

Policy on the Use of Physical Interventions

Introduction

This policy and associated procedures relate to the use of physical interventions in CEDA, for the purpose of:

- Making the use of restrictive physical intervention safe, relevant, and practical for staff and service users.
- Meeting the requirements of Section 7 of the Local Authority and Social Services Act 1970.

The book *"Physical Interventions: A Policy Framework"* (British Institute of Learning Difficulties, 1996) underpins this policy and the practice that will be adopted. Main factors underpinning the British Institute of Learning Difficulties framework are to ensure that physical interventions are used as infrequently as possible, are only employed in the best interest of the service user, and when physical interventions are used everything possible is done to prevent injury and to maintain dignity for all concerned.

There is a common misconception that any restrictive physical contact during the course of your work is in some way unlawful. The reality is that where necessary, reasonable force can be used to control or restrain people at risk or posing a risk to others, in a pre-agreed manner. However the law does forbid a member of staff from using any degree of physical contact which is deliberately intended to punish, or primarily intended to cause pain, injury or humiliation. Members of staff, and service users and their families should know what is acceptable and what is unacceptable.

Defining Physical Intervention

In this document, the term 'Physical Intervention' refers to a range of physical actions used as techniques for responding to challenging behaviour and involving some degree of direct physical force to limit or restrict movement or mobility, which can include removal of an aid to mobility, normally used by that person.

There are three main types of physical intervention:

- Direct physical contact between a member of a staff and a service user. Examples include holding another person by the arm to stop self-harm, using manual guidance to stop a person wandering into the road, or two people each holding a person and guiding him or her to a seat, if agitated.
- The use of barriers to limit freedom of movement, for example placing door catches beyond the reach of service users.
- Materials or equipment which restricts or prevents movement. Examples include using a splint to limit the movement of an arm or leg.

Physical intervention implies restriction of a person's movement maintained against resistance. It is, therefore, qualitatively different from forms of physical contact such as manual prompting, physical guidance or simply support.

Over time, the term 'restraint' has acquired a number of negative connotations. It is also a term that is closely linked with a particular kind of approach to the management of aggressive and violent behaviour - 'Control and Restraint', or 'C and R'. For this reason, this document uses the more neutral term 'physical intervention', to indicate a continuum between touching, holding and restraint, and the link with other approaches of de-escalation to be used in conjunction with physical interventions at all times.

Aims of the Policy

Implementation of this policy will help services to address important outcomes for service users - choice, rights, independence and inclusion - as outlined in policy principles and in other key documents, such as the Learning Disability Strategy. It will contribute to joint working with other agencies, particularly joint care planning, joint investment plans and risk assessments. The guidance reflects new standards on the use of physical interventions, which form part of the implementation of the Care Standards Act (2000). The safety of staff during physical interventions is of equal importance to the best interests of service users, and both take priority over the care of property which can be replaced. Other sanctions can be implemented for property destruction which may be less risky than physical intervention at the time. The British Institute of Learning Disabilities policy framework and Devon County Council Social Services stipulate certain principles and values. Hence use of physical intervention needs to be consistent with the approach that service users:

- Are treated fairly and with courtesy and respect.
- Can lead an independent life and are enabled to do so.
- Are helped to make choices and involved in decisions which affect their lives, consistent with their interests, culture and wellbeing.
- Are entitled to the protection of the law.
- Must have their rights upheld regardless of their ethnic origin, gender, sexuality, impairment, disability or age.
- Are encouraged to develop a proper awareness of their rights and responsibilities, and to respect the rights of others.

Scope of the Policy

The policy applies to all CEDA employed staff and managers in the use of physical interventions for adults, people with learning disabilities, and children. All staff will be trained appropriately in physical interventions. The main policy and related guidance relates to all service users that could be subject to a physical intervention.

