Oasis Restore

Physical Intervention Policy

July 2024

Version	Signed and agreed by	Date	Review by
1.	Responsible Individual, Registered Manager and Directors	22nd January 2024	January 2025 (or when needed)
2.	Registered Manager	May 2024	
3.	Responsible Individual and Registered Manager	July 2024	

Introduction

The Oasis Restore Physical Interventions Policy sets out our commitment to the children at the school, their families and significant others, and our staff. The policy will be reviewed annually to ensure it is adapted to the needs of our cohort and the school.

Key principles

Our model and practice is defined by our cornerstones: Relationships, Discovery and Community, the RESTORE principles, and the Oasis ethos, values and habits.

Everything we do serves our vision: *to provide a therapeutic and educational community that embeds hope, stability, and opportunity within and beyond Oasis Restore. Oasis Restore creates an environment that gives the children, and the organisation, every opportunity to reach their full potential and be the best they can be.*

Principle	Commitment
Relationships… through building trust	We will work to stay in relationship with children through the most difficult times, rebuilding relationships where they are damaged.
Empowerment… through providing choices and nurturing responsibility	We will empower children to manage their feelings and responses safely, through formulation-based planning and post-incident restorative work.
Safety… through providing consistency, a secure base, and a supportive and reflective community	We will keep children, and staff, safe, and will be open, transparent and reflective about how we do this.
Trauma-responsive practice… through creating psychologically-informed culture and systems	We recognise that physical intervention may be re-traumatising or traumatising for children and will work to prevent and minimise it at all times.
Ownership… through providing life-affirming opportunities within and beyond the school, and within it, a sense of belonging and opportunity	We will ensure that children are able to 'own' their Formulation and their Restore Plan, helping define how staff approach and work with them at the school in relation to managing crises and extreme distress.
Restoration… of hope and dignity, through offering support, challenge, and opportunities to repair damaged relationships	We will always offer a restorative process where there has been distressed behaviour, aiming for a deepening of relatedness and greater learning about self and others.
Enquiry… through encouraging openness and reflection	We will encourage children (and staff) to ask questions and reflect on their experiences, all the more where these have been distressing or difficult, towards the aim of greater understanding.

At Oasis Restore we strive to create a caring safe, stimulating environment in which effective teaching and learning can take place; with staff providing firm, caring boundaries, which are explained and discussed openly and transparently, and which give children the opportunity to express themselves as individuals and as part of a community.

We believe that all individuals have a right to be treated with respect and dignity, regardless of the differences between them in age, sex, race, sexual orientation, religion, culture, language or disability and we will make every effort to work in an anti-discriminatory manner, challenging attitudes and behaviours that disadvantage individuals and/or groups at Restore. Everyone at Oasis Restore is expected to behave in a way that acknowledges and values differences positively and not in a way that excludes, humiliates or damages.

We aim to promote good behaviour, discipline and respect for self and others. We strive for fairness, consistency of response and a safe environment free from disruption, violence, bullying and harassment, in which therapeutic work, teaching and learning can take place effectively. We aim to achieve this by understanding each child with them through the formulation process, modelling respectful and caring interactions, providing a stimulating and supportive educational environment, promoting and celebrating positive behaviour and providing bespoke and proactive support.

We recognise that occasionally the behaviour of a child at Oasis Restore may place themselves, others and the therapeutic and learning environment at immediate risk. We recognise that in these circumstances, and if there is no alternative, restrictive physical intervention may be required and will represent the physical end of the continuum of a caring response to a child's distress. In such an event it may be required to ensure that:

- the safety and wellbeing of all students and staff is upheld;
- the fabric of the building, and its resources are preserved; and
- the opportunity for therapeutic work, teaching and learning to take place is maintained

Any restrictive physical intervention will be utilised strictly in accordance with this policy and recorded in the physical intervention bound book then uploaded onto Clearcare and MyConcern (by Restore staff), and on Systm1 and Datix (by Healthcare staff) and reviewed by the Registered Manager and the Senior Leadership Team (SLT). Datix is additionally reviewed by the senior healthcare staff both internally and externally within the NHS Trust and NHSE.

This Policy and Guidance is informed by:
The Children's Homes (England) Regulations 2015.
Department for Education DfE guidance on the "Use of reasonable force: advice for school leaders, staff and governing bodies" 2012.
The Education Act 1996
Education and Inspections Act 2006
Behaviour in Schools (2022)
The use of seclusion, isolation and time out BILD's Centre for the Advancement of Positive Behaviour Support (CAPBS)
NICE Guidelines (2015) regarding the management of violence in children (NG10)
The Restraint Reduction Network Training Standards (2019)

Legal Context

All members of staff have a duty of care to ensure the safety of the children in their care.

DfE Guidance states that no schools should have a 'no contact' policy. There is a real risk that such a policy might place a member of staff in breach of their duty of care towards a student, or prevent them taking action needed to prevent a student causing harm.

Any citizen has the common law power to intervene in an emergency to use reasonable force in self-defence, to prevent another person from being injured or committing a criminal offence.
Section 93 of the Education and Inspections Act 2006 gives all school staff (or other people authorised by the Head Teacher) the power to use **such force as is reasonable** to prevent a student from doing or continuing to do any of the following:

- Committing an offence.
- Causing injury or damage to a person or the property of any person (including the person themselves).
- Prejudicing the maintenance of good order and discipline in the school or among students receiving education

What is reasonable force?

