Policy Title:	**Risk and Restraint Reduction Policy**		
Policy Code:	**ICP 12.10**		
Cross Referencing:	**QS 12** **QS 20** **QS 35** **2002** Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties. **2006** Best Practice Guidelines in the Use of Physical Restraint (Child Care: Residential Units) **2005** Holding Safely A guide for residential Child Care Practitioners and Managers about Physically Restraining Children and Young People. **1974** Health and Safety Act **1989/2004** Children's Act. Positive Environments where Children can flourish		
Authorised by:	**Clare Leach**		
Date:	**Feb 2021**	**Review Date:**	**Feb 2022**

1.0 Legislation:

1.1 The legislative framework regarding physical intervention is complex and at times confusing. This policy aims to bring together contributions from legislation and good practice guidance.

1.2 Impact for Change and all those working directly and indirectly with young people in our care will aim that the practice delivered ensures the **"welfare of the child is our paramount consideration[1]"**.

2.0 Glossary:

2.1 Below is a list of frequently used terms within this policy and their respective meanings:

- **Child:** the term children and young person is used loosely. Adolescents within the care of Impact for Change may resent being referred to as "child" or "young person". Also Impact for Change may care for clients up to the age of 18. The term child refers to ALL clients being looked after within service provisions.
- **Child-centred:** an approach to assessment, planning and action in which we put the person at the centre.
- **De-escalation:** a process by which the thoughts, feelings and behaviours are decreased in intensity and threat.
- **Trigger:** something that entices strong and immediate behavioural and emotional changes in a child.
- **Duty of care:** the welfare of children, young people and vulnerable adults takes legal precedence. It is the responsibility of all persons placed in charge of children and young people to take reasonable steps to prevent injuries to children, staff and others not employed by Impact for Change and prevent damage to property not necessarily exclusive to Impact for Change. The term duty of care arises from a relationship, employers and employees are subject to a duty of care. Employers have a duty of care to their staff and employees have a duty of care to the children and young people for whom they look after.
- **Negligence**: this term involves a breach of the duty of care, which results in injury (both emotional and physical).

[1] Children's Act 1989

For a case of negligence to be proved all three elements of the following elements must be evident:

1. There is a duty of care.
2. There is a breach of that duty of care.
3. There must be some ensuing damage or injury.

A breach of that duty may involve either taking unreasonable actions or failing to take reasonable action.

- **Assault:** is an intentional attack on another person. Attack has a wide meaning so may not involve the use of substantial violence or cause injury to the victim. Assault can therefore include touching a child without consent, where the actions were not reasonable, proportionate or necessary, to physically restraining or physically intervening with a child where the actions were with the intent to cause harm or the use of excessive force. Restraint can begin as a lawful act but can become an assault if the person holding loses control of their feeling and actions.
- **Violence:** any incident involving physical or verbal abuse of a threatening and/or racial nature, threat and fear.
- **Positive Handling:** the full range of Team Teach strategies used to de-escalate, diffuse and divert in order to prevent violence and reduce the risk of injury to children and young people and staff.
- **Physical contact:** this covers the full range of physical interactions ranging from light to firm pressure touch. It is necessary for a variety of purposes including the provision of care, comfort, communication, reassurance and safety.
- **Prompts:** the use of force to gain attention.
- **Guides:** the positive application of force to overcome minimal resistance, prompting and encouraging a person's free movements. The application should be to safeguard the person, safeguard other people and prevent significant damage to property.
- **Controls:** the positive application of force to overcome moderate resistance, guiding and directing a person's free movements. The application should be to safeguard the child, staff, and other people and prevent significant damage to property.
- **Restraints:** the positive application of force by staff to overcome rigorous resistance; completely directing, deciding and controlling a person's free movement. The application should be to safeguard the person, safeguard other people and prevent significant damage to property. The proper use of restraint requires knowledge, understanding, skill and judgment. All restraints should be reported, recorded and reviewed.
- **Reasonable:** most Common Law hangs on the word reasonable, yet the work changes depending on the context. What determines the reasonableness of a particular intervention is often governed by whether or not it was proportionate. Simply put "you shouldn't use a hammer to crack a nut". Team Teach advocates a least intrusive, least restrictive intervention for the shortest time philosophy, of which this policy will adopt.
- **Proportionate:** The degree of force used must be in proportion to the circumstances of the incident it is intended to prevent.
- **Necessary:** when force is used it should be for the reasons of safeguarding the child, young person, vulnerable adult or other people.
- **Last resort:** the use of force is described as a "last resort". This does not mean that all other alternatives must be tried and seen to fail before force may be used. It means staff should consider alternatives and balance the risks of using force against alternative, realistic options.

"If necessary staff have the authority to take immediate action to prevent harm occurring even if the harm is expected to happen sometime in the predicted future[2]."

- **Best Interest:** whatever intervention is used (physical and non-physical) the child's (whom the intervention is directed) best interest is the paramount consideration of staff and Impact For Change. Paramount means it is the first thing to consider and it takes precedence over all other considerations.
- **Risk Assessment:** the process of identifying and controlling potential hazards. *Dynamic risk assessments* are those conducted in real time when staff are faced by a situation that requires an urgent response. *Formal risk assessments* may be recorded in documents which alert people to hazards and suggest ways of avoiding or reducing risk for example positive handling plans.

[2] Para 10 p.4 Dept. of Health 1997 "The Control of Children in The Public Care: Interpretation of the Children Act 1989 – London HMSO

3.0 Principles:

3.1 Every child has the right to a childhood that is safe, enjoyable and nurturing.

3.2 Impact for Change is committed to reducing risk, restraint and restriction throughout it's provisions. Restraint and restriction will be addressed within a transparent, honest and holistic approach.

3.3 This policy is not designed to increase the acceptance of restraint, or to suggest that Impact for Care use excessive levels of restraint.

3.4 Those working within the Residential Childcare profession, often face very challenging and difficult situations; working closely with children and young people who face significant challenges and express intense emotional reactions. The weight of these responsibilities, are heaviest when children and young people are distraught, violent and unable to hold themselves physically and emotionally. It should never be forgotten that children and young people in residential care, are creative, caring, capable and most importantly children, it is the job of the childcare professional to engage with them in a way that supports their growth to reach their full potential.

3.5 Impact for Change are committed to ensuring staff members are prepared, through training, advice and supervision to undertake all aspects of their professional responsibility.

3.6 This policy will be shared with all those directly or indirectly involved with the day to day running of Impact for Change. If anyone has concerns or comments regarding this policy they should contact an Impact for Change Director.

3.7 The designated person responsible for Risk and Restraint Reduction throughout Impact for Change is Clare Leach.

3.8 Challenging behaviour can be reduced or prevented by careful management of environmental or personal setting conditions.

3.9 Impact for Change will aim to ensure all provisions are designed with positive opportunities and supports to meet the needs of the young people, taking into account; space, atmosphere, aesthetics, nurturing environment, ethos, supporting the young person to manage their own behaviour and the young person's own personal goals.

3.10 The Registered Manger has overall responsibility for ensure provisions are maintained to the standards expected by Impact for Change.