National Policy and Legal Context

The use of physical interventions involves important legal and ethical considerations, which need to be fully explored by the service concerned. Any physical intervention must employ the minimum level of force, for the least amount of time needed. It cannot be used solely to force compliance with staff instructions, unless refusal to comply would lead to safety being seriously compromised and probable

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injury. This goes against guidance from Sir Herbert Laming, 1997, in 'The Control of Children in Public Care: Interpretation of the Children Act 1989'.

It is a criminal offence to use physical force, or to act in a way that leads another person to apprehend the use of force (for example, by raising a fist or issuing a verbal threat), unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Such justification may be to prevent an injury to oneself or to others or to prevent serious damage to property. In these circumstances, a reasonable amount of force may be used.

The use of any degree of force is unlawful if the particular circumstances do not warrant such use. Therefore physical force could not be justified to prevent a service user from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force. The degree of force employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. The degree of force and the duration of its application should always be the minimum needed to achieve the desired result. Often it is a matter of patience and time; and our job is to give that patience and time, instead of reflecting back negative patterns of resolving issues that children in particular have seen elsewhere, and using violence. Trust will take time to build.

Justification also includes the right of every citizen to 'self defence', which applies for all situations for all staff and service users. The force used in any instance must be appropriate for the circumstances, to be justifiable in court.

It is an offence to lock an adult or child in a room without a court order (even if they are not aware that they are locked in) except in an emergency when the use of a locked room as a temporary measure while seeking assistance would provide legal justification. However there are instances where an adult or child could be at risk due to lack of awareness of danger, which could provide a reason for restriction to a room or area. This use needs to be part of a care plan and risk assessment, not an 'ad hoc' solution. To the extent that seclusion involves restricting a person's freedom of movement, it can be considered a form of physical intervention. The use of seclusion for people detained under the Mental Health Act (1983) is set out in the Code of Practice published in 1999.

Under The Children Act (1989) restriction of liberty of children being looked after by a local authority is only permissible in very specific circumstances - for example, when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation.

Justification (as a legal defence) for using physical interventions needs to address these questions:

- Is there clarity about how the intervention helps the person concerned?
- Are there any conflicts of interest where staff experience fewer demands or less stress when physical interventions are used?



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- What steps have been taken to reduce the likelihood that the physical intervention will be used in the future?
- Is the justification for this service user specifically, or for 'all' in group?

Under health and safety legislation, employers are responsible for the health, safety and welfare of employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of physical interventions. Employers need to establish and monitor safe systems of work, and to ensure employees are suitably trained. Use of physical intervention may give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned, making proper training and use imperative.

Providers of health and social care services owe a duty of care towards service users which requires that reasonable measures to prevent harm are taken. Hence, in some circumstances, it may be appropriate to employ certain kinds of physical intervention to prevent a significant risk of harm. Physical interventions ought only to be used when other strategies have been tried and found to be unsuccessful, or when the risks of not employing an emergency intervention are outweighed by the risks of using one. The physical intervention needs to use the minimum force to prevent injury or to avert serious damage to property, and be applied for the minimum amount of time.

Use of physical interventions needs to be consistent with the Human Rights Act (1998) and the United Nations Convention on the Rights of the Child (ratified 1991). These are based on the presumption that every person is entitled to:

- Respect for his or her private life.
- The right not to be subjected to inhuman or degrading treatment.
- The right to liberty and security.
- The right not to be discriminated against in his / her enjoyment of those rights.

Physical interventions need to be service user specific, integrated with other less intrusive approaches, and clearly part of a care plan approach to reduce risk, when needed. They must not become a standard way of coping, as a substitute for training in people related skills.

Other Organisations and Consistency

Linking with the book "*Physical Interventions: A Policy Framework*" (British Institute of Learning Disabilities 1996), and this policy framework, should ensure that CEDA is in line with Devon County Council and NHS Partnership Trusts.

