Document name
Restrictive interventions policy – including physical interventions

This document is relevant to:	
Central Support Services	✓
Education	✓
Medical Therapy	✓
Residential	✓

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Contents of document

Jargon Buster:

BSP – Behaviour Support Plan

PBSP – Positive Behaviour Support Plan

SLT – Senior Leadership Team

BILD – British Institute for Learning Disabilities

1. Introduction

1.1 St. John's is committed to supporting individuals with a learning disability to live a valued life within the community. To achieve this, the service model/provision implemented ensures:

- Community presence
- Competence
- Choice
- Individuality
- Status and respect
- Continuity relationships

However, it is recognised that some individuals that we support may require a more intensive level of support to achieve these principals, due to their complex needs and challenging behaviour.

1.2 Challenging behaviour is defined as:

Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.'
(Royal College of Psychiatrists et al., 2007, p.10).

Among many causes, challenging behaviour has been reported to

- represent a form of communication
- be caused by skills deficits
- be associated with psychiatric disorder or symptoms or physical illness
- develop through operant conditioning and reinforcement

(Koritsas & Iacono, 2012):

1.3 In order to provide appropriate responses to individuals at times of displaying challenging behaviour, i.e. the implementation of restrictive interventions, St. John's requires all responses to be in keeping with a proactive, non-aversive approach that adheres to current legislation and the law. It must be clearly demonstrated that the use of physical interventions has followed a gradient of responses or gradient of control and is not the first response implemented.

Therefore, the protocol adopted within St. John's has been formulated taking a number of factors into account.

1.4 The use of force (physical interventions) by one person on another without consent is unlawful, unless it is carried out in accordance with the law governing the use of force applicable to the particular context in which that force is used. The rules governing the use of force (physical interventions) in service settings will differ and the type of action that staff can take will depend upon the particular service setting and regulations allied to that setting. Staff therefore need to understand the different legislative frameworks and general principles of the law on the use of force in their setting.

1.5 St. John's uses physical intervention training that is accredited by the British Institute for Learning Disabilities (BILD) as referenced in the Department of Health Policy 2014 'Positive and Proactive Care – reducing the need for physical interventions'.

2. Legal context

2.1 BILD 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"

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

- 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, that puts someone at risk, carers 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 carer 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 positively respond which might include as a last resort restraining the person to prevent harm.

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 further more 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 Maybo framework and training offers guidance and a series of none restrictive and none aversive techniques to avoid/reduce the use of restrictive practices, there is an expectation that alternatives to a restrictive practice would increase with staff training, experience and knowledge of the individual. If you can find no alternative to using a restrictive practice, then you should use it.

2.2 Duty of Care – St. John's staff have a duty of care towards the people supported which requires the organization 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.

2.3 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.

2.4 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 with caring for, developing and teaching the children and adults 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.

3. Values

3.1 A value-based service is paramount in supporting all individuals. Physical interventions will only be used in the best interest of the individual. They will never be used in isolation but will be used with a proactive regime that ensures individuals are treated with dignity and respect. All individuals will be provided with opportunities that facilitate learning and skill development.

4. Prevention of behaviours that challenge

4.1 A proactive approach must be adopted in managing behaviours that challenge. This ensures a value-based service is implemented and the need for crisis management and response is eliminated. To enable this proactive response, consideration must be given to the overall service provision. This includes the individual, the service, systems and environment.

4.2 It will be possible to reduce or prevent incidents of challenging behaviour occurring by the careful management of such' setting conditions'.

5. Promoting best interests

5.1 Individuals who display challenging behaviour will receive a pre-planned response. This will be identified within the reactive plan that forms part of a person's Behaviour Management Plan or Positive Behaviour Support Plan and will be;

- Specific to an individual and based on comprehensive assessment of individual need and risk assessment
- It will identify the responses and procedures specific to the individual and the target behavior

5.2 The responses set out in the reactive plan will ensure the safety of the individual and all others.

5.3 The reactive plan will only be used with the proactive guidelines that are part of a persons' plan.

5.4 The use of the reactive plan in conjunction with the proactive guidelines will always be agreed within a multidisciplinary format and subject to regular review within that context.