3.11 Impact for Change focus on a restraint and risk reduction approach; is achieved by creating a nurturing and supporting environment[3] with staff concentrating on 95% de-escalation. Including positive role modelling from staff and staff focusing on the positive behaviour (no matter how small) displayed by the young people[4].

[3] The Quality and purpose of care standard.

[4] Reg 11 Positive Relationships Standard

3.12 Impact for Change operate a “whole” approach to risk and restraint reduction. Staff members actions are directed through agreed policies and it is understood that each member of staff support the promotion of positive behaviour, knowing that all of their colleagues will always do the same.

3.13 Impact for Change and anyone working directly or indirectly on behalf of the organisation understand:

- It is our duty to identify and address all inappropriate behaviours
- We must identify more appropriate behaviours than inappropriate.
- Effectively changing behaviour does not take place overnight.
- We recognise and celebrate small steps
- We acknowledge that there may be many disappointments and setbacks.
- WE WILL NOT TAKE THEM PERSONALLY.

A “whole” organisation approach means that:

- All staff own, know and understand the policies for the promotion of positive behaviour and attitudes.
- All staff implement the policies not interpret them.
- All staff consistently use only the agreed policies and strategies and only in a positive manner.
- All staff will identify the common rules and consistently apply them.

Within this we accept:

- There are no good or bad young people; there are only young people.
- Good or bad behaviour does not make a good or bad young person.
- We use the terms appropriate and inappropriate.

3.14 Impact for Change acknowledge that restraint should not be seen in isolation, creating a culture and practice that is safe, well-maintained, enjoyable and truly child centred is paramount in reducing risk and reducing restraint.

By taking a child centred approach, staff consistently put the needs of the children and young people before their own convenience. Fundamentally, recognising the worth of each and every child, irrespective of the behaviours displayed. All those working on behalf of Impact for Change will act in the child’s best interest and aim to see things from that child’s individual view point.

“The child’s welfare, safety and needs should be at the centre of their care”

This approach will be supported by documentation relating to the child (i.e. positive handling plans and risk assessments) and documentation relating to staff (i.e. staff meetings and supervisions).

Recognising the worth of all children and young people within the care of Impact for Change, is not restricted to “work hours”, Staff members will demonstrate a child-centred

approach within working hours, in front and away from the children and young people and also outside work hours, for example talking to colleagues while off shift or in training.

4.0 Expectations of Behaviour:

4.1 As part of improving the culture of residential childcare and improving outcomes for children and young people in the care of Impact for Change, it is important that we have high expectations of children and staff members[5]. Below are a code of conduct for all staff members based on up to date recommendations and good practice[6]:

1. Act in the best interests of the children and young people.
2. Promote and maintain safety of all those directly or indirectly affected by our actions.
3. Promote and maintain the health of all those directly and indirectly affected by our actions.
4. Promote and maintain the enjoyment and achievement of all children and young people in our care.
5. Promote and maintain the economic wellbeing of all children and young people in our care. As well as the economic wellbeing of Impact for Change as an organisation.
6. Engage and promote children and young people to make positive contributions on an individual and societal level.
7. Respect the confidentiality of children and young people.
8. Keep high standards of personal conduct.
9. Provide (to us and any other relevant regulators) any important information about your conduct and competence.
10. Keep your professional knowledge and skills up to date.
11. Act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another professional.
12. Communicate properly and effectively with children, young people and other practitioners.
13. Effectively supervise tasks that you have asked other people to carry out.
14. Keep accurate records.
15. Limit your work or stop practising if your performance or judgement is affected by your health.
16. You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you, your profession or Impact for Change.

It is important to remember that while professional codes of conduct are designed to help Impact for Change staff members make ethical decisions they will not by themselves, give you the answers to the morale problems that can be related to an incident of restraining a child. Ethically justifying the violation of a child's right to freedom of movement can only be in exceptional circumstances and where restraining them is the only practicable way to safeguard them.

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[5] The Positive Relationships Standard

[6] ICP 11.1

Impact for Change believe that in creating an ethos and culture that promotes good outcomes for children and young people, and minimises risk and restraint, children and young people placed at Impact for Change have clear expectations about their behaviour, rights and responsibilities[7]:

1. Be kept safe, promote and maintain the safety of others.
2. Be healthy, promote and maintain the health needs of others.
3. Enjoy and achieve, promote and maintain the enjoyment and achievement of others.
4. Achieve economic well-being, promote and maintain the economic well-being of others.
5. Make a positive contribution to their lives and the lives of others.

5.0 Training:

5.1 Impact for Change have adopted Team Teach as the preferred training provider[8] as it suits the organisational ethics, principles and the Home's Statement of Purpose. It is designed to reduce risk through working together to safeguard people and services.

5.2 Team Teach forms a complimentary part of the risk, restraint and restriction training.

5.3 Training provided within Impact for Change is focused on improving relationships between staff members and young people, improving emotional resilience, improving the individual's capacity to safeguard themselves and others.

5.4 Training is viewed as more than a formal "one-off" event, it starts at the recruitment stage and is supplemented and implemented in practice through reflection, supervision, coaching and mentoring.

5.5 All Team Teach training develops positive handling skills in behaviour management including verbal and non-verbal communication, diversion and de-escalation and safe effective, humane physical interventions.
Within Team Teach, **95% of positive handling strategies refer to the use of the environment, de-escalation, diffusion and distraction techniques** to support the management of challenging behaviour.
5% of the Team Teach framework refers to physical responses that may involve the use of force to control or restrain a young person.

5.6 The level of Team Teach provided is dependant upon the risks presented within the home, and the necessary level of training required to keep the young people and staff members safe as far as is possible irrespective to cost to the organisation.

5.7 Advanced modules are high risk training designed for high risk children and young people. Homes requesting advanced training should do so within a child-centred context, the training shouldn't be delivered in isolation, but supplementary to other risk reduction

[7] The Quality Standards 2015

[8] Team Teach is accredited to Institute of Conflict Management (I.C.M.)

training. If dedicated advanced ground holds are necessary the Home is to adhere to the **Team Teach Minimum Required Safeguards** framework[9].

5.8 The fundamental theory, will be included in the Induction Training.

5.9 Physically restraining a young person is an extreme form of intervention by childcare practitioners, it must never be seen as the "norm" and it must never be used to force young people to comply with the wishes of staff.

5.10 Exceptional circumstances can and do present themselves within residential care where physically restraining a young person may be necessary and appropriate due to the escalating risk of serious physical or psychological harm to the young person or another person.

5.11 Training of in the use of physical interventions and restraint is to ensure staff are aware of and implement alternative and less restrictive methods for managing and/or de-escalating the young person's behaviour if they have a realistic chance of success, they should be

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[9] Minimum Required Safeguard Standards.

