515RHS

Positive Behaviour Support and the Use of Physical Interventions – Rowden House School

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Responsible Person	Mark Ryder/Iwona Makal
Responsible Person Signature	

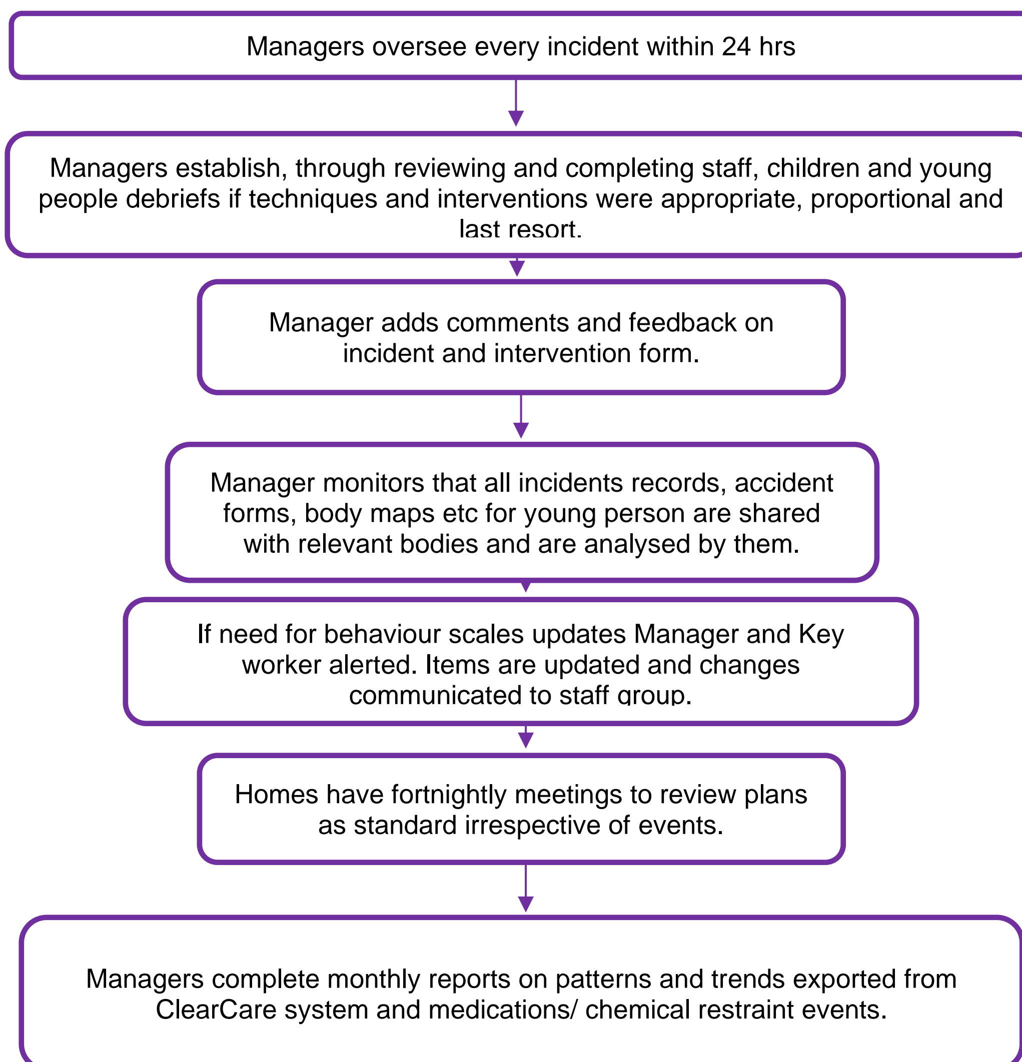
ROWDEN'S BEHAVIOUR MONITORING PATHWAY

Managers must assess the events against the 10-point check:

ESSENTIAL CRITERIA FOR NAPPI PHYSICAL SKILLS

1. Must have minimum impact on each individual supported
2. Must have minimum impact upon others within the environment
3. Must start at the point of a person's natural reaction
4. Must be easy to learn, having as few steps as possible
5. Must be likely to be recalled during a high-stress event
6. Must be disaster-proof, avoiding major injury if ineffectively applied
7. Must require minimal athletic skill and be performed by regular range of staff members
8. Must be applicable over a broad range of scenarios
9. Must be necessary (to be trained)
10. Must be effective

Monitoring and review process



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The Use of Physical Interventions: Policy Statement

Rowden House School is part of the SENAD and is committed to a service philosophy where positive behaviour support is seen as the most effective method to enable individuals who exhibit challenging behaviour due to their sensory or SEND dysregulation.

Our goal is to support our young people to have the best quality of life possible. The Group's core values are our person-centred approach to care and education, to manage the dignity of the children and adults we support and the creation of a safe environment for all.

Within this philosophy there is an understanding that some dysregulated behaviour creates a high risk of injury to the individual or to those around them. These behaviours should be clearly risk assessed based on evidence produced through individual records and effective risk control measures put in place. The risk assessments should be reviewed following adverse events and at least annually.

Where these control measures include restrictive physical interventions, these should be appropriate and proportionate and only ever be used as a last resort, for the minimum amount of time possible, with the intent to maintain safety, and where there is no effective alternative approach available. The overall aim is that any intervention will be appropriate to the level of risk, and that over time the intention is that the level of intervention and number of physical interventions will be reduced. They must never be used aversively or as a punishment or to force compliance.

Rowden House School and SENAD views restrictive physical interventions and other forms of restraint as last resort options to be used only when it is in the best interests of an individual, and when all other strategies have been attempted, and failed to remove the risk of serious harm occurring to an individual service user or others around them.

Positive Behaviour Support is used within the homes and school to promote greater levels of independence, self-regulation when anxieties are raised and general guidance for staff supporting. Staff building positive relationships, enhances the approaches used to lower anxieties, build greater knowledge base and pass this on through mentoring of new staff to further embed the working processes of using PBS to support residents positively.

This guidance is tailored to each resident to meet their individual needs and is incorporated into their Care plans with strategies, staff responses and actions required, linked from each resident Lalemand Behaviour Scales at each level, along with Individual Risk Assessments

These strategies are part of a pro-active approach, working with the resident to promote de-escalation, reduce anxiety, using sensory approaches, preferred communication methods to decrease times of anxiety. As staff awareness to lower levels of behaviour increases, predictability of behaviours increases, allowing staff to use the afore mentioned approaches to intervene at a lower level of behaviour to lessen the impact of behaviours for the resident, peers and staff supporting, improving quality of life and better outcomes.

Strategies are created and improved in line with input from Multi-Disciplinary Team (MDT), through observations, debriefs with teams and residents after incidents to tailor suitable responses and actions to individuals and their behaviours.

Sensory diet / activity grab sheets are drawn up by MDT to allow staff to better support residents with their various needs, again lowering anxieties, meeting sensory needs and promoting self-regulation. These will be tailored in line with Lalemand Green Scale, focusing on activities that meet multiple needs whilst avoiding possible stress factors.

Individual Risk Assessments are written up for each resident and also form part of the guidance for staff supporting the resident, considering cognitive, physical, sensory and processing levels for all tasks, this again is a live document and will be updated as and when required to ensure latest information is always available.

Green activities to promote a sense of belonging, building on interests and progressing with those and maintaining circles of support both at home and in care. The main aim for staff is to focus on providing plenty of choice within green to enable our residents to live lives to the fullest.

Amber level highlights the individuals stress factors across three main groups, Environmental, Individual and Other people, and the strategies in place to avoid these where possible.

Red Behaviour Scale lists the known behaviours for each resident and responses known to be successful. The Lalemand Behaviour Scales are a live and constantly updated set of documents to reflect the individuality and complexity of the residents we support, the current responses we have in place including support levels, specific needs and details for those activities.

