Cambian

Policy No: 46.00

Policy and Procedure on

Use of Physical Intervention featuring Safety Intervention (CPI)

Cambian Spring Hill School

Policy Author / Reviewer	Nigel Beckett/James Boyce
Approval Date	July2021
Next Review Date	July 2022
Version No	5
Policy Level	Group
Staff Groups Affected	All staff

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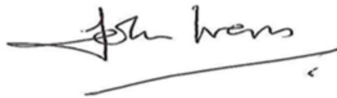
1. Monitoring and Review

1.1 The Proprietor will undertake a formal review of this policy for the purpose of monitoring and of the efficiency with which the related duties have been discharged, by no later than one year from the date of approval shown above, or earlier if significant changes to the systems and arrangements take place, or if legislation, regulatory requirements or best practice guidelines so require.

1.2 The local content of this document will be subject to continuous monitoring, refinement and audit by the Head of Service.

Signed:



John Ivers
Proprietor and Cambian Group Safeguarding Lead
Date: September 2020

Samantha Campbell
Principal
July 2021

2. Terminology

2.1 Our aim is to use consistent terminology throughout this policy and all supporting documentation as follows:

'Establishment' or 'Location	This is a generic term which means the Children's Home/school/college. Cambian Spring Hill School is a school and children's home.
Individual	This means any child or young person under the age of 18 or young adult between the ages of 18 and 25. At Cambian Spring Hill School we have children and young people attending and/or residing between the ages of 8 and 19.
Service Head	This is the senior person with overall responsibility for the school. At Cambian Spring Hill School this is the Principal who is Samantha Campbell. The registered manager for the children's home is currently vacant.
Key Worker	Members of staff that have special responsibility for Individuals residing at or attending the Establishment.
Parent, Carer, Guardian	Means parent or person with Parental Responsibility
Regulatory Authority	Regulatory Authority is the generic term used in this policy to describe the independent regulatory body responsible for inspecting and regulating services. At Cambian Spring Hill School, this is Ofsted Care.
Social Worker	This means the worker allocated to the child/family. If there is no allocated worker, the Duty Social Worker or Team Manager is responsible.
Placing Authority	Placing Authority means the local authority/agency responsible for placing the child or commissioning the service
Staff	Means full or part-time employees of Cambian, agency workers, bank workers, contract workers and volunteers.

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3. Legislation and references for further guidance

3.1 The purpose of this policy is to ensure that, as far as reasonably practicable, the safety of all employees, individuals in our care, visitors and any other individuals who may be affected by people handling activities, are safeguarded through compliance with relevant legislation, including:

- The Health & Safety at Work Act (HSWA; 1974)
- The Management of Health & Safety at Work Regulations (MHSWR; 1999)
- Manual Handling Operations Regulations (MHOR; 1992, as amended 2002)
- Lifting Operation & Lifting Equipment Regulations (LOLER; 1998)
- Provision & use of Work Equipment Regulations (PUWER; 1998)
- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR; 2013)
- Human Rights Act (1998)
- Use of reasonable force Advice for headteachers, staff and governing bodies - here
- Positive environments where children can flourish - here
- CQC Brief guide: restraint (physical and mechanical) - here
- Positive and Proactive Care: reducing the need for restrictive interventions - here
- The Children's Homes Regulations 2015 have been amended by the Children's Homes (Amendment) Regulations 2015 (the 2015 Regulations) - here
- Guidance on the Use of Restrictive Physical Interventions for Staff Working with Children, Young People and Adults who display Extreme Behaviour in Association with Learning Disability and/or Autistic Spectrum Disorders (2002) - here
- Restrictive Physical Interventions for Pupils/Students with Severe Behavioural Difficulties (2002) - here
- BILD Code of Practice for the use and reduction of restrictive physical interventions - here
- Thematic review of the use of restraint, prolonged seclusion and segregation for people with mental health problems, learning disabilities and/or autism - here
- Reducing the Need for Restraint and Restrictive Intervention (2019) - here
- Restraint Reduction Network Training Standards (April 2021) - here

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4. Introduction

4.1 This policy should be read in conjunction with Behaviour Support Policy no 45.

4.2 Physical touch is an essential part of human relationships and staff working within children's services divisions may be required to have physical contact with the children and young people they are caring for. There are occasions where it is entirely appropriate for staff to have some physical contact with the children and young people for whom they are caring. However, it is crucial that in all circumstances, staff only touch children in ways appropriate to their professional or agreed role and responsibilities. Touch can be used to facilitate relaxation or enable the child or young person to enjoy a positive emotional experience when in the sensory setting.