1. Staff likely to be involved in critical incidents requiring ground restraints must be both "authorised" and "trained" to an appropriate level. This will require additional training from an Advanced TT Tutor following the basic 12hr TT course.
2. Staff trained and authorised to use these advanced techniques must be refreshed and recertified on ground recovery techniques within a 12month period.
3. There should be a designated member of staff involved in the incident who has specific responsibilities to safeguard the head of the client. They should protect the head during a controlled descent to the ground and continually monitor the airways, breathing and circulation.
4. In any ground position the person responsible for monitoring the client's welfare must be able to see the face.
5. The hold should cease immediately in symptoms of positional asphyxia are observed.
6. Individuals should not be held in a way that completely immobilises the client. The individual being held should be able to raise their chest slightly off the ground and also move their hips when being held.
7. The head of the person should not be face down but to one side.
8. The breathing of the person should not be restricted.
9. No direct or sustained pressure should be applied to the back, ribs or neck.
10. Staff must not straddle the client.
11. Clients with serious pre-existing medical conditions (congenital heart defects, severe asthma, obesity, epilepsy, cystic fibrosis etc.) will need to have an assessment/ medical carried out by a doctor/ nurse to risk assess the likely impact of the use of front ground recovery holds. The preferred techniques should be demonstrated and explained. If the advice received is against using such responses, alternative actions/ strategies and or placement should be considered.
12. Staff who are authorised and trained to use ground recovery techniques must be first aid trained with the minimum of a nationally recognised one day qualification that includes recognising signs of physical respiratory distress, physical collapse and how to take appropriate action, including basic life support skills.
13. It is a requirement for all staff expected to use ground recovery techniques to achieve a 100% pass in the minimum safeguard standards test to show their knowledge and understanding of the elevated risks associated with ground holds and the Team Teach protocols required reducing those risks.
14. Staff should be provided with their own copy of the Team Teach minimum safeguarding standards and be given adequate time to study in the days leading up to the test. They should also have the opportunity to discuss the document on the day, before actually taking the test.
15. Staff will be allowed three opportunities for readjustment before deeming to have failed the test. Failure will disqualify individuals from using such techniques. All staff will be actively and positively supported in taking the test, with readers provided if required.
16. Service settings should have a named person responsible for monitoring and evaluating the use of ground recovery holds on a 6-8weekly basis. It is in the interests of all that a transparent reporting and recording process is in place. Services will be required to report these ground recovery figures to Team Teach LTD.

used in preference to physically restraining a young person. Restraining a young person at the right time, in the right way, for the right reasons, can be a better thing to do than failing to restrain them. If staff use restraint, they need to know how to do it safely and be aware of the risks involved.

<table>
<tr><th colspan="2">Risk and Restraint Reduction Training.</th><th colspan="2">Within first 3 months of employment</th><th colspan="3">Mandatory Training (within first 9 months of employment)</th><th>Within first 12 months</th><th>Optional</th><th></th></tr>
<tr><td rowspan="3">Recruitment process promotes Best Interest Principles and Childcare Professionalism</td><td rowspan="2">DBS checks and references sought.</td><td rowspan="2">Induction Handbook</td><td rowspan="2">Supervision, support and Induction Mentor.</td><td>Food Hygiene</td><td>Prevent</td><td>Child Sexual Exploitation.</td><td rowspan="2">Diploma Level 3</td><td>PACE</td><td rowspan="3">CONSTANT individual, managerial and organisational monitoring, supervision, assessment, reflection and action.</td></tr>
<tr><td>First Aid (minimum of 1 day at work)</td><td>Child Development and Attachment</td><td>Team Teach 6hr/12hr</td><td>DDP</td></tr>
<tr><td>Interview seeks the attitude, skills and knowledge required of childcare professionals . Questions specifically related to challenging behaviour and the need to restrain them</td><td>Induction Training</td><td>Induction mentor assesses the Attitude, Skills and Knowledge of the candidate. offering support, guidance and reassurance .</td><td>Medication (risk dependant)</td><td>Autism Awareness</td><td>Team Teach adv modules (risk dependant)</td><td>Supervision, support, coaching and mentoring.</td><td>Therapeutic Approaches</td></tr>
<tr><td colspan="3"></td><td>Safeguarding</td><td>Self Harm</td><td>Any identified external training to meet the needs of the young people and the Home's Statement of Purpose.</td><td>Diploma Level 5</td><td>Other identified training to meet the needs of the young people and the Home's Statement of Purpose.</td><td></td></tr>
</table>

5.12 In an emergency the use of reasonable force by people, who may not be trained or authorised, could be justified if a risk assessment has determined that it is in the best interest of the young person.
In these circumstances, the use of force should be reasonable and proportionate and, whenever possible, it should reflect the person's previous training in the appropriate use of physical interventions. To be clear this practice is outside the norm practices and may only be justified in an emergency.

5.13 There may be times when staff need to use non authorised Team Teach techniques, these are dictated on risk assessment and the level of harm involved for both young person and staff. Reasonable, proportionate, necessary and fundamentally the best interest principle will be the paramount consideration. If staff follow these and act in good faith they are likely to be supported by Impact for Change.

Restraint that deliberately inflicts pain cannot be proportionate and should never be used on children in children's homes[10].

5.14 Although staff members may receive training in response to weapons, Team Teach advocate a move away, guide away, take away range of responses.

5.15 If staff are confronted with a weapon their first response is to move away and call for help, followed by guide away and call for help. If there is no other way (i.e. staff member cornered in a room) staff may need to take away the weapon. Throughout this situation staff will vocalise that the young person's needs to "Put the weapon down (insert place)". Team Teach weapon modules are risk reduction responses, when presented in a high risk situation there is a quite realistic chance of injury.

5.16 If a young person has history of weapon use, as part of creating the right conditions, the environment must be effectively risk managed and all risks documented in the young person's risk assessment and positive handling plan.

5.17 On completion of Team Teach training the Registered Manger has responsibility to authorise suitable members of staff to use relevant physical interventions in line with specific young people's positive handling plan. This list will be held in the office of individual homes.

5.18 It is the responsibility of individual staff members to notify the Registered Manager if they are unable to safely undertake any physical interventions that they had completed during the training.

5.19 The Registered Manager has the right and responsibility to de-authorise members of staff if the safety of the staff member or young person is in question.

6.0 Conflict Spiral:

6.1 A core component of the Team Teach framework delivered on all Team Teach courses including refreshers is the conflict spiral.

6.2 When staff focus on behaviour important aspects of the child are missed. Behaviour is driven by feelings and feelings are affected by experiences[11].

6.3 Impact for Change believe that behaviour is a language, and staff need to look beyond the behaviour to understand what the child is attempting to tell us.

6.4 Staff members should constantly ask themselves:

"What is this child trying to tell me through their behaviour?"

[10] QS 9.51 (guide)

[11] 11 2a (ix)

By staff focusing on their reactions it can reduce rather than provoke the child's behaviour. Reducing the risk of potential conflict.

"Are my actions reducing rather than provoking?"

"Am I part of the problem or part of the solution?"

6.5 Impact for Change believe that by creating the right conditions, creates better experiences, more positive feelings and reduce the intensity of the behaviours. Therefore reducing risk and reducing restraint.

