Positive Behaviour Strategy

Safe Support and Physical Intervention

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Section 1: Values and principles

1.1 <u>Young Epilepsy believes that all children and young people:</u>

Should have the right to feel safe, secure, nurtured and cared for. They should have access to appropriate support, care and education. This includes the support to manage their emotions and their behaviours including taking account of their development, and the responsibilities that are accrued as a result.

- The use of physical interventions must **never** be used as a punishment and will always be a last resort. Safe support training highlights that 95% of behavioural incidents can be managed without physical restraint.

- Staff must **not** deliberately use restrictive physical intervention on a child / young person in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

- If restrictive physical intervention is used it must **not** include the deliberate application of pain.

- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.
- Staff must not use seclusion other than for people detained under the Mental Health Act 1983.
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

- Students who are at risk of repetitive and frequent physical intervention **must have** Individualised support plans, incorporating pastoral (behaviour) support plans[1]. This should include Risk Assessment taking into account other students and staff.

The use of physical interventions should only be considered within the context of risk, be proportionate to that risk and appropriate given the age, understanding, gender and size of the child or young person.

1.2 The input of the Multi-disciplinary team (MDT) input in supporting and managing risk as well as assessing is crucial to supporting children and young people at Young Epilepsy. Information pertinent to supporting children and young people should be disseminated and shared across the teams to provide a safe environment for our community.

1.3 All staff and students should have access to support after an incident. Initially this should be with their line manager and if deemed appropriate due to the severity of the incident the psychology team should be involved to offer further support including a de-brief for all those impacted by the incident.

Section 2: Defining terms

2.1 This policy applies to all children and young people whose behaviour may place themselves and/or others at risk.

2.2 Restrictive physical interventions may include:

Bodily contact: where the physical presence of one or more people is used to control a child or young person, for example two people holding a person so as to restrict their mobility
Environmental change: applying a change within the environment for example, the use of locked doors or swipe access to prevent access to or from an area, or
Mechanical: the use of belts, straps or clothing that restrict the freedom of movement, for example the application of arm splints to prevent self- injurious behaviours.

Any of the above may be assessed as appropriate interventions within specific settings but must always be accompanied by short and long-term behaviour support strategies that will work towards a reduction in the use of physical interventions if used in a planned or proactive manner. *(See section 2.3)*

2.3 Emergency physical intervention is the use of physical intervention in a situation of significant risk that was unforeseeable.

Planned physical intervention is the proactive use of physical intervention as part of an overall **pastoral (behaviour) support plan** aimed at reducing the level of risk presented by behaviour and accompanied by appropriate preventative strategies.

[1] Please see appendix 2 FAQ.

2.4 Seclusion and isolation or any practice, which 'restricts liberty', may infringe the rights of a child or a young person. As such it should only be considered in secure accommodation[2] approved by the Secretary of State. Further clarity can be found in the Children Act 1989.

Section 3: Legal issues and responsibilities

3.1 An employee may have lawful excuse for the use of positive handling if it's:

- Preventing a child or young person causing serious harm to them self or putting themselves in harm's way.
- Preventing the child or young person causing serious harm to another person, this may include other staff, adults, volunteers or members of the public or,
- Preventing a child or young person causing damage to property with a consequence of serious harm

Or in School/ College setting:

- Preventing any behaviour which is prejudicial to the maintenance of good order and discipline.

3.2 The decision to use positive handling or physical interventions must be taken in the context of the level of risk presented by the behaviour, the seriousness of the incident, and the relative risks of the use of any physical intervention compared with any available alternative.

- GREATER HARM (OCCURING)
- HONEST HELD BELIEF
- LAST RESORT
- BEST INTERESTS
- REASONABLE FORCE
- PROPORTIONALITY
- IMMINENT THREAT OF DANGER

3.3 The use of any physical intervention must also take account of the characteristics of the child or young person including their age, gender, special educational needs, physical needs or disability, developmental level or cultural issues.

Section 4: Risk assessment

4.1 In order to ensure the health, safety and welfare of children, young people and staff, it is essential that a risk assessment approach is adopted for all physical interventions. A record[3] of these must be kept, with control measures and responsibilities noted and actioned.

4.2 When assessing risk the following must be considered:

- The environmental context of risk

[2] Please see appendix 2 FAQ

[3] Please see appendix 2 FAQ

- Personal vulnerability factors affecting individual children and young people
- The probability of emerging risk and the seriousness of potential outcomes
- How preventative and proactive measures may affect the level of risk, and the potential outcomes of not intervening.

4.3 All children and young people who have pastoral (behaviour) support plans including suggested ways of responding to difficult behaviour. There ought to be alongside this an appropriate written risk assessment acknowledging the impact of contextual and environmental factors.