4.3 Touch is defined as any physical contact between two or more people and may include the use of objects e.g. to demonstrate how to use a specific equipment, where 'hand over hand prompting' support is required or another appropriate form of physical contact identified in the Individual's person's care plan/support plan.

4.4 This policy recognises the positive use of physical contact, as staff are likely to experience many different scenarios involving physical contact (from light to firm pressure touch) with children and young people. When touch is used in context and with empathy and due regard for the individual's dignity, it can be a means of providing care, comfort, communication, reassurance and safety.

4.5 This policy deals with the principles of restrictive and non-restrictive practices (i.e. holds and disengagements) based on the Crisis Prevention Institute (CPI) 'Safety Intervention'. It is used with the individuals in our care by staff in Cambian/CareTech locations.

4.6 This policy outlines the legal requirements and the practical procedures that Cambian/CareTech Children's Services follows to ensure the safety of the individuals in our care, staff and visitors to our locations.

4.7 It is recognised that within Cambian there are a number of children and young people for whom physical interventions may form part of a range of strategies required to meet their needs and to ensure the safety of others. These strategies must be used only once the relevant de-escalation strategies have been exhausted.

4.8 Staff may need to use the opportunity for structured play to teach boundaries and concepts. Touch may be used as a planned approach, in accordance with individual child's/young person's plans. Where required each site may have a local Guidance on physical contact with children and young people.

4.9 This policy has been written with due regard to Local Authority's policies relevant to the Cambian locations, the updated non-statutory advice from the Department for Education 'Use of reasonable force' from July 2013 and the Children's Homes Regulations 2015.

4.10 This policy applies to all staff working in our locations as well as being engaged in off - site activities.

CPI Safety Intervention Programme

4.11 This policy features CPI Safety Intervention Programme. This programme is a Crisis behaviour management system designed as a safe, non-harmful approach to assist staff in the management of a wide range of disruptive, challenging, aggressive, and violent behaviours, including the most acute behavioural disturbances and high risk behaviour. The focus is on verbal and non-verbal de-escalation, prevention, and early intervention.

4.12 The CPI Safety Intervention philosophy enables us to meet Standards, Regulation and Legislation for Individual Children's Homes, Residential Special Schools and Care Homes.

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5. Purpose

5.1 To maintain the safety of the individuals, other children/young adults, the staff working with them and others.

5.2 To ensure all staff understand the circumstances in which physical intervention is used with individuals in our care, treat all individuals with dignity, courtesy and respect. Recognising psycho-social factors that may impact on individuals, such as:

- Social support;
- Loneliness;
- Social disruption
- Bereavement
- Work environment
- Social status
- Social integration

5.3 To ensure the term 'physical' doesn't necessarily mean 'negative physical contact e.g. 'supportive/therapeutic touch'.

5.4 To clarify the procedures that should be followed to ensure that where physical intervention is used, the techniques are safe and appropriate to the situation.

5.5 To ensure that all adults working with the individuals in our locations are clear about their roles and responsibilities, in order that their own rights, and those of the individual in their care, are protected.

5.6 To ensure that staff who are likely to face situations in which physical intervention may be necessary, are trained appropriately and understand the procedures to be followed in planning, applying and reviewing the use of physical intervention.

5.7 To authorise staff using a physical intervention that is 'necessary and proportionate' when managing challenging behaviour.

5.8 To ensure that Cambian locations comply with all the relevant current legislation and other National Standards which govern this area of our work.

5.9 To support and encourage best practice, increase the use of successful de-escalation and thus reduce the need for physical intervention to be used.

5.10 Any physical intervention is applied as a last resort after all other options have been exhausted to ensure the safety of the individual or others.

6. Policy

6.1 Not only those with parental responsibility, but all practitioners responsible for care and support and, as far as possible, the individual themselves, will be involved in the planning, monitoring and review of the strategies identified to address challenging behaviour, including the use of physical intervention.

6.2 At all times our collective aim should be to seek to reduce i) the necessity for physical intervention, ii) the frequency of use and iii) when needed, the intensity and the level of intervention. (Refer to Restraint Reduction Network training standards). More information about Caretech's commitment to Restraint reduction can be found in the Appendix 2.