In some cases, where a resident reaches dangerous levels of behaviour on Lalemand Red scale, staff may need to use a Restrictive Physical Intervention (RPI) as a last resort. This can be one of a number of agreed responses to keep the individual and those supporting safe, for the minimum amount of time, to allow the individual to deescalate and regain control of their actions and emotions. An RPI will only be used as the last resort when staff have exhausted all other possibilities at that time, avoidance techniques or refocussing tools including some of the strategies mentioned above will have been tried prior to the decision that an RPI may be needed, even at this stage, a change of face or hand off to other staff may be successful to avoid the need to physically hold.

A Behaviour Support Manager will oversee and analyse incidents and interventions along with Home Managers and Registered Manager to ensure that staff are using the skills, strategies and responses to the fullest to avoid RPI usage, while also looking at how staff have managed RPI, this provides management oversight and improves responses. Behaviour support manager and home managers will update Lalemand Behaviour Scales, Individual Risk assessments and Care plans as and when required to ensure latest data available at all times.

Staff debriefs, following physical intervention, are carried out by Behaviour Support Manager and Home Managers to ensure all strategies and responses have been used prior to any RPI usage, but also ensuring the best outcomes for residents and that best practice has been observed. These reflect the incident from start to finish for each staff members participation, identifying plus points but also points for further improvement.

Resident debriefs are carried out by all support staff at a time when the discussion about the incident will least impact on the resident, this can be during an incident or after. These debriefs will be delivered in the preferred communication method for each resident at their level of understanding and added to each incident pack and also added to each resident digital filing cabinet on ClearCare recording system currently in use.

Using data gathered from incidents and interventions and debriefs from staff and residents, along with reviews including family and placing authorities, adjustments and improvements can be added to Lalemand Behaviour Scales, Individual Risk assessments and Care Plans to provide the correct levels of support for each resident.

When Restrictive Physical Interventions are used, we follow the principles of the **least restrictive alternative option described in national legislation and policy.** Early intervention can be extremely effective in reducing risks and sop the dysregulated behaviour escalating into a crisis phase. De-escalation techniques should be used before any other interventions are considered (where possible).

Within our care homes and schools, where it is identified that an individual may need Physical intervention for their or staff safety as part of their care and support, the Head of Learning (for day students) and Registered Manager (for residential students) will ensure that the individual will have appropriate and individualised risk assessments and strategies.

Risk assessment and support plans will be a key part of all strategies developed for supporting people whose behaviour presents a challenge. Individual Risk Assessments will consider physiological, psychological, and psychosocial risks, as well as those likely to be found within the physical environment. The overarching aim is to ensure the safety of individuals we support and of staff and visitors.

All staff are encouraged to contribute with regards the contents of plans and strategies to enable safe practice. These plans and interventions are regularly monitored and discussed and where necessary modified by agreement with all relevant persons, managers and professionals to ensure the safety of the individual and those supporting them.

Where possible service users will be encouraged to participate in their risk assessments and support plans. Our staff acknowledge they have a duty to recognise and support individuals to develop their skills and confidence to help them manage their behaviours.
SENAD and Rowden House school recognise that physical intervention may have a negative effect on those involved both physically and emotionally. Also, the physical environment may be damaged, the Group will strive to reduce the impact of this to a minimum by constant review of the physical environment, recognising that this is important for the maintenance of quality of life for all concerned.

To enable Rowden House School to maintain the safety of everyone, on induction staff will be trained in the accredited NAPPI self-protection framework of skills appropriate to the school and children's home they work at. There is an expectation that front line staff will receive appropriate training within 4 weeks of employment, where the risk of injury is high from service users. Additional levels of training will be determined by risk assessment and the needs to safely support individuals and to ensure the safety of others.

The Group as a whole recognise that staff often 'Go the extra mile' to keep service users safe. From time-to-time individual staff members have developed new and innovative approaches to reduce physical intervention. Where Managers identify staff members who do this, the Group encourage

managers to make Directors and Senior Managers aware of this through info@senadgroup.com Recognition as an example may be in the form of letters of commendation.

