



# **CHILDRENS, ADULTS AND HOUSING SERVICES**

## **POLICY ON THE USE OF RESTRICTIVE PHYSICAL INTERVENTIONS IN SOCIAL CARE SETTINGS**

**August 2009**

The aim of this policy is to set out the basis for the use of physical intervention within Harrow Council Social Care establishments, to help secure for all a safe environment in which their rights are maintained. The Policy provides clear guidance to both managers and staff who may be faced with a situation where they need to sanction or implement the use of Physical Interventions to protect clients/young people, visitors & staff attending these establishments. The use of restrictive physical intervention should be seen as a last resort response after all other strategies have been exhausted. **Where Physical Intervention is Identified as necessary as part of a young persons/Service Users Care Plan, it will be planned, recorded, and staff prepared through training.**

To fully understand the breadth of all the surrounding issues this Policy should be read in conjunction with the guidance from the Department of Health (DoH) and Department Children schools & Families (DCSF), the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Board (LSAB) procedures and guidance where young people are involved. This Policy has been developed in consultation, other agencies, professional bodies, LSCB and LSAB. It is recommended that this Policy is brought to the attention of all new staff and that all staff are reminded of it annually.

## **1. Introduction**

Where identified as necessary it is important that physical intervention strategies are embedded within a more holistic behaviour approach to the service user. The use of physical intervention is not a substitute for the full range of professional approaches to behaviour management and techniques to support the individual. In this context, the importance of a widely shared and clearly understood unit behaviour policy cannot be over-emphasised as well as the priority of training and professional development in minimising the need for physical intervention by staff.

While there may be **unforeseen** circumstances where the use of physical intervention is necessary, assessing and managing risk is central to the process of deciding whether to use physical intervention that is **reasonable** and **proportionate** to the circumstances. Before any physical intervention, staff should always try other methods to divert or otherwise manage the situation. Planned physical intervention strategies should be identified by the unit team working in conjunction with other

agencies and relevant carers. They should be written down and incorporated into other wider plans. Any subsequent actions must be implemented by an identified and appropriately trained member of staff.

## **2. Reasonable and Proportional Force**

**There is no single definition of “reasonable” force.** It will always depend on all the circumstances of the case and may also depend on the age, understanding and sex of the Young person/service user. Any physical intervention must be proportionate to both the behaviour of the individual that requires to be managed and the nature of the harm they might cause.

Staff must always use techniques and methods that they have been trained in, are confident in using, and that have been taught on approved training courses permitted by the Authority. Guidance from the DCSF and DoH tends to avoid a strict definition but stresses that any physical intervention should be **reasonable** and **proportional**. It should always be used as an act of care and control rather than a punitive action and applied with sensitivity & dignity for all involved, the use of physical interventions should always be in the best interest of young person/adult. Training and regular practice of physical intervention techniques and strategies will minimise the possibility of unnecessary use of force.

Any Physical intervention and associated force used should be reasonable and proportionate to;

- The seriousness of the incident,
- The relative risks arising from using a physical intervention compared to other strategies,
- The age, gender, stature and medical history of the service user concerned.
- Used as a last resort

## **3. Planning for incidents and risk assessments**

Techniques involving physical intervention to restrict movement or mobility or to escape from dangerous or harmful physical contact will involve different levels of risk that should be assessed and be as low as possible to fit the circumstance. There is also a duty under the Management of Health & Safety at Work Regulations 1999 to assess the levels of risk to young people/service users and staff, this would include

accessing the implications of moving & handling risks to staff. Assessing and managing risk is central to planning intervention strategies and embedding them within more general behaviour policies and strategies. Units also have a duty of care, to put in reasonable steps to prevent harm for example with modifications to the building or providing adequate levels of staff.

Staff should be aware of the distinction between:-

**Planned** intervention, in which staff may employ pre-arranged strategies and methods based upon a risk assessment and recorded in care plans and or **emergency** unplanned use, which happens in response to unforeseen events.