The DfE guidance provides the following clarification:

The term 'reasonable force' covers the broad range of actions used by most teachers or school staff at some point in their career that involve a degree of physical contact with children.
Force is usually used either to control or restrain. This can range from guiding a child to safety by the arm through to more extreme circumstances such as breaking up a fight or where a child needs to be restrained to prevent violence or injury.

'Reasonable in the circumstances' means using no more force than is needed.

As mentioned above, schools generally use force to control children or to restrain them. Control means either passive physical contact, such as standing between students or blocking a child's path, or active physical contact such as leading a child by the arm out of a classroom.

Restraint means to hold back physically or to bring a child under control. It is typically used in more extreme circumstances, for example when two children are fighting and refuse to separate without physical intervention.

Guiding Principles for the use of Restrictive Physical Intervention

The legal justifications for the use of reasonable force and restrictive physical intervention, however, are not in themselves license to physically intervene. Professional judgment needs to be taken on each incident on a case by case basis. Staff making a decision to use a restrictive physical intervention will exercise their professional judgement in the context of the following guiding principles;

- Restrictive Physical Intervention should only be used in the context of our Restorative Policy to regain safety and to promote positive behaviour.
- There are occasions when restrictive physical intervention is an appropriate and reasonable response to the risks presented in a particular situation. However, the scale and nature of

any physical intervention must be proportionate to both the behaviour of the individual and the nature of the harm they might cause.

- Restrictive Physical intervention must be a last resort when there is no alternative, less intrusive, course of action.
- Restrictive Physical Intervention should be used with the least restriction for the least amount of time possible.
- The physical and emotional well-being of all parties concerned is paramount.
- Members of staff will not be required/advised to carry out any form of restrictive physical intervention which will put themselves at risk.
- If a restrictive physical intervention is necessary, it must be used in ways that maintain the safety and dignity of all concerned.
- Restore staff should always try to avoid acting in a way that might cause injury. However it is acknowledged that in extreme cases it may not always be possible to avoid injury as an accidental consequence of the intervention.
- Healthcare staff will review every child who is involved in a Phase Two physical intervention (as defined by the PRICE training) and will be available to see any child who is involved in a Phase One physical intervention if needed or requested by the child.
- Healthcare staff will be called to attend any Phase Two physical intervention in order to be able to provide immediate support and monitoring of the child's vital signs, physical and emotional wellbeing.

In addition any restrictive physical intervention must

- Not impede the process of breathing or restrict the airways;
- Not be used in a way which may be interpreted as sexual;
- Not intentionally inflict pain or injury or threaten to do so;
- Avoid vulnerable parts of the body, e.g. the neck, chest and sexual areas;
- Avoid hyperextension, hyper flexion and pressure on or across the joints;
- Not employ potentially dangerous positions.
- Not take place in a residential bedroom with a door closed.

No form of physical punishment is permitted. Any physical intervention that is punitive or intended to cause pain or humiliate is unlawful and will result in staff disciplinary action.

Legislation	**Children's Homes Regulations 2015**
	Regulation 20 *'Restraint means…. using force or restricting liberty of movement'*
	Restraint and deprivation of liberty **20.**—(1) Restraint in relation to a child is only permitted for the purpose of preventing— (a) injury to any person (including the child); (b) serious damage to the property of any person (including the child); or (c) a child who is accommodated in a secure children's home from absconding from the home. (2) Restraint in relation to a child must be necessary and proportionate.

	(3) These Regulations do not prevent a child from being deprived of liberty where that deprivation is authorised in accordance with a court order.
	35.— (3) The registered person must ensure that— (a) within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home, a record is made which includes— (i) the name of the child; (ii) details of the child's behaviour leading to the use of the measure; (iii) the date, time and location of the use of the measure; (iv) a description of the measure and its duration; (v) details of any methods used or steps taken to avoid the need to use the measure; (vi) the name of the person who used the measure ("the user"), and of any other person present when the measure was used; (vii) the effectiveness and any consequences of the use of the measure; and (viii) a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure; b) within 48 hours of the use of the measure, the registered person, or a person who is authorised by the registered person to do so ("the authorised person")— (i) has spoken to the user about the measure; and (ii) has signed the record to confirm it is accurate; and (c) within 5 days of the use of the measure, the registered person or the authorised person adds to the record confirmation that they have spoken to the child about the measure. (4) Paragraph (3) does not apply in relation to restraint that is planned or provided for as a matter of routine in the child's EHC plan or statement of special educational needs.
	36.—(1) The registered person must maintain records ("case records") for each child which— (a) include the information and documents listed in Schedule 3 in relation to each child; (b) are kept up to date; and (c) are signed and dated by the author of each entry. <u>Schedule 3:</u> **15.** The date and circumstances of any measure of control, discipline or restraint used in relation to the child.
	Records show: • Compliance with the home's policy (Regulation 12) • The legal criteria continues to be met <u>throughout the incident</u> until it ends (Regulation 20) • For single separation: 'Welfare checks' in line with the home's policy and a child's individual risk assessment (Regulation 12) • If lengthy – records/plans show the care provided: Routines, Fresh Air, Education, Activities • 'Regular' management oversight and governance (R13, 45) **in line with individual needs** • Good/best practice • Work done to return the child to normal routines.

Legislation	**The Children (Secure Accommodation) Regulations 1991**
	Section 17: ensure that a record is kept of– (g) the date and time of any occasion on which the child is locked on his own in any room in the secure accommodation other than his bedroom during usual bedtime hours, the name of the person authorising this action, the reason for it and the date on which and time at which the child ceases to be locked in that room the Secretary of State may require copies of these records to be sent to them at any time.