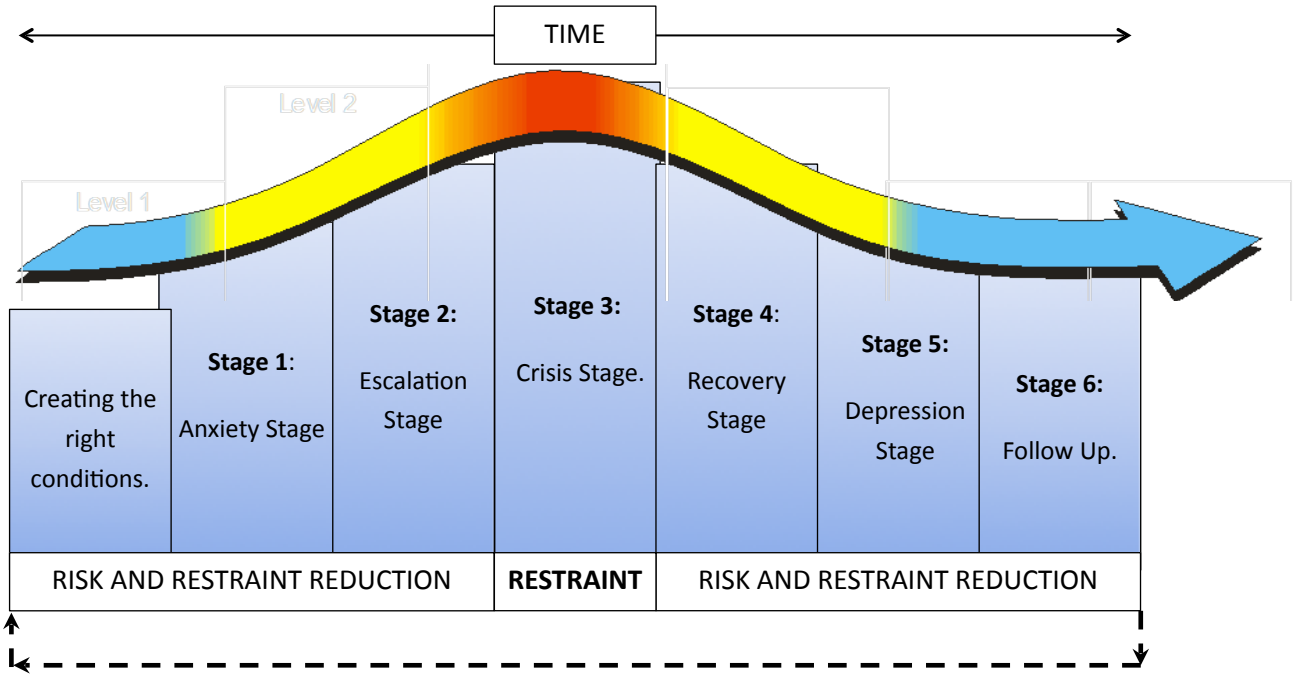
7.0 CALM Approach:

7.1 Throughout a staff members practice individuals will respond in a **CALM**[12] approach. Addressing behaviour in the right manner and at the optimum time reduces the risk and restraint.

8.0 6 Stages of a Crisis:

8.1 A core component of Team Teach framework is the 6 stages of a crisis.

8.2 Impact for Change have adopted this model throughout childcare practice, acknowledging that the stages presented are individual and unique for all young people.



[12] **CALM** is an acronym for Communicate, Awareness and Assessment, Look and Listen, Make safe

8.3 Stage 1:

When children and young people become anxious it is important for staff to recognise the minute changes in behaviour the children and young people display. Examples of anxiety behaviour are:

- Hiding face in hands or bent over / under table
- Pulling up collar or pulling down hat
- Rocking or tapping
- Withdrawing from group
- Refusing to speak or dismissive
- Refusing to co-operate
- Adopting defensive postures
- Pupils dilate
- Body position & tension- arms crossed
- Clenched jaws or fists
- Jaw jutting & chest thrown out
- Breathing-
  - rapid
  - shallow
  - audible
- Eye contact increase or decrease

On recognising the anxiety behaviours in children and young people staff need to respond promptly and sensitively to their needs. Examples of this are:

- READ[13] the body language
- READ the behaviour- Assess the situation
- Intervene early
- Communicate – "Talk and I'll listen"
- Inform of desired behaviour
- Use appropriate humour
- Display CALM stance & body language
- Talk low and slow and quietly
- Offer reassurance – including positive physical prompts
- Divert and distract by introducing another activity or topic

8.4 Stage 2:

Behavioural examples of children and young people to escalating into stage two are:

- Individual begins to display higher tension
- Belligerent and abusive
- Making personal and offensive remarks
- Talking louder – higher - quicker
- Adopting aggressive postures
- Changes in eye contact

[13] READ is an anagram for Recognise, Evaluate, Assess, Decide.

- Pacing around
- Breaking minor rules
- Low level destruction
- Picking up objects which could be used as weapons
- Challenges – "I will not…you can't make me".

On recognising escalation behaviours staff are to respond assertively, promptly and maintain sensitivity, examples of this are:

- State desired behaviours clearly
- Set clear enforceable limits
- Offer alternatives and options
- Offer clear choices
- Give a get out with dignity
- Assess the situation and consider making the environment safer and getting help
- Guide the elbows towards safety

8.4.1 These are examples of behaviours and responses; it is not a finite list. Clear and accurate recordings of the child's behaviour and necessary staff support should be documented in the child's individual Positive Handling Plan (PHP).

8.4.2 It is sometimes reasonable to use physical controls to prevent extreme behaviour from becoming dangerous provided that it is an agreed strategy. Examples of this are where children and young people have shown ritual patterns of behaviour, which in the past have led to the child becoming more distressed and violent. In such circumstances it may be reasonable to withdraw the child to a safer place when the pattern of behaviour begins, rather than wait until the child is distressed and out of control. The paramount consideration is that the action is taken in the best interest of the child and that it reduces, rather than increases, risk.

8.5 Stage 3:

8.5.1 This section addresses when children and young people are restrained.

8.5.2 Physically restraining children and young people should be acts of care and controlled and designed to make sure the child and others are safe.

8.5.3 The purpose of restraining children and young people should only be done in exceptional circumstances and the welfare of the child must be paramount consideration. Staff must reasonably believe that the action is to prevent:
- Injury to any person (including the child).
- Serious damage to the property of any person (including the child).
- A child who is accommodate in a secure children's home from absconding from the home[14].
- There may be circumstances where a child can be prevented from leaving a home- for example a child who is putting themselves at risk of injury by leaving the home to carry

[14] QS 20

out gang related activities, use drugs or to meet someone who is sexually exploiting them or intends to do so. Any such measure of restraint must be proportionate and in place for no longer than is necessary to manage the immediate risk[15].

- Any behaviour prejudicial to the maintenance of good order and discipline[16]. Applicable to education settings only.

8.5.4 Property damage is not a sufficient reason in its own for restraining a child. However, the damage done to the welfare of the child or other children by their damaging of property maybe a sufficient reason. For example a child destroying their history, photographs or pictures or destroying communal or private living space may cause significant harm to themselves or other children- psychological in this case.