Furthermore, CEDA recognises its general duty of care as well as its duties under the Health and Safety at Work etc Act 1974 to ensure that it safeguards the health, safety and welfare of its staff and others affected by its work, whilst meeting its other legal responsibilities.



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Using Physical Interventions - Operational Requirements and Context

Physical interventions need to be used in a context of risk assessment, correct use of interventions, reporting intervention use and associated incidents, investigation and follow-up, ensuring staff or service users get sufficient post-intervention support, review or risk assessments to identify factors contributing to incidents, and associated action to reduce those risks.

Badly used, restrictive physical intervention, particularly prone restraint, is a source of danger to both service users and staff. It is also a possible threat to the organisation via legal action, either by staff or service users. It can also escalate negative staff and service user relationships, when used inappropriately. The correct use of physical intervention can help with staff safety and general service user well-being. However its use is always problematic, in that there is some element of risk. This needs to be acknowledged and recognised, with restrictive physical intervention remaining an act of last resort rather than common practice.

A major concern in using Physical Interventions, particularly any more forceful restraint, is that the person may be moved from the room, before being calmed down. This is very likely to lead to injury to staff. In these situations, other service users must be moved and the person being restrained not moved to another room prematurely. However the prone restraint itself cannot be unduly long so release the person and see reactions, rather than trying to move too early, or move the person into a less restrictive position but in the same room and location. Prone restraint should not be more than 10 to 15 minutes, without medical supervision. Premature 'movement' of the service user into another room is extremely risky to staff and likely to cause serious back or other injuries.

Practice Requirements - Good Working Practice to Reduce Need for Physical Interventions

For each service user who presents a challenge there need to be individualised strategies for responding to incidents of violence and aggression. Where appropriate the strategy should include directions for using physical intervention, including a personalised approach for this service user.

The use of physical interventions needs to be minimised by adopting good working practices involving primary and secondary preventative strategies, outlined in **Prevention of Situations Needing an Intervention**.

Primary prevention is achieved by analysing the interaction between each service user and his or her environment. This discovers triggers, which need to be avoided at critical periods. This involves:

- Helping service users avoid situations known to provoke violence or aggression.
- Having care programmes which are responsive to individual needs.
- Creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement.
- Developing staff expertise in working with people who present challenges.



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Secondary prevention involves recognising the early stages of a situation or behavioural sequence which is likely to develop into violence or aggression and employing 'defusing' techniques to avert any further escalation.

All prevention strategies should be carefully selected and reviewed to ensure that they do not unnecessarily constrain opportunities or have an adverse effect on the service users welfare or quality of life. In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities which might provoke challenging behaviours compared to the impact on the person's overall quality of life if such activities are prohibited. This judgement is likely to require a detailed risk assessment.

Types of Incident for which Physical Interventions may be used

There are a wide variety of situations in which physical intervention might be appropriate or necessary. These will fall into three broad categories:

- Planned intervention
- Unplanned / emergency intervention
- As part of a therapeutic or educational strategy

Examples of situations in which physical intervention may be used are:

- To prevent a service user from running toward a busy road.
- To prevent a service user from self-injuring or from injuring another person.
- To prevent an adult or child causing serious damage to property.

Physical intervention solely to enforce compliance with staff instructions, in situations which present little risk, is unacceptable.

Before intervening physically a staff member should, wherever practicable, attempt to resolve the situation by other means. The staff member should continue attempting to communicate with the service user throughout the incident, and should make it clear that the physical intervention will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff members should never give the impression that they have lost their temper, or are acting out of anger or frustration.

Prevention of injury can also include restraint as preventive measure, for example if a young person attempts to get hold of an object for a weapon, which would make later restraint problematic and dangerous to staff.

Protection of property must only be for extreme circumstances; for example if a person starts 'trashing' an entire unit. At this stage there needs to be a risk assessment on whether or not it is worth the risk of injury, to protect property. Maintaining 'order' is not a valid reason for intervention at this stage. There are options such as putting curtains / posters up with Velcro, or developing non-physical 'reward' and

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'sanctions' systems. In extreme circumstances, such as realistically immediately threatened arson or where life is at risk, the police are obliged to attend if you make the extremity clear to them.