The guide to the children's homes regulations and the quality standards
9.42 Restraint also includes restricting a child's liberty of movement. This includes, for example, changes to the physical environment of the home (such as using high door handles) and removal of physical aids (such as turning off a child's electric wheelchair). Restrictions such as these, and all other restrictions of liberty of movement, should be recorded as restraint. 9.65 Children in secure children's homes should only be placed in single separation when necessary to prevent injury to any person or to prevent serious damage to property. (ref Regulation 15). NB Regulation 15 If the Secretary of State publishes a statement of standards in relation to children's homes under section 23 of the Care Standards Act 2000, the registered person must have regard to the statement

Restrictive practices, separation and managing away:

Single separation:

- Enforced:
  Any instance where a child is contained within any locked room or enclosure with visible or virtual barriers, away from the group and from staff (other than where staff are acting as the "visible barrier") for the purposes of control and cannot leave the room or enclosure whenever they want to do so.

- Elected:
  This is when a door is locked at a child's own request. This may be due to feeling unsafe, uneasy, or cannot share with us why they want to be locked away. This is still a form of separation, even though they can leave at any time.

Managed away:

- Is defined in the same as enforced separation, the difference being that a child is supported and is interacting with a member of staff throughout their separation who is in the room.

Ending single separation and managed away incidents:

- When the legal criteria (see reason for separating a child above) are no longer met, the incident must end.
- This essentially means when the risk has reduced enough for other strategies to be used to manage this risk.

Peer separation:

- This relates to when a child cannot mix with another child, or children and we are in the process of restorative practice with the child/children.
- This does not mean a child is separated from peers or not able to engage in their timetable, however there may be alterations to manage the risk mean a short additional layer of restriction.

Some points for consideration:

- 'Single separation'; 'Single' indicates 'alone'

Who can use Restrictive Physical Intervention?

All staff can use restrictive physical intervention to maintain safety in an emergency consistent with the principles of common law. Trained staff will relieve any untrained staff applying the principles of common law participating in a restrictive physical intervention, as a matter of urgent priority.

All staff have a duty of care. If a child is in danger or endangering other children you have a duty to act in a way to reduce or eliminate the risk as it presents itself. A duty of care extends to acts or omissions which may compromise the health and safety of the children or staff of our school.

The 2006 Education and Inspections Act gave all teachers and other school staff, who have control or charge of children, the statutory power to use reasonable force.

On very rare occasions where a children's behaviour is presenting an immediate risk of harm to themselves, others, or school property, supportive physical intervention may be used to encourage, guide or move a child to a safe area. On arrival at the safe area, calming strategies will again be used to support the child in recovery from crisis. Support may include any necessary period of rest or respite before being encouraged to re-join learning activities.

Recording the use of Restrictive Physical Intervention

When restrictive physical intervention has been used, whether in a planned or unplanned way, this will be recorded in a Physical Intervention Form on Clearcare and MyConcern. Healthcare staff will record it on Systm1 and Datix or in another given MIS system. Discussion will take place in the Safeguarding Meeting and will be minuted and subject to a Lessons Learned process that will inform future staff development and training as well as the care of the child in question. This report will include:

Post-incident support

I Any incident involving restrictive physical intervention is likely to be highly emotional and distressing for children and staff involved, whether they are involved directly or as observers. Support will be made available to the staff and children involved. This will be offered in a timely manner when individuals are sufficiently calm to be able to talk about the incident.

We will help children to debrief following an incident, to understand why the intervention was used, allow them to explain how they felt about it, explore the triggers for what happened and explore how these could be addressed. This should be a child-led or supported intervention, intended to enable them to reflect on what has happened, and what could happen differently in the future, to reduce the need for this type of intervention, and to determine how best we could support them. This information can then contribute to the development of new or existing positive handling plans within the Restore Plan, and should be factored into the child's Formulation.

Staff will attend a mandatory hot debrief and cold debrief, conducted by a member of the Senior Leadership Team and will include a discussion about how, if possible, the incident could have been managed differently. The support given to staff and children should be recorded in the follow up action section of the incident record form.

Staff are expected to discuss any physical interventions they have been involved in, in 1:1 supervision and in their reflective practice group. This should include an opportunity to talk about the incident, how they feel about it, how it might impact on their future relationship with the child and how this can be addressed.

Monitoring the use of Restrictive Physical Intervention

An audit is kept of the use of restrictive physical intervention within school and is monitored by the Senior Leadership Team overseen by the registered manager . Each physical intervention is reviewed by the registered manager who will also talk with the child involved and review the CCTV .
Training for staff is then tailored to the needs of the current student cohort. Senior staff (healthcare and Restore) will also be expected to contribute to and attend the NHS Trust Restrictive Practice Group to participate in a further level of consultation around reducing restrictive practice. This will also involve feeding into the Lessons Learned process within the school and contributing to responsively developed staff training.

Staff training includes PRICE safety intervention training which can include physical interventions as well as de-escalation and proactive strategies to prevent conflict. Wider Restore training includes Restorative Practice and Restore-specific training in therapeutic skills. Further training may be identified by audits of incidents and staff practice.

Concerns and complaints

Parents, DSL and registered manager will always be informed if a restrictive physical intervention has been used. Parents will be contacted by a member of SLT and this contact will be recorded in the physical intervention report in the bound book. The report will include children's and parents' views, and a reflective account from staff.

Where a parent makes a complaint about the use of force by a member of the school staff, it will be taken seriously and addressed by the Principal Director/Registered Manager via the Complaints Policy.

Where a staff member raises a concern about physical intervention, this needs to be reported immediately to the DSL, Registered Manager and the Principal Director and it will be handled according to the Safeguarding Policy.