The Head Teacher and Registered Manager will report the use of Physical interventions to Directors on a monthly basis. The use of Physical intervention will be reviewed by the lead director with the Quality & Compliance Manager and the Group Health & Safety Officer.

Purpose of this policy

This policy outlines the context and use of physical interventions within SENAD and has been tailored to match practice within Rowden House School. It provides broad guidance for staff who are considering the use of physical intervention. It aims to provide protection for young people/adults, staff, the organisation and members of the public.

This policy statement does not set out individual procedures for the use of physical interventions. The policy sets out the framework for the use of the NAPPI framework and physical interventions which will be deployed for each school.

This policy must also be read in conjunction with all other relevant policies such as safeguarding, record keeping, positive behaviour support, young person/adult safeguarding, sanctions and health and safety.

Where staff have concerns around the level of interventions used, they should initially discuss this with their line manager. If they continue to have concerns – **staff are referred to the Whistleblowing Policy 413 or can escalate to the Director of Children's Social Care who can be contacted on 01332 378840 or mark.ryder@senadgroup.com**

Duties & Responsibilities under this policy

At School/Home Level	Individuals
Designated Head Teacher for the School	Martin Carter
Registered Manager for the Children's Home	Iwona Makal
Head of Learning	Ruth Nolan
At Proprietor Level	**Individuals**
Person with Corporate Responsibility for Schools	Suzanne Pennington (Director of Education) Mark Ryder (Director of Children's Social Care)
Delegated Person for Organisation Physical Intervention	Craig Barrington, Group Health & Safety Officer
Delegated Person for Organisation Training	Ginette Clarke Group Training Manager

Responsibilities:

- The Head Teacher and Registered Managers have overall responsibility for ensuring physical intervention practice is safe and ethical and that staff act in ways which are within the law and are consistent with principles of good and safe practice.
- Managers at all levels should also ensure that the needs of young people and adults are properly met and take responsibility for safety in the workplace. They are responsible for the correct implementation of interventions.
- Managers at all levels should give careful consideration to any specific resources needed to manage the physical intervention, for example numbers of staff on shift, safe space for the young person/adult, gender issues, and settings.
- Managers at all levels are responsible for monitoring incidents, undertaking de-briefings, ensuring incidents are logged and reports completed.
- Effective training is an important part of a wider strategy to ensure that physical interventions are only used in appropriate circumstances. Heads of establishment must ensure that all staff receive appropriate training (including refresher training) and supervision on a regular basis. All training should be accredited by BILD. Staff should not use any physical intervention which has not been approved by the establishment in which they are working.
- Senior managers should regularly audit and analyse physical intervention records and use the data to identify areas of concern and inform service improvement strategies
- Managers at all levels are responsible for ensuring that information sharing, confidentiality and data protection policies are followed.
- After receiving appropriate training individual staff members have a responsibly to maintain their ability to recall and to practice trained skills accurately and in line with individual service user programs.
- In cases where staff members identify a need to refresh any physical skills before refresher training is due, this is to be raised with their line manager.
- Line managers may at times raise training needs with any individual staff member.
- Physical Intervention Trainers must give staff members the opportunity to access a mentoring session or have a plan to do so (typically) within 6 weeks of need being raised.

Definitions

Physical Intervention (PI) refers to any physical contact between a member of staff and a young person/adult this can take several different forms such as:

- Reassurance, guiding, redirection, prompting.
- Protecting from punching or hitting by blocking with arms.
- Releasing or "breaking away" from holds, such as hair-pull, clothing grab etc.
- Moving an individual away from a situation, these interventions are sometimes known as "escorts", or "transports".
- Holding an individual where the individual could if they tried to move away.
- Passively blocking an individual from entering a room to protect others, where the individual is free to leave the area.

Restrictive Physical Intervention (RPI) refers to:

- The positive application of force with the intention of controlling or overpowering the individual.
- The significant distinction between "Physical Intervention" and "Restrictive Physical Intervention" is that "Restrictive Physical Intervention" sometimes referred to as "Restraint" is defined as the positive application of force with the intention of controlling an individual. The intention is to control the individual, completely restricting the individuals' mobility.
- The other categories of Physical Intervention provide the individual with varying degrees of freedom and mobility.

