a student remaining in a classroom or leaving would entail serious risks to the student's safety, (taking into account the student's age and level of understanding), to the safety of other students, staff or others, or of damage to property; or Lead to behaviour that prejudices good order and discipline, such as disrupting other classes.

Where the physical intervention used is not listed in the BSP, this is known as an "unplanned restraint". In each student's BSP the number of proactive strategies must be greater than the reactive strategies – these include how to support the student in a person-centred way, promoting success and redirecting early warning signs of challenging behaviour. Reactive strategies must list non-physical strategies with increasing levels of intensity that must be attempted prior to using physical intervention. The only exception to this is where a student's safety is at imminent risk, e.g., running onto a road.

The use of ALL planned and unplanned RPIs must be recorded.

6.3 De-briefing

- For reference, debriefing in the context of this document, is giving the opportunity to an individual after an incident has occurred to discuss the emotional impact the incident has had on them. It allows the person to speak freely and openly about how the incident has made them feel and be supported to move on from the incident.
- The debriefing session should always remain confidential and not be used to influence changes to behaviour support guidelines or used as an opportunity to analyse or reflect on the individual's practice.
- Reflective supervision or debrief analysis are two other forms of post incident processes, which offer the opportunity to reflect, analyse and where possible, improve on practice, and should only take place after the debrief proper has been offered/completed.
- The Debrief is optional and the individual member of staff, or person we support has the right to refuse the opportunity to be debriefed after an incident. This should be logged on to the incident form in the appropriate section.

- In schools when a 'Debrief session has taken place, it is logged as part of the incident recording.
- Debriefing must be given to the child or young person who has been restrained in line with the guidance in their risk assessment and behaviour support plan.
- Debrief should be offered or sought out as soon after the incident as is possible.
- Narrative around the content of the debriefing session should not be taken, however, the offer of and acceptance/refusal of the session should be logged as part of the Incident recording.

7. Recording an RPI

All restraints, both planned and unplanned, must be recorded in the school's physical intervention bound book or electronically on the school's behaviour recording system. Staff will be trained during their induction period in reporting.

All incidents must be written up within 24 hours of them occurring. Parents/carers and social workers, where appropriate, must also be informed on the day the incident occurred.

All students involved in restrictive physical intervention must be offered first aid after the incident.

8. Monitoring and reviewing systems

All incident reports must be checked by senior leaders. It is the responsibility of this person to:

1. Ensure this has been recorded appropriately in the RPI bound book or electronic form.

2. To review the BSP / risk assessment where an unplanned RPI was utilised, or guidelines provided are demonstrated to not meet the student's needs.

Each setting must have in place a means of tracking any changes to a risk assessment/BSP when it gets updated. This must include the reasons for change and what changes have come about as a result.

The headteacher in each of the settings reviews all incident/accident reports weekly and completes a more detailed analysis of incidents. In addition, termly Health and Safety Reports are completed which detail incidents, accidents and near miss events and RIDDOR reports with a comparison of events against previous years' entries.

RPI logs are audited weekly to ensure:

1. RPI is being recorded when it has been used.

2. The RPI log is completed with the appropriate information.

3. Interventions are used in an appropriate manner (i.e., where non-restraints have been unsuccessful in keeping the young person safe).

4. To monitor the frequency of RPI, where there is an increasing trend in RPI the BSP must be reviewed. Archived RPI logs will be stored for a minimum of 75 years.

9. Communicating with parents/carers

Partnership with parents/carers is crucial. All parents/carers are asked to sign their child's behaviour plan which specifies the techniques to be used. In this regard, parental consent to use RPI is secured as part of admission. Parents/carers have a right to know when RPI is used and accordingly will be sent home notification of when any unplanned restrictive intervention occurs or if any injury occurs. They will also be offered an opportunity to discuss RPI and any on-going behaviour management strategies that are being adopted with their child.

10. Training

It is important that all staff are confident in managing behaviours that challenge. They need to be deemed competent and confident to do their job well.

- All staff will receive PACE training, safeguarding training, and Sherwood physical intervention training as part of their induction.
- All staff will take part in regular refresher and workshops in the appropriate use of RPI.
- All staff will have training in recording RPIs.