6.3 Specific arrangements for an individual will be recorded in their care or health plan and also their behaviour support plan. Physical intervention is only one of a number of examples of physical contact as set out below:

- Intimate care - care which involves contact or proximity to sensitive areas, (e.g. washing, bathing, changing, cleaning, assisting with menstrual management and some medical procedures);
- Communication - to function as the main form of communication or to encouraged different forms of communication, e.g. when using Intensive Interaction;
- Prompts and guides – as part of teaching, to gain attention or direct movement when guiding children and young people between different areas of the building and the site;
- Therapy - e.g. massage, sensory stimulation recommended by a therapist and provided by a trained staff member;
- Play – individuals at early levels of development (regardless of chronological age) are likely to be quite tactile and physical in play;
- Reassurance and comfort – touch can be used to communicate positive emotions, security and comfort (e.g. side–hug) to calm and reassure a distressed child/young person;
- Physical support – service for children and young people who may have physical difficulties (e.g. transfers in and out of wheelchairs, using a hoist or slide sheet, helping to hold objects),
- Physical Intervention/Restraint – in response to challenging behaviour it may occasionally be necessary to employ the use of Restrictive Physical Intervention, but only as a last resort.

Physical Intervention (Restraint)

6.4 The definition of Physical Restraint from Reducing the need for restraint and restrictive practice non statutory guidance 2019 is: 'Physical restraint is a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.

6.5 CPI's Safety Intervention training defines restraint as **'the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist'**. This definition is also consistent with Mental Capacity Act 2005 definition of restraint.

6.6 In using the above definition restraint can be applied using chemical, environmental, physical, and/or mechanical ways to manage a prevailing or perceived risk.

6.7 Within the Safety Intervention programme touching, holding or physical restraint skills (physical interventions) are used as a last resort to manage risk and qualitatively differ in degrees of restriction in terms of perception and application of intent.

6.8 In an emergency situation, interventions may be used in accordance with guidance in the BILD Code of Practice for Interventions using the relevant Safety Intervention.

6.9 A Behaviour Support Plan (BSP) identifies the specific intervention that will be sanctioned for use, and under those which may not be used under any circumstances. Where appropriate, a Safety Intervention trainer can be called upon to refresh the team on specific skills.

6.10 The Safety Intervention model consists of the following interventions 'physical holding and disengagement/emergency responses':

- Safety Intervention Holds form a hierarchy of restriction (low, medium and high). This hierarchy ranges from the least restrictive intervention that allows staff intervening to prompt and guide the individual; to an intermediate restriction that allows movement whilst being held; to the most restrictive intervention whereby all movements are limited.
- Safety Intervention Disengagements/Emergency Responses: use a physical intervention to gain a release from a holding situation whilst minimising pain or injury in situations in which the behaviour has been assessed as a low, medium, high.

6.11 In locations working with the principles of Safety Intervention will include:

- Low, medium and high level restriction in a seated position
- Low, medium and high level restriction in a standing position and transitions
- Third person holding in a seated and standing position
- Floor Transitions (Advanced Skills)
- Emergency Floor Holding (Supine only) (Advanced Skills)

6.12 No physical interventions should be intended to cause pain or harm and the risk of causing accidental harm should always be minimised.

6.13 All restrictive interventions should be used for the shortest time possible and use the least restrictive means to meet the immediate need based on guidance from the Department of Health - Positive and Proactive Care (Legislation and references for further guidance).

6.14 Staff need to use their professional judgement about how best to respond to a situation and each circumstance can only be viewed on a case-by-case basis. The Principal/Registered Manager must use effective analysis to ensure any of the situations described above are explored and steps taken to prevent those from happening again.

6.15 A measure of physical intervention/restraint may only be justified in the following 3 circumstances:

- Risk of injury to self
- Risk of injury to others
- Serious Damage to Property of any person (including the child/young person)

6.16 Physical Intervention/Restraint in relation to a child/young person must be necessary and proportionate.

6.17 A separate advice for Head teachers is available in 'Use of Reasonable Force – advice for school leaders, staff and governing bodies'.

6.18 In a school, members of staff have the power to use reasonable force to prevent pupils committing an offence; injuring themselves or others; damaging property, or to maintain good order and discipline in the classroom. More information about what is a reasonable force, who can use it and when - can be found here.

6.19 The Opt out sequence should be used as soon as a situation is brought under control, steps should be taken to decrease the intensity of any restrictive intervention as the individual calms and is able to take more control of their own behaviour.

6.20 Staff should not intervene in situations of risk without the presence of another adult, except in exceptional circumstances where the risk of not intervening outweighs the risk of intervening. Staff ratio would be based on a risk assessment of individual Children's/young people's needs.

6.21 Any individual member of staff using a specified physical intervention must have been trained in the use of that intervention. The only exception will be where the Emergency actions for safety can be justified because of the level of risk posed to themselves or others.

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6.22 There may be occasions where the situation presents such a high level of risk that no direct intervention is considered safe or appropriate. In such circumstances it will be necessary to call in outside agencies such as the Police. This is particularly important in situations where an individual has some form of weapon that increases the risk of harm being inflicted.