4.4 Medication can play a role in presenting behaviour. At times a child or a young person will experience adverse effects of medication changes or review of medication dosage. It is important to consider the arrangements in place for informing the MDT and all those involved in the care of the person of the above.

Section 5: Prevention strategies

5.1 Staff should be aware that their own behaviour has impact on the children, young people and how their colleagues respond to a behavioural incident. As mature adults staff should always be reflective about what they want to achieve through a response. It may mean that at times a change of face is a good strategy rather than persist with an intervention that is not working towards the desired goal.

5.2 Prevention of critical incidents and appropriate support of individual children and young people is paramount. Effective individualised support of children and young people can prevent challenging behaviour and reduce the likelihood of incidents escalating. We adopt a graduated response to behaviour[4].

5.3 Services and settings must ensure that they:

- Identify personal and environmental factors, which impact on individual children and young people adversely affecting their presentation and behaviour
- Assess the reasons why children and young people use particular challenging behaviours and put in place interventions that support positive interactions.
- Ensure that they develop strategies that help prevent challenging behaviour through effective support, therapeutic and professional input. Children and young people should have access to appropriate professional support such as psychology, speech & language, physio and occupational therapist as well as medical.
- Monitor and evaluate behaviour strategies and continue to review interventions as necessary.
- Raise awareness through discussions of the child or young person at the Behaviour support team meetings.

5.4 Primary prevention will be achieved by:

- Developing an ethos that is inclusive and values the individual personalities of the children and young people. It would mean a focus on person centred approaches that promote and reward positive behaviour. Staff would be

[4] Please see appendix 2 FAQ

modelling and living this way of working through their interactions with the children and young people.

- There should be clarity about the expectations staff members have of each other and their responsibilities to the welfare of the children and the young people.
- Staff would pay heed to the developmental ages of the children and young people and not focus solely on the chronological age.
- Rewards for positive behaviour should reflect person centred approaches geared towards motivating behaviours such as co-operation, peer interactions, responsibilities to the environment and the setting as well as responsiveness to the needs of the others.
- As a staff team creating opportunities to explore individual behaviours and reflect what communication is taking place when a child or a young person behaves in a certain way.

- Holding positive views of children and young people and building on the relationships valued by the child or young person
- Developing positive relationships with children and young people based on mutual respect and shared boundaries
- Creating an environment in which children, young people and staff feel safe and secure ensuring staff have the appropriate skills to effectively support children and young people
- Supporting children and young people, as far as is possible, to understand their behaviour and learn alternative ways of expressing themselves or achieving their desired aim through alternative methods.
- Recognise that we all make mistakes and that children and young people in learning new behaviours to meet their goals will at times act in their old inappropriate ways. Staff will bear this in mind and guide the children and young people as well as remind them of the expectations of them.
- Creating exciting and fulfilling lives for children and young people encouraging effective and consistent support from the family unit or carers, and involving, listening and taking account of the views held by the child or young person in their personal plan.

5.4 Secondary prevention should be used where primary prevention has been ineffective and is achieved by:

- Ensuring staff have clear guidance and appropriate skills
- Recognising the personal indicators exhibited by individual children and young people when they are having difficulty in managing their emotional state or are reaching crisis
- Identifying previously successful distraction and de-escalation strategies. These must be incorporated in to the personal behaviour support plan. Alongside this identifying emerging risk indicators and ensuring there is a written record.
- Attending Behaviour support team meetings to highlight the concerns as well as what interventions have been in place.

Section 6: Emergency physical interventions

6.1 Physical intervention must be judged as appropriate for a given situation because of the inherent risk in the environment and the unforeseeable nature of the event itself. Staff will remain responsible and accountable for their actions or inaction and must still act within current legislation[5] and guidance.

6.2 The use of force must be justified and proportional to the situation. Staff must remain aware of section 3 (pg. 3) of this document.

Section 7: Proactive use of physical intervention

7.1 Parents/ carers as well as the young person where possible should be involved in discussing and planning any physical interventions that are implemented in a thoughtful manner.

- There may be exceptions when a physical intervention is made due to exceptional circumstances that have not occurred before (see section 6 above).

7.2 The physical intervention plan should follow a gradient approach and it is an expectation that services should:

- Ensure there is an appropriate assessment of the target behaviour(s) and the function of the behaviour has been identified so far as is possible
- Be specific in identifying the target behaviours which are of concern and the behavioural indicators that lead to the difficult behavioural presentation
- Identify actions which will reduce the risk levels which lead to the behaviour being exhibited
- Identify the primary prevention strategies and link to a behavioural risk assessment
- Clearly communicates to the staff the secondary preventative strategies or actions
- Be specific in terms of long term and short term behaviour target, and identify when it may be necessary to use a physical intervention (if the behaviours are known and identified in previously) and if possible identifies which physical intervention technique is assessed as being the most appropriate.