8.5.5 It is harm to the child, not harm to the property that is the main consideration for staff members when making a professional judgment to restrain.

8.5.6 If Impact for Change are caring for children and young people who demonstrate such high risk behaviours a multi-agency positive handling plan will be agreed and signed by all those involved in its creation.

8.5.7 Prior to all restraints, staff are encouraged to stop and think before taking action. In emergency situations, rushed decisions increase the chance of poor decisions[17]. When staff remember to slow down, compose themselves and think through the options before acting they are conducting a dynamic risk assessment[18]. It's as simple as A,B,C:

- **Act:**
  - **Stop and think.**
  - **Call for help.**
  - **Direct the child to stop.**
  - Make the environment safer.
  - Adopt and CALM, non-threatening stance and posture.
  - Slow controlled voice.
  - Clear verbal directions.
  - Pause, allow time for delayed compliance.
- **Balance:**
  - Likely outcomes if force is used against likely outcomes if force is not used.
  - Short term risks against longer term risks.
  - The best interests of the child.
- **Choose:**
  - Person most likely to succeed.
  - Best place available.
  - Best time available.
  - Minimum use of force necessary to achieve desired result.

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[15] QS 9.52 (guide)

[16] Education and Inspection Act 2006

[17] Emergency services are trained to walk towards situations, no matter how dire they are.

[18] QS 9.53 (guide)

8.5.8 If, after a dynamic risk assessment and decide choose it is unsafe to move in and hold a child they should **call for help, make the environment safer, ask the child to stop.**

8.5.9 When restraining a child is necessary it must be done in a way that doesn't harm the relationship you have with them, and creates the possibility of making good progress with them when the crisis is over. This will enable the continuation of the supportive learning structure in place post incident[19].

8.5.10 There are three important processes involved when restraining children:

1. How staff think.
2. How staff act.
3. What staff do.

How staff think:

What staff think about what they are doing will dictate what they do. It is important for staff to have the right frame of mind:

- Maintain helpful thoughts:
- I care enough not to let this child be out of control.
- Everything I do is in the best interests of this child.
- I am here to keep this child safe.
- Behaviour is a language, (challenging behaviour is code for when other communications methods are not working well)
- I am in control, I am prepared.
- This isn't personal.
- Think of the child as a unique individual and each incident as a unique occasion.
- Be aware of your emotional state.
- Be aware restraint happens within the context of a relationship.
- Be aware of the child's history and of anything that may increase or decrease risk.
- Consider how to speak to colleagues and child, maintaining neutral viewpoints.

How staff act:

Restraint is part of a relationship, how staff act during the restraint has implications for the relationship post incident.

- Keep calm and controlled. Act in a way that absorbs and responds to aggression without retaliating.
- Be sensitive about the words you use, your tone of voice and your pace of speaking.
- Convey a genuine willingness to help and keep the child safe.
- Acknowledge the child's feelings and thoughts.
- Work with and don't compete with the child.
- Don't rush the process. It takes the time it takes to increase safety, bearing in mind Team Teach minimum standards and any dangers or risks associated with the restraint technique being used[20].

[19] QS 9.55 (guide)

[20] QS 9.56 (guide)

What staff do:

After a dynamic risk assessment dictates that there is a need to restrain a child, several things become particularly important:

- Check you environment. This will affect the method of restraint.
- Communicate with colleagues.
- Someone take the lead.
- Risk assesses the competence and capabilities of your colleagues.
- Risk assess the possible reactions of other children and young people. Use the techniques you have been trained in.
- Use techniques you have been trained in.
- Choose the least restrictive way of restraining the child.
- Assign the responsibility of monitoring the child's A,B,C to a competent member of staff.
- All staff aware and vigilant for the signs of position asphyxia.
- Take into account increased risk factors for positional asphyxia.
- Protect the child's head
- Consider changes to personnel.
- Take into account and make reasonable adjustments for a child who has additional needs. I.e. learning disability, physical disability or history of abuse.
- Continually review the need for restraint and the safety of all concerned.

8.5.11 Restraint is a high risk intervention and should be used in exceptional circumstances. Children and young people can die from staff limiting their breathing. A child moving does not mean the child is getting enough air to live. Do not be fooled if there is shouting and moving, this has been a factor in restraint related deaths, with the words "I can't breathe" being the child's last. Staff members should be vigilant to the signs, symptoms an

increased risk factors of positional asphyxia21. What ever factors increase the risk for holding a child it is the responsibility of those holding the child to reduce these.

8.5.12 **If warning signs occur, staff members must release the hold with immediate effect,** provide appropriate first aid and seek professional medical help regardless if the symptoms dissipate. Impact for Change advocate that if any signs of positional asphyxia are shown, the professional medical help summoned is immediately **999**. **It is therefore important that all staff are aware of the young person's positive handling plan, any medical conditions, location, and address and have access to a charged mobile phone.**

8.5.13 **If a child complains that they are unable to breathe, staff members are to release the hold immediately and reengage if necessary or seek medical assistance.**

8.5.12 **Whilst some physical injury potential can be reduced, there always remains some risk when two or more people engage and force is used to protect, release or restrain. Team-Teach techniques seek to avoid injury to the young person, 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 a regrettable and infrequent side effect of ensuring that the service user remains safe. Any injuries will be documented on the child's body map and the registered manager will monitor and**

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[21]Positional Asphyxia:
Positional asphyxia is the term used to describe deaths which have been attributed to a person's body position. Any position that compromises the airway or the expansion of the lungs may 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). The fact that a person can complain does not mean they can breathe. A person dying of positional asphyxia may well be able to speak until they collapse.

A degree of positional asphyxia can result from any restraint position in which there is a restriction of the neck, chest wall, or diaphragm. Those people being restrained in a seated position require particular caution as the angle between the chest wall and the lower limbs is already decreased. Compression of the torso against or towards the thighs restricts the diaphragm further. For an individual being held in a prone restraint body weight restricts the chest wall and abdomen, compromising diaphragm movement.

When an individual is being restrained on their back, in a supine position alcohol and vomiting increases the risk of chocking.

If an individual is being restrained in a standing position hyper flexion increases the risk of positional asphyxia, no Team Teach techniques allows hyper flexion (where the shoulders a forced forward of the hips). In a standing and seated T-Wrap the child's hands are placed onto the hips to allow the normal expansion of the rib cage and abdomen. If it is not possible to hold the young person's hands on their hips the T-Wrap is not a suitable technique. If a young person throws their body forward staff does not follow but allow the young person to return to a comfortable position.

Extreme exertion, obesity, small statue, asthma, bronchitis, blocked nose, pre-existing medical conditions, the influence of drugs and alcohol and head injuries (this is not a finite list) increase the risk of restraining an individual. If any individual has or is suspected of having any of these conditions Impact will consult with medical practitioners for advice and document all relevant information on to the young person's positive handling plan.