6.23 All staff, as authorised by the Head of Service, that are trained to do so have statutory power to use physical intervention which is reasonable and proportionate, recorded and can be explained.

6.24 All staff working with the individuals in our care are trained in Safety Intervention strategies or another appropriate methodology – please see training section.

7. Procedures

The importance of prevention and restraint reduction

7.1 Within Cambian all children will either have a Behaviour Support Plan or Risk Management Plan which incorporates behaviour support. This is a personalised framework used to identify and address any difficult behaviour which cannot be prevented/supported through other more general strategies to behaviour support. All behaviour support plans follow the same format of proactive, active and reactive strategies, enabling a consistent approach to behaviour support for every individual.

7.2 The function of a behaviour support plan is to identify the antecedents (the things that contribute towards) of particular behaviour, and to provide staff with relevant information on how to recognise and address the early signs of crisis in order to de-escalate potential incidents and avoid the need for physical intervention/restraint. All the strategies identified in the behaviour support plan should be used to minimise the use of unnecessary physical intervention.

Applying physical intervention/restraint

7.3 Staff must follow localised site-specific procedures for reporting and recording physical interventions, in accordance with our Child Protection and Safeguarding Policy, this policy and the associated documents. Caretech (including Cambian) Education division is going through phase 1 of Behaviour Watch [BW] system implementation, more information about BW can be found here. Once phase 1 of BW implementation is

7.4 Procedures for physical intervention in all locations will cover:

- A site process by which this policy will be implemented
- Who at a site level is responsible for implementation and monitoring of that process
- What records need to be kept and how long for
- Any sanctions for staff not following policy e.g. disciplinary
- Supporting documents such as forms, posters, guidance that should be used etc.

7.5 Managers will ensure that all staff have read this policy. The staff member's application of this policy and procedure will be reviewed on an on-going basis.

Special considerations

7.6 There are certain circumstances which must be fully analysed, understood and thoroughly recorded, so that the relevant plans can be reviewed and where appropriate steps taken to prevent such:

- Restraining children in their bedrooms and/or on their beds.
- Periods of physical intervention that are of unusual length e.g. an individual being routinely held for more than 10 minutes.
- High numbers of staff involved in an incident, which goes above recommended levels for each level:

- Safety Intervention Foundation level; minimum 1 and maximum 2 staff carrying out the intervention with 1 or more witnesses/auxiliary members present,
- Safety Intervention Advanced level; minimum 3 and maximum 5 staff carrying out the interventions with 1 or more witnesses/auxiliary members present.

- Situations that are escalating, with restraint being used more frequently.
- Restraint practices becoming the norm/being applied universally or indiscriminately.
- Individuals sustaining injuries.
- Repeated incidents or patterns of behaviour that are easily identifiable.
- Incidents that involve care staff being used on school premises to 'manage' children's behaviours (as opposed to staff who at the time of the incident should lead particular session e.g. teachers or teaching assistants).
- Incidents that involve children being administered prescribed medication on an 'as required' basis to calm, relax or sedate them – Administration of medication policy and procedure (060.02).
- Incidents that involve the intentional use of equipment to physically restrict children with or without staff being physically present (e.g. safe space beds, a wheelchair, reins or a safety harness or a seatbelt).

7.7 If any of the above examples have taken place it must be fully evidenced why these were the best or the only solutions at the time, how the action was proportionate to the circumstances and how the child's rights were respected. Complete all Incidents should then be recorded in the Behaviour Watch/Incident slip which includes built in Physical Intervention/Restraint Log.

The context of seclusion

7.8 The MHA Code of Practice defines seclusion as 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'. Only Health Practitioners in charge of patients' treatment under Mental Health Act can authorise seclusion of those who are detained.

7.9 In Caretech (including Cambian) children's services seclusion is **not permitted and this includes education,** more contextual information in relation to Education is available later on in this section.

7.10 At times it may be necessary for a child/young person to spend some time away from their peers or from any stimulus or triggers in order to help them to self-regulate before they are ready to safely re - engage again. This may be a strategy suggested by the school staff or a choice made by the child/young person themselves which should be respected. Staff must look at various ways in which a child/young person is separated from others (for example: if the child/young person continues to pose a significant risk to the safety of others), and use different ways of managing the situation, ranging from providing an increased level of support, helping the child/young person to transition to a quieter part of the classroom/home or transitioning outside of the classroom or the home, as this may provide staff with a greater flexibility and opportunity to re-engage with the child/young person. The school must also ensure the health and safety of children/young people and any requirements in relation to safeguarding and pupil welfare.