In both cases Interventions must only be used as a last resort to prevent

- Self-harming
- Injury to other young people/ service users, staff, volunteers, & visitors
- Serious damage to property
- An offence being committed.

Planned physical interventions should only be used as part of a broader strategy that seeks to reduce the behaviours that presents a risk. These plans should include: strategies for preventing the occurrence of behaviours; creating positive opportunities, ensuring sufficient staff are available to meet the needs of the service user; appropriate staff training; use of de-escalation strategies or diffusion of a situation.

This overall strategy should allow staff to increase or decrease the type of technique and skills in response to the clients' behaviour. Whenever possible physical intervention should be avoided, unless the level of risk identifies this as the only strategy.

<sup>1</sup>The use of planned physical intervention should be agreed at a multi disciplinary meeting. The client and carer/parent need to be informed of the recommendation and agree for the use of physical intervention in a last resort situation, **a record of**

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<sup>1</sup> This may include support from Local Safeguarding Children Board or Local Safeguarding Adults Board.

**this meeting should be signed by the carer / Service user or those with parental responsibility.**

At this meeting the risk assessment should be available, identifying the risks to the Service user and others involved. It should also set out any identified risks to the client and staff from the use of the physical intervention techniques proposed to manage this particular behaviour.

These techniques should be specific and closely matched to the characteristics of the individual service user/young person and need to be identified in the risk assessment and the clients care plan.

Only staff who have up to date training in physical intervention skills should be involved in physical intervention. **Staff should not be expected to put themselves at risk.**

From time to time service users/young people may act in exceptional ways or **unplanned** circumstances may arise and staff should apply the same principles as above using minimum force consistent with the training they have received.

### **3.1 Emergency or unplanned intervention**

Emergency or unplanned intervention should only be in response to prevent injury to others, self-harming, serious damage to property or an offence being committed. Any physical intervention technique (including breakaway techniques and <sup>2</sup>applied force) should be **reasonable & proportionate** to the situation. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration.

Before using restrictive physical intervention in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example distress or injury) will be less severe than the adverse consequences, which might have occurred without the use of physical intervention.

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<sup>2</sup> (Applied force) is the term used in the DfES DoH guidance for Restrictive Physical Interventions July 2002. All Physical Interventions should be a reasonable and proportional response to the situation and the perceived risk and used as a last resort.

**3.2** There may be times when it may necessary to move an individual away from a situation to remove or lower the potential risks to those involved. This may result in one of the following scenarios.

- **Seclusion** where an adult or child is required to spend time alone against their will
- **Time out** which involves restricting the service user's access to all positive reinforcements as part of the behavioural programme
- **Withdrawal** which involves removing the person from a situation that are causing anxiety or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities.

Any practice or measure, such as 'time out' or seclusion, which prevents a child or adult from leaving a room or building of his/her own free will, may be deemed a '**restriction of liberty**'. 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.

In care settings, if seclusion is required other than in an emergency (for periods of longer than a few minutes or more frequently than once a week) then staff should seek advice regarding the use of statutory powers under mental health or child care legislation.

Where planned physical interventions, seclusion or time out are involved in the care plan; consideration should be given regarding any consequences relating to the deprivation of liberties of the service user/young person.<sup>3</sup>

Where there may be concerns that physical interventions are being used incorrectly or that abuse may be involved then a referral should be made to either the Steve Spurr lead officer for child protection where a child is involved, Or Seamus Doherty Safeguarding Adults co-ordinator for vulnerable adults.

#### **4. Staff Training and Guidance**

All staff will receive risk and conflict management training and/or challenging behaviour training as part of their induction and those staff who could be expected to

employ physical interventions will receive further training in physical intervention skills. On successful completion of training, staff are expected to practice their skills and attend annual update training. Training should meet the standards established by the British Institute of Learning Disabilities (BILD), and guidance from the DCSF and DoH and be approved by the local authority

Only staff that have up to date training in physical intervention skills agreed by the authority as appropriate to manage the situation, should be involved in implementing the use of physical intervention. An up-to-date list of authorised staff must be kept on the unit and this must be made known to all other staff on duty at that time within the establishment.