6. Physical Intervention Risk Assessments

6.1 Physical interventions must not involve unreasonable risk. Therefore, a risk assessment must be completed with regard to the implementation of physical interventions.

6.2 Prior to the implementation of any physical interventions, all individuals must be assessed to identify any contra-indications which may preclude them from physical interventions being implemented. The physical interventions will be identified within a reactive plan that will be agreed within a multidisciplinary format.

7. Minimising risk

7.1 Physical interventions will follow a gradient of Response and/or gradient of control. The response will always be appropriate to the behaviour presented, i.e. physical interventions must be employed using the minimum force only. Only the least restrictive response must ever be implemented.

7.2 Physical interventions must be used for only the minimum time required. The aim must always be to return the control as quickly as possible back to the individual.

7.3 Physical interventions must be pain free.

7.4 Following any implementation of any physical intervention the individual will be assessed for any injury or distress.

7.5 All implementation of physical interventions will be monitored. Staff must ensure that effective reporting and recording of incidents is implemented.

8. Application of physical interventions

All learners supported by St. John's who require any form of behavioural intervention will have a Behaviour Support Plan / Positive Behaviour Support Plan that provides detailed information relating to all aspects of a person'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 function of a particular behaviour, known as contributory environmental factors, antecedents and triggers. The plan described the proactive and reactive strategies that are to be followed by those supporting the individual to improve the person's quality of life and reduce the risk of harm to themselves or others.

Part of this plan may include restrictive practices where necessary and deemed in an individuals' 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

Restrictive Practices can take several forms and may not always involve direct physical force but also chemical restraint, Pro-re-nata (PRN) medication (in the form of sedation), rapid tranquilization, mechanical restraint and environmental restraint, such as the holding of doors or blocking access by use of a person. The use of any PRN will be guided by a specific and individual protocol from the prescribing medical professional.
Restrictive practices can be categorised as planned or emergency interventions:

8.1 Planned Restrictive Practice -
pre-arranged interventions based on risk assessments and clearly recorded in care and behaviour support plans. These interventions should be 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 Intervention is within 24 hours of the Practice/Intervention taking place

8.2 Unplanned Restrictive practices -
an action used in response to unforeseen hazardous events such as a person

supported is about to run out in front of a car and there is no other alternative. The time frame for reporting the use of an unplanned Restrictive Practice is within 24 hours of the Practice/Intervention taking place

8.3 Wherever possible, an unplanned response should still be a 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 and the Maybo training, by providing a reasonable and proportionate response.

8.4 Where unplanned or unintentional incidents of restrictive practices occur they should always be recorded, opportunity given to debrief to ensure learning and continuous development of plans.

8.5 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.

8.6 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. Particular 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 always be sought following a Physical Restrictive Intervention.

8.7 All the techniques included in the training have been extensively risk assessed and **do not use pain, locks, hyperextension, hyper flexion of limbs or joints**. All movements are Bio-Mechanically assessed to ensure that they work with the body's natural mechanical movement. The techniques provide a uniform response for dealing with aggressive behaviour and tailored to ensure it can meet individual need. All taught physical skills (Breakaways/Guiding/Escorting/Safe Holding) do not employ potentially dangerous positions that may compromise breathing or the welfare and safety of the person based upon their individual characteristics and profile. Therefore, the teaching and use of **prone-restraint is not supported**.

8.8 It is imperative before staff employ any type of physical intervention that all alternative options have been exhausted and restrictive physical interventions are only used as a **last resort**. Staff will need to ensure given the individual characteristics of the individual that their response is the **least restrictive (**minimum level required), the **best fit** (type of intervention) and employed for the **shortest period of time** possible.
Physical Restraint within St. John's is only permitted for the purpose of preventing:

(a) injury to any person (including the child);

(b) serious damage to the property of any person (including the child).

