Buckinghamshire
Learning Trust

Guidance on Physical Intervention for Early Years Providers

Introduction

This document has been produced to guide early years providers in developing their procedures about the physical handling of children.

The Statutory Framework for the Early Years Foundation Stage (2014) states:

Section 3 – The Safeguarding And Welfare Requirements – Managing Behaviour (page 26)

Managing behaviour

3.52. Providers are responsible for managing children's behaviour in an appropriate way. Providers must not give corporal punishment to a child. Providers must take all reasonable steps to ensure that corporal punishment is not given by any person who cares for or is in regular contact with a child, or by any person living or working in the premises where care is provided. Any early years provider who fails to meet these requirements commits an offence. A person will not be taken to have used corporal punishment (and therefore will not have committed an offence), where physical intervention[29] was taken for the purposes of averting immediate danger of personal injury to any person (including the child) or to manage a child's behaviour if absolutely necessary. Providers, including childminders, must keep a record of any occasion where physical intervention is used, and parents and/or carers must be informed on the same day, or as soon as reasonably practicable.

3.53. Providers must not threaten corporal punishment, and must not use or threaten any punishment which could adversely affect a child's well-being.

[29] Physical intervention is where practitioners use reasonable force to prevent children from injuring themselves or others or damaging property.

The use of this guidance will be supported by advice from the Buckinghamshire Learning Trust, Early Years Service.

Background

All staff within the provision aim to help children take responsibility for their own behaviour. This can be done through a combination of approaches which include:

- positive role modelling
- planning a range of interesting and challenging activities
- setting and enforcing appropriate boundaries and expectations
- providing positive feedback

However, there are very occasional times when a child's behaviour presents particular challenges that may require physical intervention. This guidance sets out expectations for the use of physical intervention.

Definitions

There are three main types of physical intervention:

1. *Positive handling:* The positive use of touch is a normal part of human interaction. Touch might be appropriate in a range of situations:
    - giving guidance to children (such as how to hold a paintbrush, or when climbing)
    - providing emotional support (such as placing an arm around a distressed child)
    - physical care (such as first aid or toileting)

Staff must exercise appropriate care when using touch. There are some children for whom touch would be inappropriate such as those with a history of physical or sexual abuse, or those from certain cultural groups. This is not intended to imply that staff should no longer touch children.

2. *Physical intervention:* Physical intervention can include mechanical and environmental means such as high chairs, stair gates or locked doors. These may be appropriate ways of ensuring a child's safety.
3. *Restrictive physical intervention:* This is when a member of staff uses physical force intentionally to restrict a child's movement against his or her will. In most cases this will be through the use of the adult's body rather than mechanical or environmental methods. This guidance refers mainly to the use of restrictive bodily physical intervention and is based on national guidance. (See Appendix 1).

Principles for the use of restrictive physical intervention

Firstly: Restrictive physical intervention should be used in the context of positive behaviour management approaches.

Providers must only use restrictive physical intervention in extreme circumstances. It must not be the preferred way of managing children's behaviour. Physical intervention should only be used in the context of a well-established and well implemented positive framework.

Providers aim to do all they can in order to avoid using restrictive physical intervention. However there are clearly rare situations of such extreme

danger that create an immediate need for the use of restrictive physical intervention. Restrictive physical intervention in these circumstances can be used with other strategies such as saying “stop”.

Secondly: paramount. Restrictive physical intervention will only be used when staff believe its use is in the child’s best interests: their needs are paramount.

Thirdly: duty of care. All staff have a duty of care towards the children in their provision. When children are in danger of hurting themselves, others or of causing significant damage to property, staff have a responsibility to intervene. In most cases, this involves an attempt to divert the child to another activity or a simple instruction to “stop!” However, if it is judged as necessary, staff may use restrictive physical intervention.

Fourthly: reasonable minimal force. When physical intervention is used, it is used within the principle of reasonable minimal force. This means using an amount of force in proportion to the circumstances. Staff should use as little restrictive force as necessary in order to maintain safety. Staff should use this for as short a period as possible.

When can restrictive physical intervention be used?

Restrictive physical intervention can be justified when:

- someone is injuring themselves or others
- someone is damaging property
- there is suspicion that, although injury, damage or other crime has not yet happened, it is about to happen

Staff might use restrictive physical intervention if a child is trying to leave the site and it is judged that the child would be at risk. Staff should also use other protective measures, such as securing the site and ensuring adequate staffing levels. This duty of care also extends beyond the site boundaries: when staff have control or charge of children off site (e.g. on trips).

There may be times when, restrictive physical intervention is justified but the situation might be made worse if restrictive physical intervention is used. If staff judge that restrictive physical intervention would make the situation worse, staff would not use it, but would do something else (like issue an instruction to stop, seek help, or make the area safe) consistent with their duty of care.

The aim in using restrictive physical intervention is to restore safety, both for

the child and those around him or her. Restrictive physical intervention must never be used out of anger, as a punishment or as an alternative to measures which are less intrusive and which staff judge would be effective.