Section 8: Reporting and recording

8.1 Young Epilepsy's systematic reporting and recording process, must be used. In the event of the use of restrictive physical intervention it will be important to record the following:

- Personal information relating to the child or young person
- The context of the incident, time, day, location, environmental issues

[5] Please see Appendix 2 FAQ

- Who was present including other children or young people, staff, members of the public or family members
- Type of incident and relative risk
- Antecedent factors, what happened before the incident
- How was the child or the young person prepared in advance for the activity that led to the incident? Was there a social story, visual pictures and timetable?
- What alternative actions had been tried to prevent the escalation of the incident
- The reason that physical intervention was used and identify the technique
- What occurred following the incident, de-brief, support and the care of the child, young person or adult including others present,
- Information shared with others including the child, young person, and their parents/carers and other professionals.

8.2 Any injuries that occur to children, or young people during a physical intervention must be reported to Safeguarding and medical attention sought if appropriate..

8.3 Any injuries to staff during a physical intervention must be recorded and medical attention sought where appropriate.

8.4 All incidents of restrictive physical intervention will be collated and discussed at the weekly pastoral (behaviour) support team meeting and amendments made to the individual support plan for the child / young person as appropriate.

Section 9: De-brief

9.1 Following the use of restrictive physical interventions de-brief should be offered to the child/young person, anyone present including other children and young people as well as the staff involved in holding the child or young person.

9.2 The child / young person who has required restrictive physical intervention to be applied should be given the opportunity to be debriefed and talk through their experience by a responsible adult who was not involved in the restrictive physical intervention incident within 24 hours. The child / young person should be encouraged to add their views, feelings, wishes and comments to the incident report. The child / young person must be offered the opportunity to have access to an advocate to help them with this.

9.3 De-brief may be offered in a formal or informal manner. It is the responsibility of managers to ensure that de-brief is offered to staff affected by incidents.

Section 10: Training

10.1. Young Epilepsy believe The BILD physical interventions accreditation scheme is a good indicator of best practice standards when commissioning training. Young Epilepsy therefore have commissioned PRICE Training to provide a bespoke in-house training package. (Safe Support).

10.2 This decision was made to ensure that the training will:

- Meet current needs based on behaviour audit and risk assessment
- Should focus on the skills of prevention, de-escalation and diversion
- Promote positive relationships
- Offer alternative actions and responses
- Promote and discuss the rights of children and young people
- Promote and discuss the rights, responsibilities and legal protection for employees
- Establish links to health and safety legislation
- Discuss ethics and the legal framework
- Deliver information in an appropriate context taking account of the individual service users with specific reference to needs
- Enable staff to develop their personal skills
- Enable staff to respond to incidents that occur frequently in the service, and
- Provide necessary protection against litigation.

Section 11: Leadership, assurance and accountability

11.1 A board level, or equivalent, lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions

11.2 Board must maintain and be accountable for overarching restrictive intervention reduction programmes.

11.3 Executive board (or equivalent) must approve the increased behavioural support planning and restrictive intervention reduction to be taught to their staff.

11.4 Governance structures and transparent polices around the use of restrictive interventions must be established by the organisation.

11.5 Young Epilepsy must have clear local policy requirements and ensure these are available and accessible to users of services and carers.

11.6 Young Epilepsy must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns.

11.7 Board must receive and develop actions plans in response to an annual audit of behaviour support plans.

11.8 Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.

Section 12:Transparency

12.1 Providers must ensure that internal audit programmes include reviews of the quality, design and application of behaviour support plans, or their equivalents.

12.2 Accurate internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes and details of training and development in annual quality accounts or equivalent.

12.3 Service commissioners must be informed by providers about restrictive interventions used for those for whom they have responsibility.

12.4 Accurate internal data must be gathered, aggregated and reported by providers through mandatory reporting mechanisms where these apply, e.g. National Reporting and Learning Service (NRLS) and National Mental Health Minimum Data Set (NMHMDS). [Paras 110-112]

Section 13: Monitoring and oversight

Ofsted inspections for children's homes and Care Quality Commission's (CQC) for adult residential homes will carry out monitoring and inspection against compliance

with the regulation on use of restraint and its ratings of providers will be informed by this guidance

Ofsted inspections for children's homes and CQC will review organisational progress against restrictive intervention reduction programmes.

Ofsted inspections for children's homes and CQC will scrutinise the quality of behaviour support plans which include the use of restrictive interventions.