Planned Physical Intervention

Pre-arranged strategies and methods to deal with a situation should be planned where a risk assessment has identified the likelihood of the need for physical intervention. For certain situations, an earlier intervention might be more effective, and be able to be implemented at a lower level and with less risk, than a later intervention. This use of intervention needs to be incorporated into planning.

Planned physical interventions should be:

- Agreed in advance by relevant professionals working in consultation with the service user, his or her carers, an independent advocate if appropriate and, in the case of a child, those with parental responsibility.
- Implemented under the supervision of an identified member of staff who has relevant qualifications, training and experience.
- Recorded in writing so that the method of physical intervention and the circumstances when its use has been agreed are clearly understood.
- Included as part of the care plan or individual service plan.
- Routinely reviewed.

Where planned physical interventions are employed, they should be just one component of a broader approach to meeting that person's needs.

Unplanned and Emergency Use of Physical Interventions

Emergency use of physical interventions may be required when service users behave in unforeseen ways. Research evidence shows that injuries to staff and to service users are more likely to occur when physical interventions are used in an emergency.

An effective risk assessment procedure together with well-planned preventative strategies will help to keep emergency use of physical interventions to an absolute minimum. However, staff should be aware that in an emergency the use of reasonable force is permissible if it is the only way to prevent injury or serious damage to property. In the event of a service user leaving to commit a crime, the advantage of explaining the consequences, and explaining that you will phone the police as soon as they leave, is that the service user will make a choice, and may choose to stay (particularly if offered alternatives).

Even in an emergency, the force used must be "reasonable", that is, it should be proportionate to the risk posed by the situation. The staff member or members concerned should be confident that the potential adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences which would have occurred without the use of a physical intervention. The use of time and patience can help in many situations.



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Sometimes, for personal safety reasons, a staff member should not intervene in an unplanned situation without help. Some situations when this might apply are:

- If dealing with a physically large service user or more than one service user.
- Where an intervention technique cannot be applied safely by one person.
- If the staff member believes he or she may be at risk of serious injury.

In these circumstances the staff member should, as appropriate, remove other people who might be at risk, summon assistance from colleagues, or where necessary phone the police. Until assistance arrives the staff member should continue to try to prevent the incident from escalating whilst remaining mindful of their own safety. It may be appropriate for staff to withdraw from the situation.

Proactive use of Physical Intervention as Part of a Therapeutic or Educational Strategy

In most circumstances, physical interventions will be used reactively, to prevent injury or to avoid serious damage to property. Occasionally, it may be agreed to be in the best interests of the child or adult to use a physical intervention involving the use of some degree of control as part of a therapeutic or educational strategy.

For example, a way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of physical intervention employed according to the child's behaviour. Similarly, it might be agreed that staff use a physical intervention as part of an agreed strategy to help a person who is gradually learning to control their aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy. Such use must never be painful or likely to cause injury.

Where this approach is employed it is important to establish in writing a clear rationale for the use of the physical intervention and to have this endorsed by a multidisciplinary committee which includes, wherever possible, family members and/or an independent advocate.

The service user should agree physical interventions used for learning. Where consent cannot be gained for reasons of mental incapacity then decisions made following the principle contained within "Making Decisions" the Government's proposals for making decisions on behalf of mentally incapacitated adults, is followed for adults.

Procedural Requirements - Risk Assessment

Whenever it is foreseeable that a service user might require a physical intervention, a risk assessment needs to be carried out. This identifies the benefits and risks associated with different intervention strategies and ways of supporting the person concerned. It is essential that the outcome of any assessment is made known to all relevant staff and other parties.