Who can use restrictive physical intervention?

It is recommended that a member of staff who knows the child well is involved in a restrictive physical intervention. This person is most likely to be able to use other methods to support the child and keep them safe without using physical intervention. In an emergency, anyone can use restrictive physical intervention as long as it is consistent with the provider's policy and procedures.

Where individual children's behaviour means that there is a probable need to use restrictive physical intervention, the provider should identify staff who are most appropriate to be involved. It is important that such staff have received appropriate training and support in behaviour management as well as physical intervention. Staff and children's physical and emotional health is considered when such plans are made.

What type of restrictive physical intervention can and cannot be used?

Any use of physical intervention in a provision should be consistent with the principle of reasonable minimal force. Where it is judged that restrictive physical intervention is necessary, staff should:

- aim for side-by-side contact with the child; avoid positioning themselves in front (to reduce the risk of being kicked) or behind (to reduce the risk of allegations of sexual misconduct)
- aim for no gap between the adult's and child's body, where they are side by side; this minimises the risk of impact and damage
- aim to keep the adult's back as straight as possible
- beware in particular of head positioning, to avoid head butts from the child
- hold children by "long" bones, i.e. avoid grasping at joints where pain and damage are most likely
- ensure that there is no restriction to the child's ability to breathe; in particular, this means avoiding holding a child around the chest cavity or stomach
- avoid lifting children

Staff are not allowed to use seclusion (which is where children are forced to spend time alone in a locked room) except in an emergency situation. Restrictive physical intervention is not used to bring children to, or hold them in, time-out.

There may be situations where it is necessary for staff to receive specific training in the use of restrictive physical intervention. Where this is the case, the provider will only seek this training through a model that is accredited by BILD (British Institute of Learning Disabilities). Staff should have access to appropriate refresher training.

Planning

In an emergency, staff do their best within their duty of care and using reasonable minimal force. After an emergency, the situation is reviewed and plans for an appropriate future response are made. This will be based on a risk assessment which considers:

- what the risks are
- who is at risk and how
- what can be done to manage the risk

A risk assessment is used to help write the individual behaviour plan that is developed to support a child. If this behaviour plan includes restrictive physical intervention it will be just one part of a whole approach to supporting a child's behaviour. The behaviour plan should outline:

- an understanding of what the child is trying to achieve or communicate through their behaviour
- how the environment can be adapted to better meet the child's needs
- how the child can be taught and encouraged to use new, more appropriate behaviours
- how the child can be rewarded when he or she makes progress
- how staff respond when the child's behaviour is challenging (responsive strategies)

Staff should pay particular attention to responsive strategies. There are a range of approaches such as humour, distraction, relocation, and offering choices which are direct alternatives to using restrictive physical intervention.

The physical intervention policy should state that responsive strategies are chosen in the light of a risk assessment, which considers:

- the risks presented by the child's behaviour
- the potential targets of such risks
- preventive and responsive strategies to manage these risks

The provider will draw from as many different viewpoints as possible when it is known that an individual child's behaviour is likely to require some form of restrictive physical intervention. In particular, the child's parents/carers will be involved with staff from the provision who work with the child, and any visiting support staff (such as the Buckinghamshire Learning Trust Early Years Service, Educational Psychologists, Speech and Language Therapists and Social Workers). The outcome from these planning meetings will be recorded and a signature will be sought from the parent/carer to confirm their knowledge of the planned approach. These plans will be reviewed at least once every four to six months, or more frequently if there are major changes to the child's circumstances.

Recording and reporting

It is important that any use of restrictive physical intervention is recorded. This should be done as soon as possible and within 24 hours of the incident. According to the nature of the incident, the incident should be noted in other records, such as the accident book or child tracking sheets. (See Appendix 2)

After using restrictive physical intervention, a provider should inform the parents by phone (or by letter or note home with the child if this is not possible). Parents should be given a copy of the record form. The head of the provision should also be informed.

Supporting and reviewing

It is distressing to be involved in a restrictive physical intervention, whether as the person doing the holding, the child being held, or someone observing or hearing about what has happened. After a restrictive physical intervention, support is given to the child so that they can understand why they were held. A record is kept about how the child felt about this where this is possible (See Appendix 3). Where appropriate, staff may have the same sort of conversations with other children who observed what happened. In all cases, staff should wait until the child has calmed down enough to be able to talk

productively and understand this conversation. If necessary, an independent member of staff will check for injury and provide appropriate first aid.

Support should be given to the adults who were involved, either actively or as observers. The adults should be given the chance to talk through what has happened with the most appropriate person from the staff team.

A key aim of after-incident support is to repair any potential strain to the relationship between the child and the adult that restrained him or her. After a restrictive physical intervention, staff consider reviewing the individual behaviour plan so that the risk of needing to use restrictive physical intervention again is reduced.