7.11 The content of Seclusion / isolation rooms in schools is explored in Behaviour and discipline in schools - Advice for Head teachers and school staff which suggests schools could adopt a policy which allows disruptive pupils to be placed in an area (an isolation room) away from other pupils for a limited period. It says use of this strategy as a disciplinary measure should be clearly stated in the school's behaviour policy. The advice adds that only in an exceptional circumstance should any use of isolation that prevents a child from leaving of their own free will be considered. It is not clear what those exceptional circumstances are, as the context of the use of isolation is disciplinary rather than safety. There is no clear guidance as to how isolation should be managed by education staff, and this is dangerous. Some students (with and without learning disabilities) are likely to feel secluded even if they are not locked in - as a threat or the presence of staff outside the door may be enough to keep them from leaving of their own free will. There is a clear risk in some circumstances within schools

that isolation can become seclusion and schools must act lawfully. **We maintain that seclusion must not be used by Caretech schools/colleges, however we do recognise that circumstances described in p.7.10 may apply.**

7.12 Furthermore, The SEN Code of Practice (2015) advises that reasonable adjustments should be made to ensure that expectations of students with disabilities are developmentally appropriate and fair. It would not be fair, for example, to isolate a child with ADHD or other special needs because they were not able to sit still when required to do so.

Restrictions on Children's Liberty

7.13 Use of any restrictions on an individual's movement and/or the use of intrusive observations will be carefully considered and questioned where appropriate.

7.14 Managers and staff should know and check what has been done and what else has been tried, that the practice is kept under review and that steps are taken to find **a less restrictive approach** wherever possible. In many circumstances, an individual needs change over time. All managers and staff need to recognise that and think about what the least possible restrictions are to keep an Individual safe.

7.15 There are various types of restrictions such as those mentioned in section 7.6 which in certain circumstances may suggest that an Individual has had their liberty restricted. Other forms are: Locking a door, leaving alone a disabled Individual who cannot move independently, use of high bed sides or high door handles so that Individuals cannot leave the bed or room without staff support.

7.16 However on some occasions, Individuals may find that time on their own is a positive intervention at times of distress, but these interventions should be used sparingly and the situation must be managed sensitively. It also needs to be remembered that some restrictive interventions can form part of a child's and young person's education, health and care plan for example in Children's Homes, but this will be explored in children's Care Plans so it is fully understood.

7.17 It should be noted that the requirements about the use of restraint may differ between school settings and children's homes. However a consistent approach to the management and support of behaviour is what best meets the needs of children and young people. Therefore, it is expected that the regulations and statutory guidance for children's homes about restraint are consistently applied across both the educational and children's home settings where they are co-located. If there are differences between the home and school, there needs to be shared understanding amongst staff around how this is managed and how this is in child's best interest.

Deprivation of Liberty Safeguards

7.18 In CQC registered homes/hospitals care arrangements/regime which may amount to deprivation of liberty must be explored and advice sought from the relevant Local Authority DoLS department to ensure no deprivation of liberty is taking place without authorisation and DOL safeguards are being applied for – more information read Deprivation of Liberty Safeguards policy.

7.19 Local authorities are under a duty to consider whether any children in need or children looked after are subject to restrictions amounting to deprivation of Liberty. It is our responsibility as a provider to identify potential deprivation of liberty situations and refer each case to relevant authority such as Child's or Young Person's Local authority who will assess and make a decision about whether any of the cases referred meet criteria for court application.

Liberty Protection Safeguards

7.20 The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements. More information about LPS can be found here.

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Reporting and recording

7.21 Employees have a legal duty to report any matter in which safety is compromised. Any physical violence directed towards staff or others needs to be reported and recorded even if individuals feel able to tolerate different levels of aggression Third Party Aggression policy.

7.22 Reporting of incidents enables incidents to be reviewed so that in the future preventative measures can be put into place to avoid the continuation or escalation of aggression. It also addresses the need of individuals to develop more appropriate behaviours in response to difficulty.

7.23 Staff must record any incident using Incident report (45.03.01) or Behaviour Watch/Incident slip (services using BW).

7.24 The use of physical or restrictive intervention needs to be reported to the Principal/Registered Manger and recorded as soon as possible after the event and definitely within 24 hours. There may be a need at a later stage to demonstrate that decisions about the intervention used were appropriate, given the circumstances.

7.25 Information must also be entered onto either the software tool for tracking and analysis of Individual behaviour e.g. 'Sleuth' or another electronic Restraint log (especially where services transition from one system to Behaviour Watch for example) which will allow analysis of trends and themes and which will assist the multi-disciplinary team working with the individuals in our care.