So that a consistent approach in supporting a service user is maintained across all Services involved with the individual. Unit managers should contact the Training and Development Officer for Risk & Conflict Management within childrens/ Adult services who can provide information on training and general guidance. This is to ensure that any strategies are consistent with this Policy and training is in line with current best practice.

P.I. trained staff will have to attend annual update refresher training as directed.

## **5. Record Keeping**

Where a risk assessment indicates that the use of planned physical intervention may be necessary as a last resort or where other strategies have failed, this needs to be recorded and the use of physical intervention agreed at the multi-disciplinary meeting. A copy of the risk assessment to be kept in the clients file.

Following this meeting the protocol for the use of physical intervention with service user must include;

- A description of the behaviour sequence and the settings that may require a physical intervention as a response.
- The results of an assessment to determine any contra indicators for the use of physical interventions, including any medical information contained in the care plan.

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<sup>3</sup> See section 8 additional guidance re Mental Capacity and (Deprivation of Liberty: Appointment of Relevant Person's Representative) (Amendment) Regulations 2008

- A risk assessment that balances the risk of using a restrictive physical intervention against the risk of not using a physical intervention.
- Techniques need to be demonstrated and agreed with those with parental responsibility, in the case of children, and their views recorded.
- In the case of Adults their views and the views of family members may be considered and recorded
- A system of recording behaviours and any physical intervention however minor, including copies of the relevant accident incident form
- Any near misses (attempts) that assist with the identification of potential risk and success/ failure of existing strategies need to be recorded.
- A description of the specific physical intervention techniques that have been assessed as appropriate and the dates that these have been reviewed.
- A description of the behaviour sequence and the settings which may require physical intervention
- Previous methods which have been tried without success
- A description of the staff that are judged to have the competencies and skills to work with and if necessary use physical intervention with the service user.
- The review process, including frequency and who should be involved.
- The ways in which this approach will be reviewed.
- A copy of the protocol to be kept in the clients file and / or care plan

**5.1 The unit policy on the use of physical interventions** should detail the procedure for recording incidents. This may help prevent any misunderstanding of the incident and it will be helpful should there be a complaint or investigation. All incidents, however minor, must be recorded and monitored as required under Care Standards or at least monthly by the unit manager. The frequency and pattern of incidents should be included in the monitoring process.

An up-to-date record of all such incidents must be kept on the unit. Immediately following any such incident the member of staff concerned should inform their line manager and provide a signed and dated physical intervention report form within 24 hours.

This should be kept in a book with number pages.

The report should include:

- Name(s) of the service user(s) involved, when and where the incident took place;
- Name(s) of staff involved and name(s) of other staff or service users who witnessed the incident;
- The reason physical intervention was necessary (rather than another strategy);
- How the incident began and progressed, details of the service users behaviour, what was said, what steps were taken to defuse the situation, the specific type of physical intervention employed, how it was applied and for how long;
- The service user's response and the outcome of the incident;
- Details of any injury or distress suffered by the service user or others and if so what action was taken
- Details of any damage to property.
- A health & Safety incident/accident report should also be completed

A copy of the completed physical intervention record form must be forwarded within **five days** to either Steve Spurr lead officer for child protection, 2nd Floor Civic Centre.

Or

Seamus Doherty Safeguarding Adults co-ordinator, 2nd Floor Civic Centre.

Respectively depending on a child or vulnerable adult being involved.

A second copy to be sent to Bryan Shewry Training & development officer CSRU team 2nd Floor Civic Centre

Staff may find it helpful to seek advice from a senior colleague or a representative of their professional association when compiling a report. It is always advisable to provide an opportunity for staff to reflect on and review the incident.