High Risk Restrictive Physical Interventions (HRRPI) refers to:

These interventions are not acceptable practice and are not used within SENAD.

- Restrictive Physical Intervention that through either the intervention itself and its impact on the body, or through contra-indications such as physical conditions affecting the individual increase the risk of serious damage or injury to the individual.
- These include physical interventions that are known to be unsafe such as interventions where the individual is held face down, or interventions that apply pain or pressure to joints or hold that body in unnatural positions.

When restrictive practice should not be used

- The use of barriers, for example, locked doors, to limit freedom of movement e.g. placing door catches or bolts beyond the reach of young person/adult in care.
- Containing a young person/adult in care within a room by blocking the exit, or holding the door.
- Aversive practices such as taking a young person/adult in care's possessions away from them in response to their behaviours, but it may be appropriate to remove items that might be used to self-harm
- Approaches designed to gain compliance rather than to support the individual.
- Cancelling an outing for an individual as a response to their behaviour.

- Where a female student may be pregnant
- Where there is a known health condition which makes some or all physical interventions dangerous

Containment should not be used except in extreme circumstances and where there is no safer alternative. Planned containment should only be used following multi-agency consultation, as defined under DoLS, as a short-term strategy and with the written agreement of the young person/adult's placing authority and parents or carers. The SENAD executive team must be informed of all such agreements. Where the strategy ceases to be short term the SENAD executive team may instigate a serious case review.

But following Deprivation of Liberties (DoLS) Assessment, shortly to be called Liberty Protection Safeguarding (LPS), by a multi-disciplinary team and an approving Authority, an agreement may be given to:

1. Hold Doors
2. Containing by blocking exits
3. Increased use of BPRN

LPS/DoLS are authorised by the approving Authority on a time-limited basis. They should be periodically reviewed and a copy placed on the behaviour support planning file to ensure compliance with the Mental Capacity Act.

SENAD is committed to stopping the use of High Level (NAPPI Level 3) & floor restraints.

In exceptional circumstances floor restraints (face up) may be required for the safety of the young person/adult and others as a very last resort.

In the event of the use of any floor restraint a Senior Manager or an Authorised person identified by the Registered Manager or Head Teacher or Head of Learning must review the restraint – including interviews of relevant staff within 72 hours of the intervention.

This may need to be reported to the LADO.

Floor restraints must only be used when an individual is either already on the floor or moves themselves to the floor and is at risk of harm or harming others. An example would be an individual taking themselves to the floor during a capture wrap and continuing to exhibit seriously harmful behaviour.

Restraint Reduction Network Training Standards in children's care and education

Restraint Reduction Network Training Standards:

SENAD adopts emerging best practice and, like our CQC services, the Physical Intervention Training will be compliant with the Restraint Reduction Network Training Standards.

Planning:

All physical interventions must be planned within the context of proactive approaches, anticipating and managing all known triggers. The inter-disciplinary team must agree and ensure that:

- Alternatives have been tried and proved ineffective.
- Improvement in, or maintenance of quality of life, is anticipated.
- The intervention is in the paramount interest of the young person/ adult in care.
- The use is required for specific situations
- To adopt best practice, there will typically be a restraint reduction plan with an aim to reduce the amount and level of intervention.
- A regular inter-disciplinary review is planned
- Parents and referring authorities are informed at the earliest opportunity about the physical intervention plan
- If possible, the arrangements are discussed with the young person/adult taking care to use communication methods which are appropriate and accessible

Planned Interventions:

Planned appropriate physical interventions to be used must be set out in the individuals risk assessment and interventions as per their personalised Lalemand Behaviour Scale (LBS) and included in the care or placement plan.

To follow best practice, planned interventions typically will form part of the Restraint Reduction Plan.