Linked policies

Restorative Policy

Critical Response Framework

The Restore Framework

Safeguarding Policy

Appendix 1: Healthcare Local Operating Procedure for the use of phsycial safety intervention at Oasis Restore

Healthcare staff involvement in the use of physical safety intervention at Oasis Restore Secure School

Aim: To ensure all healthcare staff working at Oasis Restore Secure School, either directly employed or employed by a sub-contracted organisation, understand their role in the use of physical safety interventions.

Applicable to: All healthcare staff working at Oasis Restore Secure School, either directly employed or employed by a sub-contracted organisation to provide a healthcare service.

Key additional policies/guidance and legislation:

This Local Operating Procedure should be read in conjunction with:

- Oasis Restore Physical Intervention Policy
- Oasis Restore Critical Response Framework
- Oasis Restore Restorative Policy
- CNWL Prevention and Management of Violence and Aggression Policy
- Oasis Restore Safeguarding Policy
- CNWL Safeguarding Children and Young People Policy
- Guidance for healthcare staff attending incidents in the Children & Young People Service Line

The ways of working set out in this document, and in the above policies, are informed by broader organisational policy and national legislation, all of which is listed in the above policies.

The legislation which allows for the use of physical intervention at Oasis Restore Secure School is The Children's Homes (England) Regulations 2015.

The role of healthcare staff during incidents requiring the use of physical safety intervention:

As a member of staff employed by Central and North West London, or a sub-contracted partner, working as part of the integrated Oasis Restore Secure School you will be trained in physical safety intervention by the organisation PRICE (Protecting Rights In a Caring Environment). PRICE is an RRN (Restraint Reduction Network) authorised training provider; this is the quality standard for NHS commissioned services. The Positive Approaches to Challenging Behaviour (PACB©) curricula provided by PRICE are approved for Education, Health and Social Care settings.

In accordance with the training you undertake with PRICE, there may be occasions where you need to participate in physical intervention in order to keep a child or colleague safe from

harm, to prevent further harm or to move a child to a safer environment. When physical intervention is needed, you are expected to act in accordance with the training you have received. All staff at ORSS have a duty of care to the children living at the school and can use restrictive physical intervention to maintain safety in an emergency consistent with the principles of common law. (See *Oasis Restore Physical Intervention Policy* for further guiding principles of when physical intervention may be required and justified).

Healthcare staff members, specifically nurses or those taking on the Hotel 1 role each shift, are also required to attend incidents which may or may not involve physical intervention. The PRICE training staff undergo classifies physical interventions as Phase 1 or Phase 2, with Phase 1 interventions as being gentle guiding or diverting interventions, and Phase 2 being 'holds' that restrict movement. Healthcare staff members are expected to be called to all Phase 2 interventions and may also attend a Phase 1 intervention.

When healthcare staff arrive at the incident, they must monitor the safety and wellbeing of the child and members of staff and provide clinical advice to the person in charge if they identify any distress or deterioration of a child's physical condition or the warning signs and symptoms associated with medical distress. If the member of staff allocated as Hotel 1 is involved in the physical intervention itself, an additional appropriately trained member of the healthcare team should be requested to attend in case there any urgent or emergency medical needs present.

Training provided:

All staff members employed by Central and North West London, or a sub-contracted partner, working as part of the integrated Oasis Restore Secure School will be trained in physical safety intervention, namely The Positive Approaches to Challenging Behaviour (PACB©) curricula provided by PRICE.

All registered nursing/paramedic staff will be trained in Immediate Life Support (ILS) as part of mandatory training, with annual compliance (Resus Council recommended). Other child-facing members of staff who are directly employed by CNWL will be trained in Emergency Life Support (ELS) and also complete Paediatric Emergency Life Support (PELS Level 2 E-learning) on the CNWL LDZ system.

Acute Life-threatening Events - Recognition and Treatment (ALERT) training is available for registered healthcare professionals and those in post at Oasis Restore Secure School will be supported to attend this training.

Support provided:

Opportunity to debrief as part of the team involved in or witness to an incident will be provided by members of the Oasis Restore management team, including healthcare senior leaders. There may be occasions where it is helpful to have a 1:1 debrief or a debrief as a

healthcare team; this will be arranged and supported by the Head of Healthcare, Deputy or other senior healthcare staff.

Monthly Safeguarding and Clinical Supervision is provided for all healthcare members of staff, including sub-contracted partners. This will provide an opportunity to discuss your experiences of being involved in and/or witnessing incidents which may or may not have involved physical safety intervention. These incidents can be distressing and it is important that you know who you can approach in the team for ad hoc support, if needed in between supervision sessions.

CNWL have a monthly *Reducing Restrictive Practice Forum*, chaired by the Chief Nurse, which brings together learning and expertise across the trust. The Head of Healthcare, Deputy Head of Healthcare or nominated other will attend this monthly, and will disseminate learning and examples of good practice to the healthcare and wider Oasis Restore team.

Documentation:

Healthcare staff will document any involvement in an incident involving physical safety intervention on the child's health records on SystemOne and as part of the overall incident reporting on the Datix incident report form (as per CNWL policy). They will also liaise closely with Oasis Restore residential staff to ensure health input is accurately documented on Clear Care (either by directly documenting this themselves or by contributing to an overall incident report). Any safeguarding concerns will also be reported on the Datix system.

How to manage concerns:

If safeguarding concerns arise during an incident, healthcare staff will report these through the agreed Safeguarding procedure and where necessary seek support from CNWL local and trust Safeguarding leads. This should also be documented on Datix.