WARNING SIGNS:

During a restraint and in the period following a restraint individuals must be monitored and supported for the following danger signs:

- STRUGGLING TO BREATHE.
- COMPLAINING OF BEING UNABLE TO BREATHE.
- EVIDENCE OF VOMITING OR REPORTING OF BEING SICK.
- SWELLING, REDNESS OR BLOOD SPOTS TO THE FACE OR NECK.
- BLUE TINGE TO THEIR LIPS, NOSE OR SKIN.
- MARKED EXPANSION OF THE VEINS IN THE NECK.
- SUBJECT BECOMING LIMP OR UNRESPONSIVE.
- CHANGES IN BEHAVIOUR EITHER ESCALATIVE OR DE-ESCALATIVE.
- LOSS OR REDUCED LEVELS OF CONSCIOUSNESS.
- RESPIRATORY OR CARDIAC ARREST.

IF ANY WARNING SIGNS OCCUR THE RESTRAINT IS RELEASED OR MODIFIED TO IMPROVE BREATHING WITH IMMEDIATE AFFECT AND MEDICAL ATTENTION IS SUMMONED, FIRST AID IS PROVIDED IN LINE WITH THE FIRST AID POLICY AND TRAINING.

evaluate the incident. If a child complains they are being hurt, staff response is to ask where and adjust and/or modify the technique to minimise risk further.

8.5.13 After any incident of physical intervention young people are asked if they received any injuries and are offered appropriate medical support. The medical support offered depends on the injury received.

9.0 Letting Go:

9.1 The process of how a restraint or physical intervention is ended and the action taken immediately after will have a large influence on its overall effect. Impact for Change have decided to address this in 2 areas:

1. **When to let a child go.**
2. **How we regain a positive working environment post incident.**

9.2 When to let a child go:

The process which you give back control to the child and let go is important in terms of the effect it has on the child and the relationship with staff involved. Releasing too soon and having to immediately manage violent or high risk behaviour again is obviously something staff wish to avoid (excluding warning signs of positional asphyxia). And holding a child longer than is necessary, is not only poor practice, but in some cases abuse, assault or negligence.

9.2.1 This creates a fine line between letting go to soon and holding too long. Staff require skill and knowledge to make this judgement.

9.2.2 Preparing to let go:

- One person should take control and lead the process of letting go.
- Gain a level of cooperation from the child; this can be very small for example “wiggle your fingers”. Tell the child clearly how they can let staff know they are ready to be released.
- Use a firm, neutral reassuring tone throughout the process. Avoid statements that could provoke the child, accusations and demands. Avoid the words CALM DOWN, as these are antagonistic when in a heightened sense of arousal.
- Letting go is a process rather than an abrupt event. Assess throughout whether the child is regaining control and safety. A gradual release of limbs is required. For example in FGR
  - Ok, you are doing really well. I am asking “Dave” to let go of your feet. Excellent, right “Sally” and I are going to give you back your arms (move into FGR de-escalation on arms). Excellent, right what we are going to do is all sit up together, excellent, right, “Sally” would you like to get “Dave” a drink while I sit here with him”
- Keep statements short and simple.
- Offer reassurance and praise throughout the process.
- Deliver messages in a child-centred manner.

9.2.3 Emergency Letting Go:

For some children and young people, holding them escalates the behaviours to a level of risk that is too high to keep all those involved. If this is the case, in a calm authoritative tone, staff are to use the script:

- **Let go NOW.**

Staff are required to:

- Call for help.
- Make the environment safer.
- Ask the child to stop.

9.3 Regaining a positive environment:

9.3.1 It is difficult to give specific advice on how to regain a positive environment. It varies on a variety of factors:
- The location of the incident.
- The time of the incident.
- Whether other children and young people were present.
- Whether there are any subsequent injuries.
- The numbers and skills of other staff that are available to help.

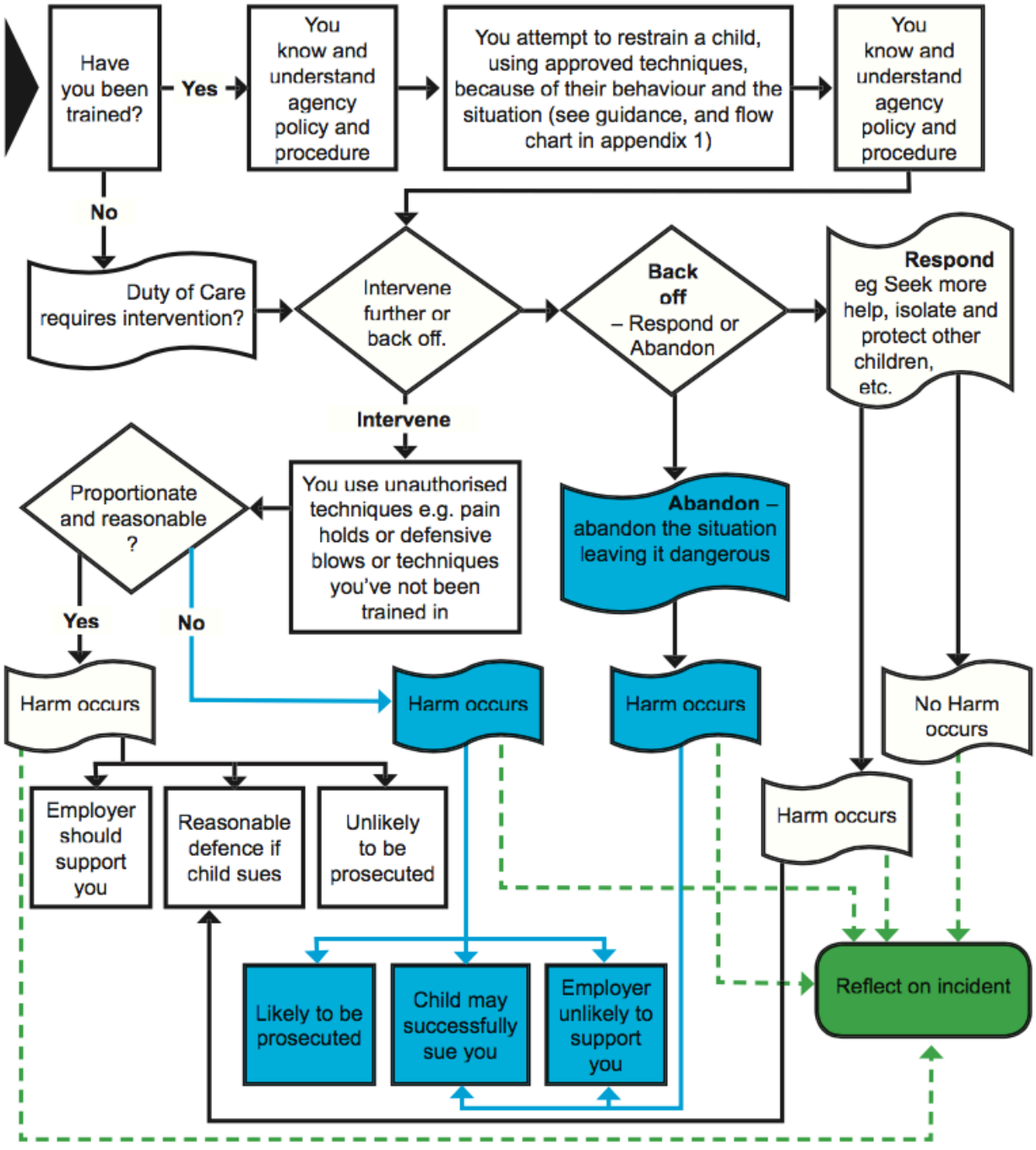
9.3.2 However there are good practice recommendations that form the basis of all practice:
- See, ask, and check if the child is hurt and/or needs any medical assistance. Seek medical help immediately if any warning signs of positional asphyxia are shown.
- Continue to care for the emotional needs of the child.
- Decide whether the child needs to be “insulated” from others for a period of time.
- Decide on who should be the most suitable person to work with the child.
- Decide if the child needs some time on their own, this doesn’t mean isolation staff need to be proactive in offering support, but understanding if the child wishes to be alone.
- Support the child on the best way to reintegrate back into the group.
- Make sure that by your actions and by what you say, the child knows that you still care for them and want to continue to help.