## **6. Carers/Parents**

A carer/parent of a service user should always be informed of an incident and given the opportunity to discuss it. This should be done as soon as possible after an incident. In the event of a complaint being received by the authority in relation to the use of physical intervention by staff, the matter should be dealt with in accordance with agreed procedures for handling allegations against members of staff. Where a child is involved then the lead officer for child protection in the authority should also be notified.

## **7. Post-incident support**

Following an incident where physical interventions are employed, it is important to ensure that staff and service users are given appropriate support and if required basic first aid treatment or other medical help. A member of staff, who was not involved in the incident should be present when a service user/ young person is examined for injury and a body chart completed.

The following steps should be taken to ensure that those involved should have had time to regain their composure and be ready to communicate.

The debriefing process must support both service user and staff and include:

- The service user understands why the physical intervention was used and has the opportunity to reflect with a supportive adult. Service users with communication issues should be given suitable support by trained staff to express their feelings and views;
- Staff involved have time to calm down and discuss the incident with a supportive colleague;
- Staff should be given the chance to talk to their line manager or service manager about what happened and include the effects on the participants. (If the member of staff involved in the incident is a unit manager s/he should take time to speak with the service manager about the incident).

The debriefing process must be positive and a supportive process for all involved for further advice see Harrow Councils Debriefing guidance.

- The recording of any injuries sustained are treated in accordance with the Health & Safety Regulations 1999 and The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

## **8. Additional Guidance regarding Mental Capacity**

1. Staff should always record capacity issues – if none present this should be noted.
2. Apply the core principles of the MCA to all actions.
3. The MCA applies to everyone over 16 relating to people who lack capacity.
4. Be aware of Section 5 of the MCA and the limits to restraint set out in Section 6 of the MCA. i.e. Restraint in relation to someone who lacks capacity can only be used when:
  - a) the person using it reasonably believes that it is necessary to prevent harm.
  - b) It's use is proportionate to the likelihood and seriousness of the harm. The restraint must be in the person who lacks capacity's best interests. Restraint which does not meet these conditions is unlawful.
  - c) Only the minimum amount of restraint for the shortest duration should be used to prevent harm occurring. This reflects the least restrictive option principle.
  - d) Any restraint amounting to a deprivation of liberty is only legal if authorised. Authorisation can only be granted by supervisory bodies (Local Authority/PCT) in relation to residential homes and hospitals. Deprivation of liberty is only legal in other settings if a prior declarative judgement has been made by the Court of Protection.
5. Guidance on what may amount to deprivation of liberty is found in Sections 6.49 to 6.53 of the MCA Code of Practice.
6. In relation to under 16's. The zone of parental responsibility and the Frazier/Gillick competency rules apply.
7. If in doubt seek legal advice or contact MCA/DOLS Lead – Mark Hall-Pearson.

This policy should be used in conjunction with current guidance in the use of physical intervention including  
DfES DoH guidance for Restrictive Physical Interventions July 2002

### **Guidance and Legislation**

Harrow multi-agency Safeguarding Adults Policy and Procedures  
[http://www.harrow.gov.uk/downloads/Safeguarding\\_Adults\\_Policy\\_Final\\_Draft\\_Apr\\_06\\_1\\_.pdf](http://www.harrow.gov.uk/downloads/Safeguarding_Adults_Policy_Final_Draft_Apr_06_1_.pdf)

Post Incident Response to Violence at Work - Debriefing and Supporting Staff (HSG 17-00)  
[http://harrowhub/site/scripts/download\\_info.php?fileID=3367](http://harrowhub/site/scripts/download_info.php?fileID=3367)

DoH (1995): *The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations*

DoH (1999): *The Management of Health and Safety at Work Regulations*  
[www.legislation.hmso.gov.uk/si/si1999/19993242.htm](http://www.legislation.hmso.gov.uk/si/si1999/19993242.htm)

DfES/DoH (2002): *Guidance on the Use of Restrictive Physical Interventions for Staff Working with Children and Staff who Display Extreme Behaviour in Association with Learning Disability and/or Autistic Spectrum Disorders.*

DfES (2003): *Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties.*