- The assessment process is the same as for assessing any other form of risk. For this:

- Involve key people external to the service such as field social workers, a specialist challenging behaviour nurse, a psychologist, or similar.
- Use an appropriate risk assessment form.
- Identify behaviour and settings which result in harm or damage.
- Determine how likely an incident needing physical intervention is to occur.
- Identify degree of potential harm / damage resulting from not intervening.
- Assess the non-intervention situation as high, medium, or low risk.
- Where possible and especially for high or medium risks, identify strategies for reducing the risk including, if needed, physical intervention.
- Re-assess the risk taking these strategies into account.
- If within acceptable levels write up appropriate section on service plan. If not possible to reduce risks to acceptable levels, refer to line manager.
- Agree a review date in line with the protocol within your service.
- Implement necessary training.

When the need for physical intervention is agreed, it is important that appropriate steps are taken to minimise risks to staff and service users.

Among the main risks to service users are that a physical intervention will:

- Cause pain, distress or psychological trauma.
- Cause injury.
- Be used when less intrusive methods could have achieved the desired outcome.
- Become a routine, rather than an exceptional method of management.
- Increase the risk of abuse.
- Undermine the dignity or otherwise humiliate or degrade those involved.
- Create distrust and undermine personal relationships with staff / adults.

The main risks to staff are that as a result of applying a physical intervention:

- They suffer injury.
- They experience distress or psychological trauma.
- The legal justification for using physical intervention is challenged in court.
- Disciplinary action is taken for inappropriate or unjustified use of physical interventions.

Consent

According to the UKCC Guidelines for Mental Health and Learning Disabilities:

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"First is that you must act in the best interests of the client, obtain consent before you give any treatment or care. Secondly, you must ensure that the process of establishing consent is rigorous, transparent and demonstrates a clear level of professional accountability. Thirdly, all discussions and decisions relating to obtaining consent must be recorded accurately."

Valid consent consists of three elements:

- It is given by a competent person, who may be a person lawfully appointed on behalf of the service user.
- It is given voluntarily.
- It is informed.

The criteria for whether or not a service user is competent will depend on whether or not they understand and retain relevant information, and can weigh it up to make an informed choice. For people with a learning disability, or other people with communication difficulties, access to advocacy services and total communication methods may be needed for facilitating consent. Any physical intervention procedure must identify if the service user is able to consent and has been consulted about the use of physical intervention.

Information relating to care and control should be discussed with the service user and their families or carers prior to the admission to the home or service unit. All service users potentially requiring a physical intervention should have a care plan and a risk management plan. All parties should be in agreement with the care plan, or if not, differences of opinion must be documented.

For children accommodated by CEDA, parental consent must be obtained; however parents must also realise the consequences of consent being refused. In the case of children accommodated by CEDA, parents need to be made fully aware of the rules of conduct and the practices of the home, and their consent should be obtained for agreed physical interventions.

Restraint must be in a way that recognises previous injuries, disabilities and personal susceptibilities and vulnerability. Therefore an agreed 'handling plan' must be developed, in negotiation with the service user that will reduce the negative impact of any physical intervention. This involves developing agreed holds, for if that person needs it. This must be adhered to where possible, and staff, including relief staff, advised of the intervention strategy.

Medication

Medication should never be used as a sole method of gaining control over a person who displays violent or aggressive behaviour, but part of a holistic care plan. Medication should only be administered upon medical advice and reviewed annually, and not used as a routine method of managing difficult behaviour.

Devices for Restricting Movement



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Devices that are required for a therapeutic purpose for a disabled adult or child, such as buggies, wheelchairs and standing frames (including any supporting harness) may also restrict movement. Such devices should never be provided solely for the purpose of preventing problem behaviour, although in extreme circumstances, they might be used as a last resort to reduce risks.