9.3.3 Working with other children:
- Look after the needs of the other children.
- Get the other children reengaged in activities.
- Stay attuned to the mood of the group.

9.3.4 Working with staff:
- Recognise that although you have let go, stage 4 is a high risk time. Be aware of continuing risks.
- Make sure that no staff are hurt, injured or in need of medical attention.
- Check staff are feeling ok.
- Avoid power-plays.
- Consider the impact on the relationship between staff and the child. Give the time, space and contact they require.
- Return the environmental safety of the place. This should be done subtlety.
- Follow the reporting procedures in place.

- Record the incident. **This process should not be at the expense of regaining a positive working environment.** Staff should not allow the pressures of recording to distract from what is in the child's best interest.

9.3.5 Decision Tree[22]:



[22] Holding Safely 2005

10.0 Stage 4 Recovery:

10.1 The recovery stage can be easily confused with stage one anxiety behaviours. The difference is, the child can revert to crisis behaviours very quickly and without the build-up demonstrated in stage 2.

10.2 Staff positive handling responses, are to respond, support and insulate the child from potential triggers (internal or external). It may not be appropriate to offer physical reassurance as it can provoke a reversion to crisis.

11.0 Stage 5 Depression:

11.1 After an incident the child may become depressed, this isn't a clinical depression, more of a reflection process. The child requires support, monitoring and reassurance.

11.2 Positive handling responses are to show concern and care, but do not attempt to fix any residual issues. Respond sensitively to signs the child wishes to communicate.

12.0 Stage 6 Listening and Listening:

12.1 Stage 6, is the most important stage for the child and staff members to learn from the incident, and, more importantly to inform and shape future practice to reduce the likelihood of the incident happening again.

12.2 Within 48 hours of the use of physical intervention, the registered person, or a person who is authorised by the registered person to do so[23]:

- Has spoken to the user about the measure.
- Has signed the record to confirm it is accurate and
- Within 5 days of the use of the measure has spoken to the child about the measure.

12.3 Though the above is required acknowledgement needs to be made to each child requiring space to reflect and learn from the incident. Some children and young people will want to be comforted in the period immediately after the restraint, (some children and young people may prefer comforting during the restraint i.e. children and young people with autism) and as part of that will see the immediate opportunity to discuss the event as helpful. Other children and young people may be angry, resentful and extremely resistant to any discussion. It is the responsibility of staff members to find the right time to talk with the child about how they can be helped to manage similar situations differently.

"The guiding principle must be the needs of the young person, and the timing of the discussion should reflect these needs.[24]"

12.4 Staff members must assess the situation and decide, preferably by discussions with the child, how best to go ahead. Staff need to consider the child's emotional state, as well as factors relating to age and developmental ability.

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[23] QS 35 3b

[24] Holding Safely 2005

12.5 There is often a benefit when the person who took the lead in the restraint takes the lead in the listening and learning. The discussion focusses on the process of restoring the relationship, rather than “he said/she said”. However staff must be sensitive to the needs of the child, and if they wish to have the discussion with a preferred member of staff that may be facilitated if appropriate. As with stage 3, special consideration should be made for those children and young people with communication difficulties, staff will use the communications approaches that are detailed in the child’s care plan.

12.6 The adult conducting stage 6, needs to consider their own emotional state, skills, experience and training to decide if there are any obstacles to promoting the best interests of the child.

12.7 Stage 6 is unlikely to be undertaken in isolation, further follow-ups should be re-explored during key worker meetings, and/ or with external agencies like social workers or advocates.

12.8 Discussions need to be facilitated in a manner whereby the child is confident that staff members are considering their views and not blaming them. Similarly, staff need to be confident that the child is considering their view point and not blaming them. Staff need to listen to the child’s point of views first, just listening to the child speak at length, instead of challenging them about who did what and when, creates a rapport of openness and child-centeredness.

12.9 Stage 6 discussions should aim to cover:

- The child’s views on being restrained. “How do you feel about being restrained [insert date]?”
- The child’s views on why the adults restrained them. “Why do you feel staff had to restrain you?”
- The events leading up to the restraint. “What do you feel led up to the restraint?”
- The part played by other people in the events leading up to the restraint. “Do you feel you were provoked in anyway?”
- The behaviour of the child and the staff that led to the restraint.
- The child’s thoughts and feelings and how that affected their behaviour.
- What the child was attempting to achieve by their behaviour.
- The process of the child regaining control.
- Helping the child identify and understand the connection between thoughts, feelings and behaviour.
- What has been learnt from the process of the restraint and surrounding events? Including a plan for the child and staff about what they will do differently the next time the child has similar difficulties, or experiences similar thoughts and feelings.
- What support is needed from both the staff and the child to maintain and promote the relationship?
- Space and support for the child to begin dealing with any difficult memories that the restraint may have brought up.

12.10 The period after a restraint is a time when the child and staff can learn how to deal with consequences of poor choices and learn about repairing relationships, it is staff members responsibility to lead this learning.

12.11 Stage 6 Listening and Learning for Staff:

12.12 Impact for Change aim that after all incidents, not just those incidents involving restraint, for example absconding, self-harm, verbally abusive attacks. Staff have an opportunity to reflect on what happened.

12.13 This discussion should be led by a facilitator that may not necessarily be the manager; it should be ideally someone who wasn't involved in the incident. This will support a non-blame culture and challenge any power play.

12.14 This process serves 3 primary functions:

1. The person's involved in the incident have an opportunity to express the difficult emotional pressures created by the need to restrain a child.
2. It enables all those involved in the incident an opportunity to reflect, in detail, on what happened and establish the facts.
3. It gives all involved an opportunity to reflect on what has been learnt and how that will influence future practice and professional development.

12.15 These discussions should take place as closely to post incident as possible. Discussions should be centred on the welfare of the child. The discussion should encourage reflection on the following:

- What has been learnt about the child as a result of the restraint and the events leading up to the incident?
- What have staff learnt about themselves and their colleagues?
- What staff think the child's views about the incident are?
- The view point of the child as to the reasons staff restrained them.
- What went well, what didn't go so well and what can staff do in the future.
- Any implications for staffing ratios, training and other organisational issues.
- Whether and how this discussion should be shared with the child.