The school and home will ensure that it has **clear documented approach** to set out:

1. Why a physical intervention is required?
2. What behaviour or conduct is seen for the intervention to occur?
3. What type of intervention is authorised and by who?
4. That the least intrusive/restrictive intervention is used
5. How this is deescalated as quickly as possible
6. That interventions are recorded
7. That debriefs for the student/resident and staff occur afterwards
8. That the intervention is reviewed objectively
9. Is reported as necessary to other external agencies and parents/guardians

These documents and plans should include:

- Descriptions of the dysregulated behaviours, which may require the use of a physical intervention procedure.
- The precise circumstances when the intervention may be employed and likely triggers.

- The role of each staff member during an incident.
- How the physical intervention should be terminated using gradients of support.
- How the young person/adult in care should be supported afterwards and the steps needed to restore relations with staff and other service users.
- Time referenced targets for the reduction in the level and number of interventions
- Physical interventions should always be recorded in an agreed specific format **and formally recorded.**
- Special consideration should be given to young people/adults who have been sexually or physically abused in the past, and staff must be sensitive to the individual issues this may raise.

In addition to the above all adult services must have a “Restraint Reduction Plan” (RRP) in place highlighting the planned steps in reducing the restrictions along with timescales and contingency plans, if the intervention is unsuccessful.

To promote the reduction of floor restraints, Rowden House School is working with NAPPI UK and PODS UK to deploy an alternative to supine restraint.

PODS UK manufacture safety pods that are designed to end the reliance of highly restrictive techniques to manage behaviours that challenge. The safety PODS are situated in the homes and classrooms. The use of the PODS for each individual is detailed in their risk assessments and support plans. NAPPI UK have produced a risk assessment for the interventions involved whilst using the pods.

Emergency or unplanned intervention (‘out of the box’ actions)

- Distinguishing between emergency or unplanned interventions and planned interventions is important. Whilst it is always preferable to have undertaken a full assessment and have appropriate care plans in place there may be occasions where emergency interventions are appropriate. These would have to be carried out “on the spur of the moment” based on a need to ensure that behaviour does not escalate to an unsafe level and this may mean there is no previous preparation in cases where the need for such an intervention could not have been anticipated and is not known to have happened before with that individual.
- The intervention used must be of the least intrusive method and be discontinued as soon as is safely possible. All other methods of supporting a person must have been tried e.g., redirection, calming. Any incident of an emergency intervention being used must be recorded at the time of the incident using the appropriate reporting form with an independent check for injuries.
- If an unplanned intervention is used a review of the young person/ adult risk assessment and risk control measures should take place as soon as possible.
- The plan should be revised in response to this review.

Enhanced Personal Protective Equipment

SENAD do not operate secure unit principle when working with children or adults. Some of our children may engage in physical behaviour which can cause injury to an adult supporting them.

We may therefore use personal protective equipment to protect the member of staff.

Managers need to ensure such equipment is fit for purpose. Advice from the Group Health & Safety Manager should be sought as necessary. Directors will support the acquisition of appropriate PPE.

Safe practice principles when using physical intervention

The following principles of good and safe practice must be followed:

- Only minimum reasonable force will be employed.
- The interventions will not cause pain or anxiety.
- Staff who may need to use physical intervention in the course of their work will dress in a way that enables them to do so appropriately.
- Parents'/carers/young person/adult's preferences about the gender of staff working with the young person/adult will be considered.
- Age, culture and ethnicity will also be taken into account during the care planning process.
- Physical intervention will not be used to gain compliance. In some settings a skilled practitioner may use prompts and physical guidance to assist a person in completing a task or learning skill.
- It is important for leaders to be aware that a physical intervention is not used to develop compliance, such as he sustained use of an interventions linked to an activity.

Health risk assessment:

Individual risk assessment based on a health review to identify contraindication to physical intervention should be carried out before any Intervention plans are implemented. Staff should take medical advice from the young person's Paediatrician on the use of physical interventions if the service user has the following contra-indications:

- Difficulties with movements e.g., cerebral palsy
- Breathing difficulties e.g., asthma
- Fits or seizures.
- Circulation difficulties
- Obesity
- Any syndrome which makes it inadvisable to use physical Intervention
- Anything else that raises staff concerns.