7.26 Staff must record as much information about the incident as possible, as a minimum the incident report must contain:

- Establishment name
- Date
- People involved (full names)
- Event being reported – description of incident including – antecedent, what has been observed
- Behaviour and consequences; any physical intervention used; the duration of the physical intervention used on any individual hold, the injury, where appropriate – body chart.
- Schools/colleges are required to keep contemporaneous written records of all incidents where physical or restrictive intervention has been used for example a bound incident book with numbered pages. The Restraint Log which is part of the Incident slip in Behaviour Watch will replace bound book once the BW system is fully implemented.

7.27 There are particular aspects in relation to the use of physical interventions which Heads of Service / Registered Managers must explore:

- How does the recording influence practice within school/college/care home?
- How trends and patterns about Individuals, individual staff and groups of staff being monitored?
- How the views of Individuals, including those who communicate non-verbally are taken into consideration?
- How Individual's consent (Young Adults) in relation to what information can be shared and who with is taken into consideration?
- Where Individual have fluctuating capacity – when and what plans are being made with the Individual in relation to use of Physical Intervention for the time they are unable to make decision or provide consent?

7.28 If the school and residential services are on the same site, it is expected that any incidents are recorded where the incident occurred. It is critical that relevant managers review practice to ensure there is shared understanding of what happened and how the Individual can be supported in the future.

The importance of debriefs

7.29 Within a reasonable time following a physical intervention, both the staff and child/young person should be given opportunities to share what has happened. These must be separate opportunities and ideally, those should take place in a calm and safe environment where each can reflect back on the situation and learn from it. '**45.13 Staff Reflective Debrief Form**' is to be used for staff, and '**CSHS-RDFS Reflective Debrief Form Student**' is to be use for young people.

7.30 De-briefs of staff member must take place within 48 hours of the incident. Staff debrief is a structured conversation with someone who has just had a stressful or traumatic experience. When conducting a debrief session with the staff member(s) the meeting must be a supportive nature.

7.31 Where incidents included the use of physical intervention in which the staff member was involved, this must also be discussed in staff supervision as part of reflective account. This should support the review of practice and trigger further recommendation around the necessary changes in relation to risk assessment process and behaviour support, should it be required.

7.32 De-briefs of an individual in our care must take place within 5 days of the incident. The purpose of the debrief session with an individual is to reflect on what has happened during the incident and the behaviour displayed by the Individual in order to assist them in adapting their behaviour in the future. This can be supported by the use of visual aids where necessary. Due to the nature of autism and other conditions it may not be possible for all the individuals in our care to successfully access a de-brief and only in the few circumstances will it be clearly recorded within the individual's plan of care or the behaviour support plan the reason why this is not useful to them.

Accident and injury associated with physical interventions

7.33 Individuals who receive a restrictive physical intervention should be routinely assessed for signs of injury or physical or emotional distress. Such assessments need to take into account their ability to recognise and communicate their response to harm. Any necessary medical examination must be carried out by appropriately trained staff.

7.34 **A Body Map Record** must be used to record any bruising or marking caused as a result of physical intervention, including the context in which the bruising occurred. Staff are to use the body map within the incident form/ Behaviour Watch/Incident slip/Body map or separate body map where this is not part of the incident form and authorised by Managing Director. Any injuries reported by the individual must also be recorded, whether or not there are visible marks. It is also suggested that where possible any injuries are given an actual time of when injury occurred.

7.35 Parents/guardians and/or social workers must be informed of any injury within 24hrs unless there is other specific agreed timeframe. In the case of Children/Young people who are Looked After it is essential that the social worker is informed without a delay, ideally within the same timescale.

7.36 Any physical intervention can result in positional asphyxiation. Therefore, health monitoring will be in place during and after the event and recorded as required (24 hour blocks as needed). An additional monitoring may also be triggered by the Manager or Health Professional. There could be various reasons for the additional monitoring, some may include: duration or the intensity of the hold, possible injury or unexpected emotional or physical response during a hold. Each case should be assessed individually and medical attention sought regardless of the additional monitoring taking place.

7.37 An accident form in the accident book or in the Behaviour Watch must be completed for any accident or injury sustained to any party as soon as possible following the incident and the record must clearly state whether the injury was as a result of the incident or any intervention carried out.

7.38 In the case of any injury to an individual, appropriate records must be added to the medical file, by the nurse, or other medical professional for example and visual check or examination by the Nurse, GP or first aid trained staff.

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7.39 Each location must maintain an up to date Accident returns summary (GHS 04.01.01) and report any RIDDOR incidents through appropriate channels and on Cambian KPI (GHS 04.01.05/06). Services using Behaviour Watch must use the Accident function to record and to report on accidents taking place.