9. Principles for the use of restrictive practices

9.1 When facing behaviour that is potentially dangerous, staff must act in a measured way, bearing in mind their duty to try to keep the people we support, staff members and themselves safe.

9.2 Additionally, staff have a responsibility to take all reasonable steps –through the use of Behaviour Support Plans and up-to-date risk assessments related to individuals we support – to safeguard the wider public and property from any potential physical danger from people we support when in the wider community.

9.3 Individuals should, where possible, be involved in any discussion about the use of restrictive practice. Almost all individuals will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed their views in the past. Wherever possible and reasonable, the person's informed, free and full consent to any restraining action should be obtained. The individual's relatives, advocates, guardians, should be involved in discussions about the use of restrictive practice should be agreed as in a person's best interest. In all cases explanation should be given, at a level the person can understand.

9.4 Under no circumstances should the use of restrictive practices result in pain or pressure on joints.

9.5 Wherever possible, staff should consult and collaborate with colleagues. The person who is most familiar with the individual and has the best understanding of how to respond to the behaviour should take the lead role. This may cut across line management and seniority.

9.6 Staff should always explore other possible alternatives. For example, restrictive practices should not be used when a change of staff could have meant it was not necessary.

9.7 Except in an emergency or where the behavior support guideline indicates to the contrary the only restrictive practices involving bodily contact used should be those approved by Studio III / PBM and only used by staff with appropriate training. It is understood that this may not always be possible during an emergency or where the bespoke behavior support guideline indicates to the contrary

9.8 Wherever possible, staff should consult and collaborate with colleagues. The person who is most familiar with the individual and has the best understanding of how to respond to the behaviour should take the lead role. This may cut across line management and seniority.

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10. Seclusion

The Human Rights Act 1998 sets out important principles regarding protection from abuse by state organisations or people working for these institutions. It is an offence to lock an individual in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency.

The right to liberty and personal freedom is enshrined in Article 5 of the Human Rights Act 1998 and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act and **should only be considered in exceptional circumstances** and should always be proportional to the risk presented by the child or person supported.

In Adult services, any form of environmental restriction imposed on individuals should be legally authorised. Therefore, if it is foreseen that it may be necessary to use a form of environmental restriction such as seclusion beyond dealing with an initial emergency in a community setting, an application should be made for a DoLS under the Mental Capacity Act 2005 should be considered.

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 children homes 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.

St. John's does not support the blocking of exits or the holding the of doors as a routine approach to managing behaviours that challenge. However, we do recognise that there may be situations that arise where this is deemed necessary in order to safeguard the individual or other learners. In such situations a senior member of staff must be informed that this is occurring or has occurred and should only ever momentary until the risk has reduced or passed.

Anyone using any form of restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

Where restrictive practices are used they must be proportionate to the risk of harm and the seriousness of that harm.

11. Use of Safe Spaces

11.1 St. John's acknowledges that the use of safe spaces have proven beneficial for some learners. They provide a calm, low stimulation environment needed to help some learners to successfully self-regulate. Learners can use the safe space as a means of managing their own behaviour, by requesting time in it when they recognise their stress/anxiety levels are rising or be directed by staff as a part of a secondary preventative strategy.

11.2 When challenging behaviour is presented, use of a safe space can reduce the extent and frequency of physical interventions. It can mean that relationships with staff members are less likely to be damaged by more restrictive practices

11.3 The use of any safe space within St. John's must however adhere to the following conditions: -

- The learner must access the room or space voluntarily.
- The learner must be accompanied by, a support worker/teacher or other person whilst in the room.
- The learner must be free to leave the room independently.
- The learner must have capacity to know how to get out of the room or area.
- The safe space must be part of an assessed and agreed behaviour support plan.
- If any of the above conditions are not met, then the use of the safe space cannot be used.

12. Management Responsibilities

12.1 St. John's will ensure that a policy is implemented and reviewed regarding the use of physical interventions for responding to incidents of aggression from service users.