Monitoring

Monitoring the use of restrictive physical intervention will help identify trends and therefore help develop the provider's ability to meet the needs of children without using restrictive physical intervention.

Complaints

The use of physical intervention can lead to allegations of inappropriate or excessive use. Where anyone (child, carer, staff member or visitor) has a concern, this should be dealt with through the provider's usual complaints procedure.

Appendix One

Background to this policy guidance

Acknowledgement is made to Hampshire County Council whose Physical Handing Policy forms the basis of this document.

This guidance has been written to support providers in fulfilling the Statutory Framework for the Early Years Foundation Stage (Safeguarding and welfare requirements: managing behaviour).

This guidance has been written in the light of more specific guidance that is available to schools. The main national guidance is:

- DfEE circular 10/98, which refers to section 550A of the Education Act 1996
- Department for Education and Skills/Department of Health (2002) *Guidance on the Use of Restrictive Physical Interventions for Staff Working with Children and Adults who Display Extreme Behaviour in Association with Learning Disability and/or Autistic Spectrum Disorders*
- Department for Education and Skills (2003) *Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties*
- Department for Education (2012) *Use of reasonable force - Advice for head teachers, staff and governing bodies*

We note that this refers only to maintained schools. This policy guidance therefore sees the above guidance as indicating good practice rather than applying directly to early years providers.

The main legislative context for this policy guidance comes from Health and Safety at Work legislation (1974 & 1999) and the Criminal Law Act (1967).

Appendix Two

Record form for physical intervention

Name of child:	**Date:**
Member of staff:	**Time:**
Reason physical intervention was used:	
Type & duration of physical intervention used:	
Injuries caused during the incident and who injured (if applicable):	
Post incident support:	"Supporting a child after a physical intervention" form completed? **YES / NO**
Additional comments:	
Member of staff signature:	
Report shared with parents / carers **Parents / carers signature:**	**Date:**

Appendix Three

Support after a physical intervention

Physical intervention is distressing both for adults and the children who are restrained. It can also be distressing to observe an incident where physical intervention has been necessary. Following such incidents, it is important to support and "debrief" those involved. The Life Space Interview can be used below as a framework for this purpose. Adaptations should be made to reflect the age and understanding of the children who are being supported.

Supporting a child after a physical intervention

What happened? (The child's view)
What happened? (The adult's view)
Looking for patterns
Planning for the future
Child's printed name …….. Signature (if appropriate) …….. Adult printed name …….. Signature …….. Incident date ……Incident time ……..

Life Space Interview

The Life Space Interview (LSI) was developed by Fritz Redl, an Austrian psychoanalyst. With his colleague David Wineman, he thought that all children and young people, including those with challenging behaviour, possess the ability to understand and change their behaviour. In particular, he saw crises (such as those involving physical intervention) as opportunities for the child to learn new ways of behaving, provided that appropriate support was available. A provider should make sure that this support is provided when the child has calmed sufficiently to be able to reflect on what has happened – this may be as much as 90 minutes or more after the event has finished.

This process can be remembered through the acronym **I ESCAPE**

Isolate the child

Explore the child's view **S**hare the adult view **C**onnect with other events

Alternatives – consider other possibilities

Plan how the alternatives might be put into place

Enter the normal routine

Although the precise method will vary with the child, LSI process can be recorded through the record form at the end of this document.

Steps in the Life Space Interview

Isolate the child – find a quiet place so that the chid can think and talk about what has happened. This has nothing to do with punishing, but with reducing the amount of distraction and stimulation, in order to maximise the chances of a helpful conversation.

Explore the child's view. This stage comes before sharing the adult view, as the child will feel most willing to receive this after they feel that they have been listened to with respect and without interruption or correction. This involves listening to their perception of what happened, and encouraging the child to reflect on the result of the behaviour that they chose. The child should be encouraged to think about whether they feel their choices were good.

Share the adult view. The LSI process recognises that there will be more than one point of view. This is the stage for the adult to explain why certain

courses of action were taken, and to share their views about how they interpreted and reacted to the situation. If there was more than one adult involved (including those involved as observers) it is important to include all adults in the LSI process.

Connect with other events that the child has managed well, or not so well, so that the child can look for patterns that help make sense of what happened, and which offer hope of different solutions. The child should be helped to look for a connection between what they thought, how they felt, and what action they took. (This stage is called "Looking for patterns" on the record sheet.)

Alternatives – what other options are available to the child if they face a similar situation again? Discussion about the child's view of how adults can best support them in similar situations can be included here. This will offer an insight into the most appropriate "reactive strategies" for responding to difficulties in future.

Plan by choosing the best option from the alternatives, and discussing what role the child, and those around him or her, can have. How will new skills be taught and practised? How will the child be rewarded and supported in following the plan? (This stage, and the alternatives stage, are summarised under "Planning for the future" on the record sheet. There is a clear link between these plans and any approaches recorded on the individual behaviour plan.)

Enter the normal routine that the child follows, at a time when it is easier to rejoin the group.