Sharing other information - Individuals 16+

7.40 Every person has a right to privacy under the European Convention on Human Rights (Article 8), but if there are any worries or doubts about the wellbeing of a Young Person it will have to be decided whether personal or confidential information need to be shared. Sharing information appropriately is often the key to putting in place effective safeguarding. This part should be read in conjunction with Consent and Mental Capacity policy and procedure.

7.41 If the incident constitutes a safeguarding concern for the individual or member of staff the Child Protection and Safeguarding Policy no 25 takes precedent and should be followed.

Monitoring & Review

7.42 Each Establishment will maintain on-going monitoring of all use of physical and/or restrictive interventions. They will ensure that at all times the associated risks of carrying out physical and/or restrictive interventions are carefully weighed against the risks associated with not carrying out the physical and/or restrictive intervention.

7.43 Each establishment will maintain a restraint log (08.02.07)/Behaviour Watch/Incident slip/Restraint Log. This may be included within the overall incident log but the Head of Service, senior management and MDT must additionally be able to analyse restraint data in isolation.

7.44 Each establishment will ensure that accurate weekly figures are made available for submission to CambianKPI on a Monday morning. Data is published to every site on a Wednesday.

7.45 The use of any Behaviour Support Strategies and any use of physical intervention should be the subject of on-going review. Evaluation of the effectiveness of the approaches used will help to clarify an individual's needs. Specific strategies will need to be varied according to individual circumstances and the context in which they are being used.

7.46 For some individuals in our care the complexity of their needs means that the fact the level of intervention has stayed constant and not increased, itself represents success. Nevertheless, it is important to ensure that the use of physical or restrictive intervention never becomes routine.

Complaints

7.47 At any time if the individual being restrained is not happy with the approach, process or staff/other individuals they have the opportunity to either complete a complaint leaflet (doc. 22.07-22.08), which is available in all locations on display or follow the Complaints Procedure and/or use the Whistleblowing procedure, which is also on display in all locations.

7.48 When individuals join the location they are made aware of this and this is reiterated in individual local meetings. Sites must make sure that Individuals are provided with accessible resources to allow them to participate fully in the complaints process.

7.49 The NYAS Independent Visitor and Advocate are also further options provided by Cambian should the Individual want to pursue this.

7.50 Parents and individuals have a right to complain about the actions taken by staff within the location. If an allegation of abuse is made against a member of staff the Location needs to follow guidance set

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out in Child Protection and Safeguarding Policy which is underpinned by Local Safeguarding Board Inter Agency Safeguarding Procedures.

7.51 Other complaints should be dealt with under Complaints Policy and the Whistleblowing Policy.

Staff Training

7.52 All staff who will be required to employ restrictive physical interventions should have Safety Intervention (CPI) training (foundation level or foundation and advanced level depending on the need of the Individual) and should only, except in emergencies, employ those physical interventions for which they have had training. It is required that all staff are trained with Safety Intervention at the start of employment during their induction period and are provided with the annual refresher, to ensure that staff retain their skills and remain confident in their ability to support the individuals in our care to manage their behaviour. Each site will have an agency/bank worker training plan providing details around the level and frequency of Safety Intervention training.

7.53 The level of taught Safety Intervention will depend on the specific needs of the individual/s, which will be thoroughly assessed and agreed by the Multidisciplinary Team which consist of therapy department and senior manage team.

7.54 An up to date record of the training that staff have received, including refresher training, is maintained by a staff member identified by the Head of Service/Registered manager. This should be recorded on MYRUS.

7.55 In line with Cambian's ethos it is important that any training promotes a preventative methodology (Restraint Reduction Network Training Standards) and emphasises that physical and restrictive interventions should be used as a last resort.

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8. Standard Forms, Relevant Documents, Letters & References

Documents relating to this policy

8.1 Restraint Log / Physical Intervention Log

Related Policies and procedures

8.2 Behaviour Support (045)

8.3 Child Protection - Safeguarding Policy (025)

8.4 Whistleblowing Policy (GHR30)

8.5 Complaint Policy (022)

8.6 Deprivation of Liberty Safeguards (50)

8.7 Third Party Aggression (94)

Related templates

8.8 Individual Risk Assessment

8.9 Incident report

8.10 Individual debrief form

8.11 Staff debrief form

8.12 Monthly Body Chart

8.13 Static Body Chart

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9. Appendices

Appendix 1. Glossary of terms

Restraint by the Mental Capacity Act 2005 (MCA) – MCA defines restraint as when someone "uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person's liberty whether or not they are resisting".

Physical restraint: a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Chemical restraint: the use of medication which is prescribed and administered (whether orally or by injection) by health professionals for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

Mechanical restraint: the enforced use of mechanical aids such as belts, cuffs and restraints forcibly to control a child or young person's individual's movement.