Any concerns related to the health or wellbeing of the child should be discussed in a timely manner with Oasis Restore and healthcare senior staff members, to ensure the child is supported appropriately and any health needs are attended to. The concerns present, and the plan of support, should be clearly documented on SystemOne and where appropriate on Clear Care.

Appendix 2: Technique Recaps and Summary Risk Assessments for safety interventions on stairs and in doorways

The Technique Recap & Summary Risk Assessments are intended for reference purposes only and not as a self-teach aid or a substitute for comprehensive training. It is essential that the fidelity of a technique is not compromised, by way of modification or adaptation or an absence of contextual understanding.

Technique Recap and Summary Risk Assessment

Technique: Negotiating stairs in a Standing Double Embrace — **Phase Four**

Suitable for use with (subject to individual behaviour support plan)	Adults	Young People	Children
	✓	✓	✓

Description	• Four person technique. • Standing only • Two staff members in a Standing Double Embrace and two further staff to negotiate the stair well safely • For use moving down stairs only • Need to ensure you are familiar with the summary risk assessment for variables including size, health conditions and appropriateness of the hold.
Purpose	• For use where a person you are supporting is unable to be held safely away from the stairwell. • For use when disparity in height means that the Cupped Hand is not possible/effective • Based on an assessment of risk and in line with the 'Best Interest' criteria this technique can be used (once all other strategies have been exhausted) to safely escort a child down stairs.
Effectiveness	• Medium to high effectiveness in response to a medium to high level of arousal. • Very effective if the person you are supporting is known to bite. • Very good for phasing up or down, particularly good for phasing down to Figure of Four or Single Embrace.

Skill retention factors to consider	• ONLY TO BE DONE IN A STANDING POSITION. • Ensure that all skill retention factors in relation the SDE technique are cons • Engage in dialogue as appropriate. • Communication with other member of staff is essential, Whilst in a Cuppe further staff members (as a minimum) are required to negotiate a stairwell s leading the movement and direction of travel. And one maintaining the 'Sta members to the opposite side. • Bolster person guidance - Side on, wide stance, neutral spine. Both hands staff member holding the child (towards the bottom of the stairs) , one ha one to the belt area, keep the arm to the belt area slightly bent and the ot out, this is in order to lead the momentum of the escort down the stairs Stability person guidance - Side on, wide stance, neutral spine. Both hands staff member holding the child (towards the top of the stairs) , one hand t to the belt area, keep both arms bent in order to maintain stability of th supported.

Technique: Negotiating stairs in a Standing Double Embrace	**Phase Four**

Potential Risks

Person we are supporting

- Losing balance and falling on the stairs if the technique is not applied correctly and/or if the child's level of behaviour becomes unmanageable
- Potential pressure from support workers knuckles on rib cage.
- This technique should never be used as a seated version due to the elevated risk.
- In terms of psychological impact, consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.

Support Workers

- Losing balance and falling on the stairs if the technique is not applied correctly and/or if the child's level of behaviour becomes unmanageable.
- Support workers may be open to head-butting, hitting, striking out if the technique is not appropriate to the circumstances.
- Risk of sprains whilst negotiating stairs

Date	April 2024

Technique Risk Assessment

Technique: Negotiating stairs in a Standing Double Embrace **Phase Four**

Identification of Risk	
Describe the foreseeable use:	
Based on an assessment of risk and in line with the 'Best Interest' criteria this technique can be used (once all other strategies have been exhausted) to safely escort a child down stairs. The Standing Double Embrace maybe considered when there is a difference in height between the person being supported and the staff members supporting the child (as such a Cupped Hand not being possible or effective)	
Does the technique intentionally inflict pain or use pain compliance as a means of control or effective component of the technique:	~~*Yes*~~ */* ***No***
Potential psychological impact:	
Consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.	

Assessment of Risk	
In which aspects of the techniques does the risk usually occur?	
Potential risk of staff/child losing balance on the stair well and as such falling. The position of the staff member's inside arm may potentially lead to pressure on the ribs. Potential risk of staff member being struck by the person if technique is not appropriate to the circumstances. Application and maintaining of technique.	
Does the technique have an elevated risk	*Yes*

*Potential risk of harm to **staff member** (including Bio Mechanic considerations):*					
Risk Assessment Score	Low	Low to med	Med	Med to high	High
Airway/Breathing/Circulation	✓				
Fracture / Dislocation				✓	
Ligament sprain				✓	
Nerve Damage	✓				
Soft Tissue Injury	✓				

*Potential risk of harm to **service user** (including Bio Mechanic considerations):*					
Risk Assessment Score	Low	Low to med	Med	Med to high	High
Airway/Breathing /Circulation		✓			
Fracture / Dislocation				✓	
Ligament sprain				✓	
Nerve Damage		✓			

Soft Tissue Injury		✓			

Technique suitable for use with service groups:		
Groups	**Yes/No**	**Group Specific Risk Identification (Also refer to risk reduction strategies)**
Children	Yes	Disparity in height.
Young People	Yes	Disparity in height.
Adults	Yes	Disparity in height.
This technique avoids vulnerable areas of the body		Yes
This technique avoids the use of hyper flexion and / or hyper extension of joints		Yes