Some devices are designed specifically to prevent problem behaviours and their use must be considered a form of physical intervention. For example, arm splints or protective garments might be used to prevent self-injury. Such devices should be seen as a last resort and used only when other preventative strategies have not proved successful. They should only be introduced after a multidisciplinary assessment that includes consultation with family carers and, in the case of children, those with parental responsibility. If employed they should be selected carefully to impose the least restriction of movement required to prevent harm while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions.

Recording

If it is agreed that a child or adult will require some form of physical intervention, there must be an up-to-date copy of a written protocol included in the person's individual care plan, including:

- A description of behaviour sequences and settings which may require a physical intervention response.
- The results of an assessment to determine any counter reasons for the use of physical interventions.
- A risk assessment which balances the risk of using a physical intervention against the risk of not using a physical intervention.
- A record of the views of those with parental responsibility in the case of children and family members or independent advocates in the case of adults.
- A system of recording behaviours and the use of physical interventions.
- Previous methods which have been tried without success.
- A description of the specific physical intervention techniques which are agreed and the dates on which they will be reviewed.
- The ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

The use of a restrictive physical intervention, whether planned or unplanned (emergency) must, as a minimum, always be recorded in an incident book with numbered pages. In some cases, interventions will need to be reported immediately to line management and where this is the case, managers must ensure all staff are aware of when and how to do so.

The written record should indicate:

- The names of the staff and service users involved.



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- The reason for using a physical intervention (rather than another strategy).
- The type of physical intervention employed.
- The date and the duration of the physical intervention.
- Whether the service user or anyone else experienced injury or distress and, if they did, what action was taken?

The contents of the Physical Interventions incident book should be reviewed on a monthly basis and appropriate action taken.

Action to Take Following Physical Interventions

If there is any reason to suspect that a service user or a member of staff has experienced injury or severe distress following the use of a physical intervention, that person must receive immediate medical help or counselling and debriefing, as required? The use of immediate support can prevent the event becoming 'set' in a person's mind, and contributing to a post-traumatic stress disorder via repetition.

Being involved in physical interventions may be an unsettling experience for all parties and managers should recognise that staff and service users may need some form of reassurance. If an intervention has involved the use of force to an extent that someone has been injured, or claims to have been injured, then medical attention / examination should be an immediate priority. People involved, both staff and service users, should be separately debriefed after the intervention, which is particularly important when the intervention was unplanned.

Any concern about the validity or method of intervention should be thoroughly investigated. This includes using interventions when other methods would have been slower but still got there, using interventions to maintain 'discipline', and using interventions for a sense of 'control' over the person. Such investigations should seek to protect the safety and well-being of staff and service user alike. Managers need to ensure that an individual's care plan is reviewed in the light of any intervention, if required.

Reviewing Risk Assessments

It is essential that following an intervention the risk assessment be reviewed. It may be necessary to call a formal risk assessment review meeting and revise the risk assessment and management plan.

Investigation of the use of physical intervention needs to address:

- Trends, such as certain staff - service user personality dynamics, over time.
- Surrounding factors contributing to the incident.
- What happened in the days and hours beforehand, and look for triggers or contributing factors.

Staff need to be constantly addressing these issues through in-house training and team discussions, so that they have a consistent team approach to making sound judgements and implementing methods of care, control and intervention.

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The staff member and manager may agree a need to alter work duties as a result of the incident. This should be done such that the member of staff is not put under duress or made to feel guilty.

Guidelines on Using Interventions

The term physical intervention is used to describe both appropriate and inappropriate methods of restricting movement. Methods of physical intervention that might, under certain circumstances, be appropriate include:

- Two or more members of staff holding a service user to prevent them from assaulting somebody.
- Using a safe hold on a smaller child intent on hitting people or destroying everything in sight, until he or she calms down, while listening to the child.

Where possible, it is preferable to grasp clothes or hold arms and / or legs still. It may prove necessary to grasp other parts of the body, (avoiding genital areas) but this should be transferred to limbs or clothes as soon as it is safe to do so. While the grip should be firm, it should not inflict pain.