Seclusion and long term segregation – Only people detained under the MHA should be considered for seclusion or segregation.

Seclusion: The MHA Code of Practice defines this as 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'.

Appendix 2. Restraint Reduction Network Standards

- CareTech is committed to reducing restraint across all of our services, Children's, Adults and Specialists services, the organisation has agreed to commit to work towards the RRNTS (Restraint Reduction Network Training Standards) and BILD (British Institute of Learning Disabilities) to ensure that those that use our services get the highest level of care, support and education we all expect.
- CareTech has agreed to regularly review our Restrictive Practice methods of delivery and ensure all staff are aware of the appropriate use of Restrictive Practices. It will monitor internal data, and quality assurance methods, to provide feedback on the number of restraints and strategies used, as to their appropriateness.
- CareTech's staff will receive regular annual training in the use of non-restrictive practices, and positive behaviour support to ensure that our staff have the knowledge understanding and how to apply their skills. All training received will be of high quality and accredited through the RRNTS.
- Each of Caretech services that require restrictive practice will complete a TNA (Training Needs Analysis) that will allow central teams to best support delivery of training required and how it is delivered.
- All Individuals who use our services will have personal behavioural support plans.
- Advanced training will need to be agreed with the Leads and appropriate committees.
- Caretech commitment will be reviewed annually by the board of directors and care governance board to ensure that the Organisation is adhering to local and national guidelines and recommendations.

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Reflective Debrief for Staff

Name of the school/home	
Date	
Staff leading the session and their role	
Staff involved in the session and their role	
Description of event this reflective debrief is related to	
Accident/ Incident reference no	

Please record discussion in the space provided for each of the following sections (1-5) on pages 2- 4

1. **Describe the event**

- What happened?
- Who was involved?
- What did you expect was going to happen?
- What was important to you at the time?
- What did you like/dislike about the event?
- Do you have fears/anxieties following the event?
- Are you worried that this can happen again?

2. **What happened leading up to the event?**

- What happened for you and others in the time leading up to the event?
- What were the feelings and emotions of you have experienced at the time?
- What are your feelings and emotions now?

3. **How do you feel things went during the event?**

- What went well during and post the event?
- What didn't go so well?
- What has changed during the event and why?

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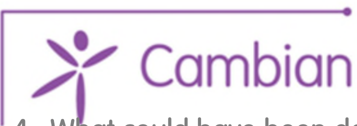

4. What could have been done differently?

Existing knowledge can be built on or restructured by theorising about what could have been done differently. In order for this to be effective critical thinking in a safe learning environment is essential with a **'no blame' attitude.**

5. What do we need to change as a result of this reflective debrief?

Each reflection can inform practice and should be used not only as a building block to learning but as a celebration of good practice. Reflection is not a passive contemplation but an active, deliberate process that requires commitment, energy and a willingness to learn as a team.

1. Describe the event

2. What happened leading up to the event?

3. How do you feel things went during the event?

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4. What could have been done differently?

5. What do we need to change as a result of this reflective debrief?

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Ref:
CSHS/RDFS

Reflective Debrief Form - Students

Prior to starting this, please ensure that the individual is physically and emotionally in control so thoughts and perceptions aren't led by irritation / anger and can be more factual and considered.

Location	
Date of Debrief	
Staff leading the session and their role	
Student involved in the session	
Brief summary of event, as recorded, that this reflective debrief is related to	
Date of Incident	
Accident/Incident Reference No.	

Please record discussion in the space provided below. Follow the guidance, using language appropriate to the Young Person then you can delete it, leaving just the headline & their response.

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The Facts
Establish what has happened, factually. How something has made someone feel is important to understand in terms of being able to empathise but the number 1 priority is establishing the basic facts / timeline of the incident. If multiple people were there and have differing accounts then it doesn't necessarily mean someone is lying or wrong, but could have arrived at a different time from a different angle etc so heard and observed things differently.
Antecedents / Triggers / Patterns
Are there patterns in past behaviour and events preceding the crisis? Can you identify triggers for that particular behaviour?
Alternatives
Can they identify different ways to manage their behaviour? Are there any resources that would be useful in making changes in terms of sensory need?
Negotiate Adaptations
Look at behaviour contracts, expectations etc. Expectation needs to be clear and make sure they have an understanding of both positive and negative consequences for behaviour.
Offer Support / Give Back Control
Return (appropriate levels of) control where possible to the young person. Give back responsibility to control own behaviour, along with your support and encouragement. A little bit of control given goes a huge way to building rapport, respect & trust and will only strengthen your relationship with the young person.

This form has been guided by the Crisis Prevention Institute's C.O.P.I.N.G Model.

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