Technique Risk Assessment		
Technique: Negotiating stairs in a Standing Double Embrace		**Phase Four**
Proactive interventions to prevent risks	1. Technique should be used in a manner consistent with individual risk assessments and individual behaviour support plans i.e. the technique is fundamentally appropriate to the person being supported, their safety needs, their level of arousal, and the specific circumstances within which it is about to be applied.	High
	2. Ensure that all practitioners are competent in using the technique and receive regular refresher training. PRICE Training recommends annual refresher training and regular practice sessions to avoid skill fade and practice the motor skills required for the safe application of this technique.	High
	3. As per PRICE Training's principles: • No holds or movements against joints • No hyper-flexion or hyper-extension • Consider gender issues and avoid vulnerable areas of the body	High
	4. Staff should always approach and disengage from the person safely, adopting the defensive stance or appropriate guiding technique when in close proximity to them.	High
	5. Be conscious of the environment. Consider removing other people from the environment, except where staff are needed to support. Remove any primary or secondary triggers from the immediate environment where possible. Consider sensory stimuli and their initial/continuing impact on presenting behaviour.	Medium
	6. A clear instruction to stop is given, to give the person the opportunity to stop and self-regulate. The staff arrive at the first point of contact with the person at the same time adopting the defensive stance. When leaving use the "PRN" script (Prepare Ready Now) or phasing down as appropriate to the circumstances).	High
	7. Techniques should only be undertaken as per Technique Guidance and not adapted or changed in any way.	High
	NB: This technique should never be used as a seated variation i.e. you should never seat the service user whilst holding them in a Standing Double Embrace.	

Risk Management Strategy
Actions for the future
• Review teaching and in house Physical intervention logs. • Ensure post restraint physiological/psychological assessment.

Technique Risk Assessment

Technique: Negotiating stairs in a Standing Double Embrace **Phase Four**

Technique Guidance – Main points	
Physical Intervention	**Performance Criteria**
Prior to using the technique	Ensure all other options are completely exhausted and that physical intervention is ABSOLUTLEY necessary. Staff members MUST be able to demonstrate that their actions were reasonable, necessary and proportionate and that they were acting in the person's best interests. Ensure that you have given the person the opportunity to stop and that physical Intervention is NOT used to either force compliance or as any form of punishment.
Approach	Defensively from rear – shoulder to shoulder.
Defensive stance	Protect yourself, stability, lower centre of gravity.
Use/position of hips	In close side on to service user.
Position of head	Head up, face away.
Position of hands	As per Standing Double Embrace
Application	Draw person's elbows backwards to facilitate your partners over grasp with their furthest hand.
Double embrace position	Over grasp on further forearm.
Inside hand	Under grasp on nearest forearm.
Use of voice	Calming using reassuring tone of voice as appropriate. Clear and concise communication essential when negotiating the stairs – See below.
De-escalation	Use de-escalation and defusion strategies as per individual behaviour support plan.
Leave option	If appropriate.
Teamwork	Team work, communication and timing essential – 2 way. The person leading the negotiation of the stair well is the 'Bolster' person - Clear communication to be used 'Step' and 'Pause'

Risk Assessment Date: **April 2024**

Review Date: **April 2024**

PRICE TRAINING

Technique Risk Assessment

Technique: Negotiating stairs in a Cupped Hand **Phase Four**

Identification of Risk	
Describe the foreseeable use:	
Based on an assessment of risk and in line with the 'Best Interest' criteria this technique can be used (once all other strategies have been exhausted) to safely escort a child down stairs.	
Does the technique intentionally inflict pain or use pain compliance as a means of control or effective component of the technique:	~~*Yes*~~ */* ***No***
Potential psychological impact:	
Consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.	

Assessment of Risk	
In which aspects of the techniques does the risk usually occur?	
Potential risk of staff/child losing balance on the stair well and as such falling. Potential risk of flexion if technique is applied incorrectly and technique guidance is not followed. Application and maintaining of technique. Wrist kept straight and splinted. Potential risk to abrasions to the arms if using the wall/s handrail/s for stability	
Does the technique have an elevated risk	*Yes*

*Potential risk of harm to **staff member** (including Bio Mechanic considerations):*

Risk Assessment Score	Low	Low to med	Med	Med to high	High
Airway / Breathing / Circulation	✓				
Fracture / Dislocation				✓	
Ligament sprain				✓	
Nerve Damage	✓				
Soft Tissue Injury		✓			

*Potential risk of harm to **service user** (including Bio Mechanic considerations):*

Risk Assessment Score	Low	Low to med	Med	Med to high	High
Airway / Breathing / Circulation	✓				
Fracture / Dislocation				✓	
Ligament sprain				✓	
Nerve Damage	✓				

Soft Tissue Injury		✓			

Technique suitable for use with service groups:		
Groups	**Yes/No**	**Group Specific Risk Identification** **(Also refer to** risk reduction strategies**)**
Children	Yes	Disparity in height.
Young People	Yes	Disparity in height.
Adults	Yes	Disparity in height.
This technique avoids vulnerable areas of the body		Yes
This technique avoids the use of hyper flexion and / or hyper extension of joints		Yes