Methods of physical intervention that are potentially dangerous include:

- One or more members of staff sitting on a service user.
- The use of clothing or belts to restrict movement.
- Any procedure which involves pressure against the joints.
- Any procedure which restricts breathing or impacts upon the airways.

To the extent that seclusion involves restricting a person's freedom of movement, it is also a form of physical intervention. The use of seclusion for people detained under the Mental Health Act (1983) is set out in the Code of Practice in 1999.

Physical interventions are usually employed by staff or carers to gain control over behaviour that is likely to cause injury to people or animals, or serious damage to property. If the violence is solely directed at property, employees should only attempt to control it if there is no personal risk. Property is expendable! Talking or careful listening, as appropriate, is a very effective way of helping a client to keep self control by expressing him or her self in other ways.

Physical interventions need to be introduced as part of a 'graduated response'. This seeks to establish a 'gradient of control'. That is, when staff respond to challenging behaviour, they follow a pre-determined sequence which begins with the application of the least restrictive options and gradually increases the level of restriction. The sequence is terminated as soon as control is established over a person's behaviour. Low levels of force and less intrusive measures are likely to be effective early on while physical management may become the only option if the situation escalates. The use of de-escalation needs to continue throughout. Except in extreme emergencies, physical interventions need only be used after less intrusive methods have been explored fully, and found to be inadequate.



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Prevention of Situations Needing an Intervention

The use of physical interventions should be at as low a level as possible along a continuum of control, discussed above, and should be minimised by the adoption of primary and secondary preventative strategies included within the risk assessment and management plan (SS12/SS12(a) - Adults, SS(C)12 - Children).

Primary prevention is achieved by proper management of environmental setting conditions as they interact with personal setting conditions. Environmental setting conditions are the factors in a person's environment, such as providing enough activities. Personal setting conditions are a person's physical and psychological make-up. Personal setting conditions could be communication difficulties, history of trauma or abuse, or dementia. A combination of wrong setting conditions, plus a trigger event, is likely to lead to an incident.

Primary prevention is achieved by:

- Changing aspects of a person's living and working environment to reduce the likelihood of challenging behaviour occurring.
- Helping service users and staff to avoid situations which are known to provoke violent or aggressive behaviour for example intrusion on personal space.
- Care plans that are responsive to individual needs.
- Creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement.
- Developing staff expertise in working with service users who present challenging or problematic behaviours.
- Preventing a build-up by being aware of personal 'triggers'.
- Being aware of the person's boundaries, as he or she may need to feel some control over his or her physical environment for personal security.
- Developing Relationships between staff and service users based on honesty, mutual respect and good practice.

Control is more likely to be achieved where there is a structure to the service user's day, with the correct balance between free and controlled time. For this reason liaison with other agencies, for example, schools for statemented children, is essential, preferably in advance of the placement.

Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing techniques to defuse / avert any further escalation. Secondary prevention procedures are designed to ensure the proper management of problematic episodes, using non-physical interventions aimed to reduce the likelihood of a person becoming violent and aggressive.



**Patrons- Roger Jefcoate CBE &
County Councillor Saxon Spence CBE**

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Creating Opportunities with Disabled People

For secondary prevention techniques, staff can:

- Make options available so a person isn't boxed into a corner, including a person not being 'psychologically' boxed into winning a confrontation.
- Be aware of the physical proximity; will that person be reassured by contact or does he or she need space.
- Reduce demands on the person as much as possible.
- Change the people who are with the person.
- Talk to the person about their concerns and how these could be overcome.
- Verbally request a person to stop doing destructive behaviours.
- Use 'tangents' such as distraction, changing topics, changing setting.
- Remove any 'audience' so the person can back down.

All prevention strategies should be carefully selected and reviewed to ensure that they do not unnecessarily constrain opportunities or have an adverse effect on the service users welfare or quality of life.



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