12.2 Managers will ensure that any physical interventions required for individuals are always clearly set out within the written reactive plan guidelines. They will then ensure that all staff adhere to and implement only these agreed guidelines.

12.3 Managers will ensure that following any incident requiring the use of physical interventions, all necessary documentation is completed, i.e.:

- Behaviourwatch report
- Incident / accident form
- MAR chart

12.4 All individuals and their families or representatives must be made aware of the complaints procedure. Access to this must be freely available.

12.5 In instances where the use of physical intervention is required and advice or additional resources are needed urgently, staff must contact their line manager. Where a Physical intervention is used this must be reported to the allocated social worker or duty team of the funding authority. This should be no more than 24 hours after the event. It is the responsibility of the Residential/Education Manager to ensure that this is reported.

13. Staff training

13.1 St. John's recognises and acknowledges that it has responsibility for the safety and wellbeing of its' staff under the current legislation and Health & Safety requirements.

13.2 Accordingly, St. John's will ensure that all staff that are required to use physical interventions will receive the necessary training on managing challenging behaviour, which will include proactive and reactive interventions.

13.3 The model of support and training adopted by St. John's is Specialist Services Training Solutions Physical Interventions (SSTS). & Maybo. These are both accredited by both the British Institute for Learning Disabilities (BILD)

13.4 All staff participating in physical intervention training will be required to meet and adhere to the training regime and fitness criteria specified by SSTS& Maybo as specified in the agreed training contract.

14. Frequency of training

14.1 All staff will be required to complete physical intervention training. The level of training will be congruent to their job role within the organisation. The initial training for staff will be between two to four days, on induction. All staff will then be required to attend refresher training every 12 months.

15. Monitoring and evaluation of training

15.1 A database has been established to ensure that all staff training requirements regarding behavioural management and physical interventions are met.

15.2 All staff training provided is monitored and evaluated. Evaluation forms are completed by trainees.

15.3 Staff in receipt of physical intervention training must only employ the physical techniques that they have been taught. They must only ever be implemented under the agreed guidelines and conditions specified within the individual Reactive Plans.

16. Post incident support

16.1 St. John's has a statutory obligation for the safety and wellbeing of its staff and if an incident of aggression occurs the following actions must be considered:

- Do staff require medical treatment
- What support systems do people need, e.g. emotional, psychological and physical

16.2 Following an incident of aggression, both staff and learners will experience a range of physical and psychological emotions. To ensure a person's wellbeing at this time, post incident support will be provided to all individuals involved.

16.4 The support offered must be reflective of the individual's needs. Therefore, a range of support systems will be required to address short, medium and longer terms responses.

17. Responsibilities

17.1 Governors

- Governors review of policy on the use of Restrictive Practices.
- Governors will monitor the reduction in use of Restrictive Practices on a termly basis.

17.2 SLT

- Monitoring of implementation of this policy
- Monitor the use of Restrictive Practices on a regular basis
- Ensuring the allocation of internal and external resources (including clinical and counselling) to address the needs of individuals we support and staff with regard to the implications of serious challenging behaviour

17.3 Heads of Learning, Deputy Head Teacher, Care Managers

- Enforcing the implementation of this policy in their setting
- Maintaining a comprehensive recording and reporting process relating to the use of restrictive practices
- Ensuring relevant staff undergo training in the use of restrictive practice, with regular refreshers
- Supporting teams in developing risk assessments

17.4 Behaviour Team

- Creation of BSP/PBS plan
- Ensuring plans are shared with parents/advocates, purchasers and other interested agencies, and where appropriate with the child or adult concerned, recognising the importance of consent in terms of the fundamental issues of respect and dignity.
- Regular monitoring of such plans.

17.5 All Staff

- Working always in the best interests of the child or adult.
- Taking part in training provided in the use of restrictive practices and applying the principles and strategies taught.
- Satisfying themselves that they are clear on what they may and may not do in terms of restrictive practices, seeking clarification as necessary.
- Using Support & Supervision sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary. Following the recording and reporting procedures.

- Contributing to the development of BSP's, and good practice.