Technique Risk Assessment

Technique: Negotiating stairs in a Cupped Hand **Phase Four**

Risk Management Strategy		
Measures set out	**Risk reduction**	**Impact on risk** High, Medium, Low
Proactive interventions to prevent risks	1. Technique should be used in a manner consistent with individual risk assessments and individual behaviour support plans i.e. the technique is fundamentally appropriate to the person being supported, their safety needs, their level of arousal, and the specific circumstances within which it is about to be applied.	High
	2. Ensure that all practitioners are competent in using the technique and receive regular refresher training. PRICE Training recommends annual refresher training and regular practice sessions to avoid skill fade and practice the motor skills required for the safe application of this technique.	High
	3. As per PRICE Training's principles: • No holds or movements against joints • No hyper-flexion or hyper-extension • Consider gender issues and avoid vulnerable areas of the body	High
	4. Staff should always approach and disengage from the person safely, adopting the defensive stance or appropriate guiding technique when in close proximity to them.	High
	5. Be conscious of the environment. Consider removing other people from the environment, except where staff are needed to support. Remove any primary or secondary triggers from the immediate environment where possible. Consider sensory stimuli and their initial/continuing impact on presenting behaviour.	Medium
	6. A clear instruction to stop is given, to give the person the opportunity to stop and self-regulate. The staff arrive at the first point of contact with the person at the same time adopting the defensive stance. When leaving use the "PRN" script (Prepare Ready Now) or phasing down as appropriate to the circumstances).	High
	7. The member of staff must raise the person's hands to their shoulders BEFORE rotating the shoulder and moving the person's arms into the final position.	Medium

	8. The person's wrist must be kept straight and using the member of staff's inside hand. Doing this correctly will guard against the wrist being bent and subsequently applying flexion. The fingertips of the staff member should be resting on the knuckles of the person. Pressure should not be applied.	High
	9. Techniques should only be undertaken as per Technique Guidance and not adapted or changed in any way.	High

Actions for the future
• Review teaching and in house Physical intervention logs. • Ensure post restraint physiological /psychological assessment.

Technique Risk Assessment

Technique: Negotiating stairs in a Cupped Hand **Phase Four**

Technique Guidance – Main points	
Physical Intervention	**Performance Criteria**
Prior to using the technique	Ensure all other options are completely exhausted and that physical intervention is ABSOLUTLEY necessary. Staff members MUST be able to demonstrate that their actions were reasonable, necessary and proportionate and that they were acting in the person's best interests. Ensure that you have given the person the opportunity to stop and that physical Intervention is NOT used to either force compliance or as any form of punishment.
Approach	Defensively from rear – Arrow Head position - the shorter of the two members of staff must be at least the same height at the shoulder as the person being supported.
Defensive stance	Protect yourself, stability, lower centre of gravity.
Use/position of hips	In close sideways on to the person.
Head position	Face turned away.
Position of hands (leading and trailing hands)	• Lead arm mid-point between shoulder and elbow with a flat aspect of your arm. • Trailing hand protects face, draws down the line of the person's arm to take an under-grasp of the wrist, no thumbs. • Raise the person's hand towards their own shoulder. • Leading hand then circles through to cup the person's hand.
Movement to complete technique	Whilst in a Cupped Hand technique two further staff members (as a minimum) are required to negotiate a stairwell safely, one as a 'Bolster' leading the movement and direction of travel. And one maintaining the 'Stability' of the child/ staff members to the opposite side. Bolster person guidance - Side on, wide stance, neutral spine. Both hands make contact with the staff member holding the child , one hand to the shoulder and one to the belt area, keep the arm to the belt area slightly bent and the other straight and locked out, this is in order to lead the momentum of the escort down the stairs Stability person guidance - Side on, wide stance, neutral spine. Both hands make contact with the staff member holding the child (towards the top of the stairs) , one hand to the shoulder

	and one to the belt area, keep both arms bent in order to maintain stability of the staff and child being supported.
Use of voice	Calming using reassuring tone of voice as appropriate. Clear and concise communication essential when negotiating the stairs – See below.
Teamwork	Team work, communication and timing essential – 2 way. The person leading the negotiation of the stair well is the 'Bolster' person - Clear communication to be used 'Step' and 'Pause'
Leave option	If appropriate or necessary.
De-escalation	Use de escalation and defusion strategies as per individual behaviour support plan.

Risk Assessment Date: **April 2024**

Review Date: **April 2025**

PRICE TRAINING

The Technique Recap & Summary Risk Assessments are intended for reference purposes only and not as a self-teach aid or a substitute for comprehensive training. It is essential that the fidelity of a technique is not compromised, by way of modification or adaptation or an absence of contextual understanding.

Instructor Plus

Technique Recap and Summary Risk Assessment

Technique: Doorway negotiation (half scoop) — Phase Two

Suitable for use with (subject to individual behaviour support plan)	Adults	Young People	Children
	✓	✓	✓




Description	• Two person technique.
Purpose	• This technique allows staff members to remove a person from a room where necessary.
Effectiveness	• Medium to high effectiveness to a medium to high level of arousal. • Effective way of transitioning people through doorway avoiding the person placing their feet on the door posts.
Skill retention factors to consider	• Team-work, timing, and communication. • Moving the person safely in the engine and brake position. • Use the correct language as approaching the doorway i.e. preparing to post, "posting". • Stay in close to the person you are supporting and control a smooth transitional rotation through the doorway. • Keep all elbows in close to the body to avoid banging them on the door pillars.

Technique: Doorway negotiation (half scoop)	Phase Two

Potential Risks

Person we are supporting

- Falling over if the hips are not connected to the person when moving towards the door.
- Bruising to the elbows of the person and staff if they are not kept in close to the body when moving through the door.
- In terms of psychological impact, consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.