Staff must always be aware of and monitor any physical changes during intervention and after an intervention:

Monitoring ABCs

Airway –
- look for obstructions such as vomit, the persons tongue,
- Listen for type of breathing
- Looking into their mouth
- Are they talking?

Breathing
- Watch for chest movements
- Are the breaths easy
- What is the rate
- Is the breathing quite or noisy
- Is the individual talking?

Circulation
- Colour of Skin

- Cyanotic tint (blue tint to lips, nose)
- Constant shouting/talking
- Colour of extremities

Vital Signs

There are 4 primary vital signs

1. Body Temperature
2. Blood pressure
3. Pulse
4. Breathing Rate

The normal ranges for a person's vital signs will vary with age, weight, gender, and overall health. It is important that the service user returns to a normal condition post incident.

Staff should monitor and react appropriately if the individual shows any signs of:

- Difficulty with breathing
- Physical distress
- Vomiting
- Seizures
- Reduced blood circulation (change of colour)
- Hyperventilation

The intervention must be STOPPED (terminated) immediately and medical intervention sought.

Where there is a potential for a material head injury, medical assistance MUST be obtained, typically 111 or if more serious 999. **If in doubt, seek medical assistance!**

Post Incident Support in cases of Physical Injury or Psychological Distress

- Following a reactive intervention, which may have caused physical injury, young people/adults should be assessed for apparent signs of injury and psychological distress by a trained member of staff not involved in the incident itself and referred for medical advice if required or requested by the young person/adult.
- The assessment should be carried out within an appropriate time period considering the individuals' presentations and any obvious signs and symptoms, a maximum of eight hours should be the limit and it should be recorded on an incident/accident form.
- Indicators that medical advice is required would include any evidence that the young person/adult in care is in pain, if the young person/adult in care fell or banged his/her head during the incident or shows any signs of head injury, or bruising.
- Debriefing and supervision by appropriate manager will be offered to staff following any intervention where the young person/adult in care has become distressed. If an injury occurs the individuals risk assessment and care plan must be reviewed within 48 hours.
- All young people/adults should be spoken to and their feelings (if possible) ascertained within 48 hours and recorded, and any appropriate action taken following the consultation.

The manager on duty has a responsibility to ensure that:

- Parents/carers are informed about any injuries the young person/ adult in care has sustained and the steps taken in response to these.
- Appropriate steps are taken to de-brief and support staff involved.
- Appropriate steps are taken to de-brief and support the young person/adult involved.

Governance: Impact overview & Pattern recognition

The Headteacher and Registered Manager will systematically collate and report on physical intervention information.

A summary will be regularly shared with the Proprietor (SENAD)

Patterns and trends will be reviewed, evaluated and actions taken to reduce physical interventions.

Where this analysis indicates sustained escalation and/or dangerous dysregulated behaviour that cannot be reduced, in line with the principles of ***Working Together***, this will result in an escalation meeting with stakeholders to address issues around the child/adult wellbeing and the stability of the placement at the school/home.

Guidance: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

Keeping Children Safe in Education 2024

Safeguarding

All staff members are responsible for safeguarding the students and residents at Rowden House School. If you are concerned about a physical intervention, then you **MUST raise it via the school's Safeguarding Policy**. 506RHS

- ✓ You do this by following Rowden's ABC flow chart procedure
- ✓ You do this without delay
- ✓ You ensure that the child is safe from harm now and remains safe from harm
- ✓ You ensure that the concern is reported and is documented

Medication used to support the management of behaviour

Use of medication:

A child/adult's psychiatrist may prescribe medication to support behaviour regulation.

- Regular medication may be appropriate as advised and prescribed by a specialist or consultant, this will be part of the care plan and will be regularly reviewed by the specialist.
- The psychiatrist will make a clinical decision and provide written direction to the medication – this will be managed by the School's EMAR system.
- The psychiatrist as the designated physician, will keep the medication under review and coordinates with the child/adult's General Practitioner (GP) doctor, as well as parents/guardians with parental rights.
- Reports from the psychiatrist will be shared with a child/adult's social worker

The psychiatrist may prescribe 'use as necessary' medication to deal with acute dysregulation; this is known as BPRN.