12.16 As well as listening and learning discussions, further communication should be delivered in staff supervision and team meetings. The discussions had in supervision should mirror the agenda put forward for listening and learning sessions, but focus on the individual staff perspective, emotional wellbeing, training and development needs.

13.0 When things go wrong:

13.1 In an extreme situation, it may be decided that the practice was abusive. Abusive practice could be a single serious event that is not managed properly or it could be a working culture, or a series of incidents when added together amount to abuse.

13.2 It is important for all staff to remember that the term abuse does not just reflect physical abuse, also, sexual, emotional and neglect are considerations for Impact for Change.

13.3 Staff working with vulnerable children and young people and adults rely on each other to do their job well. This is a mutual reliance which exists to a far greater extent in working with high risk children and young people. As a result staff may feel conflicted between supporting their colleague and reporting abusive practices. It is a difficult decision staff members will face.

13.4 When faced with a difficult decision, you may wish to discuss it with a member of Impact for Change who is not involved. The most important factors influencing your decision must be:

- Is this practice in the best interest of the child?
- Are the child's safety and welfare needs being promoted?
- Are the child's rights being promoted?

Please refer to Impact for Change Whistle Blowing policy ICP 12.5.

14.0 Reporting:

14.1 After physically restraining a child and identified physical interventions as documented in the child's positive handling plan. Appropriate people must be informed:

- The child's family, where appropriate.
- The child's social worker.
- Impact for Change Restraint Designated Lead Clare Leach.
- Impact for Change Registered Individual and the Registered Manager.
- Police; in cases where an assault or criminal damage may have occurred, any contact with the police is after discussion with Directors and/or DSL.

Upon discussion with the Registered Manager, in exceptional circumstances it may be necessary to report to:

- The Health and Safety Executive.
- MASH.
- LADO.
- Ofsted.

15.0 Recording:

15.1 Recording incidents of physical restraint serves a variety of purposes:

- It provides an account of the care and control within Impact for Change.
- It encourages staff and child reflection on incidents.
- It supports how staff manage and plan the care provided to the child.
- It enables Impact for Change Senior Leadership Team to monitor the care within the organisation.
- It forms evidence in criminal, civil court cases or formal enquiries.

15.2 Impact for Change have 3 reporting systems specific, but not exclusive to physical intervention:

- Positive Handling Plans.
- Physical Intervention Forms.
- Bound and Numbered book.

15.3 Paperwork relating to restraint is kept for 75 years[25].

15.4 Positive Handling Plans:

15.5 The Positive Handling Plans (PHP) are documented risk assessments for a child. PHP's are "living" documents that are updated as and when risk increase or decreases. The PHP outlines the risk involved planned and agreed risk and restraint reduction (stage 1, stage2 and 3) strategies.

15.6 Risk assessment information should provide guidance to ensure that, where risk is present, all staff and others who are responsible for managing risk have the knowledge, skills and understanding to reduce risk within the organisations.

15.7 Impact for Change promote, that the Registered Manager involves all professionals responsible for the care provision of the child in its creation.

"PHP's are documented evidence of a truly child-centred approach. They are not generic paperwork exercises."

15.8 Everyone with a legitimate interest should be made aware of the PHP.

15.9 PHP's are an intrinsic part of the cyclic child-centred care provided by Impact for Change. Placement plans and care plans feed into them as do reflection from incident forms, physical intervention forms and key worker sessions.

15.10 Aspects that should be included on a PHP:

- The nature of risk.
- Trigger situations.
- What the behaviour looks and sounds like at the different stages.
- Preferred risk and restraint reduction strategies.
- Praise points.
- Bridge builders:
  - What the child really likes, when a child is anxious or escalating it is a good distraction tool for staff to use,
- Medical and emotional conditions to consider if restraint becomes necessary.
- Preferred physical interventions.
- Post Incident support structure.
- Recording and reporting required.
- Agreeing parties.
- Our understanding of the behaviour.
- Environmental changes.
- How progress will be rewarded.

15.11 The PHP's should be continually updated, concise and as factual as possible and available to anybody who needs to reduce risk presented to themselves and others.

[25] QS 36 2b and SCH 3

15.12 Physical Intervention Forms:

15.13 Physical intervention forms (PIF) record incidents where physical interventions are used. Not all physical interventions will be recorded in PIF's, for example a child who requires regular "caring c guide" as sometimes their feet become "stuck" or for a child a "mischievous" child who attempts to get into the office and requires single person turning, may not require PIF's, but it will be documented in the child's PHP that this technique is used on a regular basis and it will be documented in the child's daily record.

15.14 Similarly, it may be that a child placed at Impact for Change has never needed any physical support, but on one day a caring c guide is required, even though this is a low level physical intervention it identifies a change in the child's behaviour that requires investigation and monitoring.

15.15 All break away techniques, 2 person guides, seated holds, t-wrap, and advanced modules require a PIF to be completed.

15.16 Staff have 24 working hrs[26] to complete a PIF and they should be completed after the staff member has recovered. Areas that should be covered in a PIF are:

- Staff involved directly or indirectly in the incident.
- Details of any other professional, children and young people, visitors witness to the incident.
- Details of the events leading up to the incident.
- Details of the child's behaviour prior to the incident.
- Details of staff responses before the incident.
- A statement about how the physical intervention was:
  - In the best interest of the child.
  - Reasonable.
  - Proportionate.
  - Necessary.
- Details of which technique was used its duration and sequence.
- Details of how the incident concluded.
- Details of who the incident has been reported too.
- Details of support offered to the child after incident. Including the requirements under Team Teach minimum standards.
- Any injuries to child and/or staff.
- Listening and learning with the child post incident.
- How events fit into the child's PHP and changes in risk assessment.
- Registered Managers monitoring.
- Signatures.

15.17 Impact for Change promote a clear and accurate recording system. Staff must ensure their records are factual, concise and clear.

[26] QS 35 3a

15.18 Impact for require staff to use the names of Team Teach techniques rather than describe them. If professionals would like to know what the techniques are, staff must refer to Clare Leach.

15.19 Bound and Numbered Book:

15.20 This is a hardback bound and numbered book kept at each home detailing the following information:

- The name of the child concerned.
- Details of the incident.
- A description of the measure used.
- Date, time, location of incident.
- Staff involved.
- Signatures.

16.0 Conclusion:

16.1 Every staff member is responsible for making sure policies are safe to practice, if you have any questions, concerns or amendments you are required to contact Clare Leach ASAP.

16.2 On reading this policy you are required to sign confirming that action, the signature confirms that you have read, understood and agree to comply with this policy.

16.3 Impact for Change acknowledge the sector in which we work can be a challenging and difficult one. However it is, and will remain to be rewarding and positive one.

16.4 Impact for Change are committed to raising the standards of care delivered within the organisation, but also raising the profile of care within the work sector.