Support Workers

- Risk of person you are supporting breaking out of technique by continuously pushing forward.
- Due to the body positioning in this technique, there is:
- Risk from spitting by person we are supporting
- Risk of head -butt by person we are supporting
- Risk of scratching by the person we are supporting
- Risk of bites by person we are supporting

Date	May 2022

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Instructor Plus

Technique Recap and Summary Risk Assessment

Technique: Moving and seating the person — **Phase Two**

Suitable for use with (subject to individual behaviour support plan)	Adults	Young People	Children
	✓	✓	✓

Description	• Two person technique. • Moving and seating the person in a Phase Two technique i.e. Cupped Hand or Figure Four (Please note: **NOT** in a Standing Double Embrace).
Purpose	• To move the person we are supporting to a seated position in order to deescalate and phase down as appropriate.
Effectiveness	• Medium effectiveness.
Skill retention factors to consider	• Maintain the Phase Two technique i.e. Cupped Hand or Figure Four. • Ensure good communication with colleague (Engine and Brakes) the person who is 'braking' leads the technique. • Maintain good hip contact, leading leg slightly turned in and leading foot 'up on the toes'. • Push through the hips with a wide base and neutral spine. • As you reach the place to be seated (once the seat is directly behind the legs) start to bend forward slightly, sit down in a controlled motion whilst maintaining the Phase Two technique. • Once seated maintain hip contact and turn knee in slightly to reduce potential kicks. • Phase down as circumstances dictate.

Technique: Moving and seating the person	Phase Two

Potential Risks

Person we are supporting

- Low level risk of ligament sprain.
- Low level risk of nerve damage.
- Low level risk of the person we support becoming off balance if they have mobility issues.
- In terms of psychological impact, consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.

Support Workers

- Low level risk of ligament sprain.
- Low level risk of nerve damage.
- Low level risk of soft tissue damage.

Date	June 2021

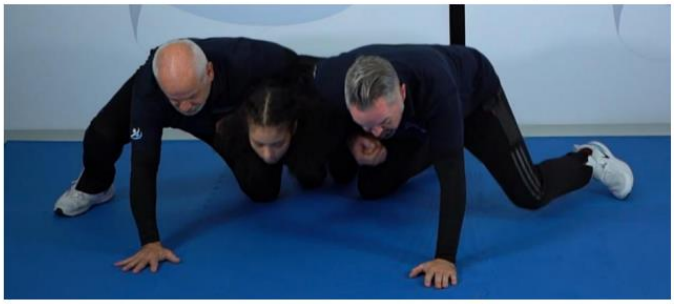
The Technique Recap & Summary Risk Assessments are intended for reference purposes only and not as a self-teach aid or a substitute for comprehensive training. It is essential that the fidelity of a technique is not compromised, by way of modification or adaptation or an absence of contextual understanding.

Advanced

Technique Recap and Summary Risk Assessment

Technique: Lower Rest Transition — **Phase One**

Suitable for use with (subject to individual behaviour support plan)	Adults	Young People	Children
	✓	✓	✓



Technique Recap and Summary Risk Assessment

Technique: Lower Rest Transition	Phase Two
Description	• Two person Phase Two transition technique.
Purpose	• To support a person to the floor safely to transition into a more supportive technique.
Effectiveness	• Medium to high level of effectiveness for a medium to high level of arousal.
Skill retention factors to consider	• As the person falls forward, trailing hand places on the floor at right angle, as does trailing foot. • Leading hand splints wrist (as per Cupped Hand). • Lower person gently onto forearms on leading arms. • In breast-stroke motion, bring person's arms out to the side of their body. • Rotate the person 180° onto their back, ensuring their face is upwards at all times.

Potential Risks

Person we are supporting

- Falling face down when transitioning from Safe Location to the Knees or Level 2 Straight Arm.
- Potential breathing difficulties when lying face down (for short time).
- Sprain of wrist if Cupped Hand is not splinted properly.
- In terms of psychological impact, consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.

Support Workers

- Falling face down when supporting person to the floor.
- Potential wrist damage when supporting person to the floor.

Date	July 2022

The Technique Recap & Summary Risk Assessments are intended for reference purposes only and not as a self-teach aid or a substitute for comprehensive training. It is essential that the fidelity of a technique is not compromised, by way of modification or adaptation or an absence of contextual understanding.

Advanced

Technique Recap and Summary Risk Assessment

Technique: Supine with Leg Support Two **Phase**

Suitable for use with (subject to individual behaviour support plan)	Adults	Young People	Children
	✓	✓	✓





Description	• Phase Two technique (can be 3 or 4 with Leg Support).
Purpose	• To support a person in distress on the floor who is presenting harm to themselves or to others.
Effectiveness	• High level of effectiveness in response to a high level of arousal. • Very effective in containing kicking of the legs.

Technique Recap and Summary Risk Assessment

Technique: Supine with Leg Support	**Phase Two**
Skill retention factors to consider	• Approach from the head, hands towards head. • Inside knee drops down near person's head. • Outside knee drops down and places in between person's elbow and wrist. • Guide the person's arm to the side of their body. • Leading arm hovers above the person's shoulder, arm straight. • Trailing arm places fingers underneath the person's forearm, arm straight resting on knuckles. • Heads interlock like a scrum with the tallest person facing the person being supported. **Leg Support:** • Approach from the side of the feet, hands in defensive stance towards the feet (twin walking stick block). • Drop knee down as arms go over the top of the person's legs (shins). • Scoop legs up as the knee goes underneath, head facing feet.

Potential Risks

Person we are supporting

- Potential breathing difficulties (due to being held on the floor).
- Pressure on joints if the hold is not maintained correctly.
- Potential for person to bang their head on the floor.
- In terms of psychological impact, consideration should be given to reconstructive anxieties and previous experiences in relation to trauma of the person being supported.

Support Workers
• Risk of the person breaking out of the hold if not done correctly. • Potential for staff to be spit at. • Potential to be kicked before legs are supported. • Potential damage/risk of sprain or dislocation to wrist if hold not applied correctly.
Date