Monitoring BPRN:

Where Behavioural PRN (BPRN) is used, this must be recorded in the relevant intervention form and in the EMAR (Electronic medication administration record as a form of restrictive restraint and must be reviewed by the Registered Manager on at least a monthly basis).

BPRN medication should not be used routinely to manage acute episodes of challenging behaviour.

Where patterns and trends emerge either for the young person or staff members the Registered Manager must investigate with a view to resolving the issues surrounding the use of BPRN.

This may require a strategy review with the placing Authority and parents.

Complaints and whistleblowing

All young people/adults, parents and carers must have ready access to an effective complaints system. It needs to be recognised that young person/adult may need support from a parent/carer or advocate, to make a complaint.

Managers at all levels are responsible for dealing promptly and effectively with complaints in line with the SENAD complaints policy & procedure.

The Head Teacher and the Registered Manager have a legal duty to ensure that there is a written record and that these records are reviewed and analysed including the risk assessments, care and support plans and accident incident information and the supporting documentation for example body maps, contact records, debrief forms etc.

Where pattern and trends emerge either for the young person/adult or staff member the Registered Manager must investigate with a view to resolving the issues.

Staff pregnancy and other health restrictions

The use of Physical Intervention is high risk whilst pregnant, this includes Physical Intervention training. Statistic indicate that the loss of pregnancy is likely to occur in the first 13 weeks. Therefore, pregnant staff should only be trained in the psychological models.

If the trainee should wish to take part in the physical skills, this can be done as a coaching session where the trainee will be walked through the skills at low speed with no resistance. This will not meet the criteria of certification but will be shown on training records. A coaching session is best done on a 1:1 basis away from a formal training session.

Pregnant staff should avoid situations where PI may occur, this will be identified on the New Mothers Risk Assessment with phrases such as “The staff member should leave the room or area in a situation where PI is imminent”.

On return to work following maternity leave staff should complete the relevant PI levels/ modules and psychological modules linked to the sites/ services.

As part of the requirements for frontline staff there is an expectation that occasionally physical Intervention may be needed as a last resort. Where there is a clear long-term physical condition which may exclude the individual from the use of Physical Intervention, they will be risk assessed using form 217.1 by the Strategic Behavioural lead or a nominated PI Trainer to assess their physical competency.

Staff who have a Risk Assessment for any health conditions or have concerns about being able to complete the physical skills modules should discuss with the trainers prior to commencement of PI training.

Physical Intervention trainers should not train any physical interventions or self-protection skills after identifying their own pregnancy.

Staff Conduct during Training

Trainers have a duty under the BILD Code of Practice to report any concerns about a participant direct to their Employer. SENAD take their responsibilities for the Care of service users & Equality & Diversity seriously therefore any comments made by Staff or trainers relating to:-

- Inappropriate comments, values or beliefs
- Observed inappropriate sexual behaviour (comments or contact)
- Information shared about mistreatment or service users
- Information shared about inappropriate approaches including physical intervention
- Negative and discriminatory language
- Poor performance skills, knowledge and unsafe use of physical skills.
  will not be tolerated and will be dealt with appropriately through HR procedures and SENAD Complaints and Concerns procedures.

Training of Visitors, and parents/guardians.

From time to time non SENAD personnel may request support in the use of the psychological de-escalation techniques. Sometimes, this request may move to Physical Intervention training, such as defensive approaches for a 'hair pull' or using the X shield to defend from a strike by an arm.

SENAD **will not teach parents/guardians how to actively restrain a child**. Parents will be referred to their placing authority for such support.

Any parental/guardian support approach must be agreed with the Group Health, Safety Manager prior to delivery as this affects the home's NAPPI registration and potentially the public liability insurance.

The Group Health & Safety Officer will seek approval from the Group Insurers. The training must be delivered by a qualified trainer and should be restricted to de-escalation & self-protection skills. The individual being trained must complete the health checks recommended by the Training organisation.