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Physical handling guidance for Early Years Settings

Introduction

This document has been produced to guide Camp Glide's staff about physical handling and intervention.

Camp Glide's staff within the setting 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 handling. This guidance sets out expectations for the use of physical handling.

Definitions

There are three main types of physical intervention:

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 is further guidance in the Child Protection policy written by each setting). 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. The setting's policy is not intended to imply that staff should no longer touch children.

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.

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 5.

Principles for the use of restrictive physical intervention

The principles underpinning the use of restrictive physical intervention.

Firstly: the behaviour management policy and the physical handling policy need to state that restrictive physical handling should be used in the context of positive behaviour management approaches.

Settings must only use restrictive physical intervention in extreme circumstances. It must not be the preferred way of managing children's behaviour. The setting's policies need to recognise that physical intervention should only be used in the context of a well-established and well implemented positive framework. It is important to describe the setting's approach to promoting positive behaviour in the behaviour management policy.

Camp Glide aims to do all it 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: duty of care. The physical handling policy should state that all staff have a duty of care towards the children in their setting. 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.

Thirdly: reasonable minimal force. The physical handling policy should state that when physical intervention is used, it is used within the principle of reasonable minimal force. 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.

Who can use restrictive physical intervention?

The physical handling policy states that any staff member 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 setting's policy.

Where individual children's behaviour means that they are likely to require restrictive physical intervention, staff should identify members 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. The physical handling policy needs to emphasise that staff and children's physical and emotional health is considered when such plans are made.

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 or damage has not yet happened, it is at immediate risk of occurring.

Camp Glide has a duty of care that means staff might have to 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.

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

Any use of physical intervention in a setting 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.

(See Appendix 1: Summary guidance for staff on the use of physical intervention.)

Camp Glide will identify and arrange access to appropriate staff training (e.g. Positive Approaches to Challenging Behaviour, Managing Behaviour in the Early Years in house training DVD, IDP behaviour training materials)

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:

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

A risk assessment is used to help write the individual behaviour plan that is developed to support a child. If a 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 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).

(See Appendix 2 Guidance on writing a behaviour plan and ABCC chart)

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.

Camp Glide 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 setting who work with the child and any visiting support staff (such as Area InCos, Educational Psychologists, Portage, the Behaviour Support Team, Speech and Language Therapists and Social Care team). 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

Camp Glide has recording and reporting procedures. It is important that any use of restrictive physical intervention is recorded. The records will show who was involved

(child and staff, including observers), the reason physical intervention was considered appropriate, how the child was held, when it happened (date and time) and for how long, any subsequent injury or distress and what was done in relation to this. (See Appendix 3.) 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.

After using restrictive physical intervention, a setting should inform the parents by phone if they judge it is appropriate to do so (or by letter home with the child if this is not possible). Parents should be given a copy of the record form. The setting manager and the local authority (where required) should also be informed.

Supporting and reviewing

Camp Glide recognises that 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. The policy should state that 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 4). Staff should help the child to record their views. 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 is 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. The policy should emphasise that 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

The Camp Glide Director is responsible for reviewing the policy[1] and that the policy is reviewed at least annually, and more often if needed. Camp Glide has the opportunity to seek support from the Area InCo where appropriate and this should be noted. The policy should specify that monitoring the use of restrictive physical intervention will help identify trends and therefore help develop the setting's ability to meet the needs of children without using restrictive physical intervention.

[1] This should be a member of staff working with someone from the management committee.

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 setting's usual complaints procedure.

Appendix One

Summary guidance for staff on the use of physical intervention

Introduction

This guidance for staff is a summary of our setting's detailed policy on the use of physical intervention. Where staff are in any doubt about the use of physical intervention, they should refer to the full policy.

This summary guidance refers to the use of restrictive physical intervention (restraint) which we define as "when a member of staff uses force intentionally to restrict a child's movement against his or her will". Staff should not feel inhibited from providing physical intervention under other circumstances, such as providing physical support or emotional comfort where such support is professionally appropriate. The use of such support must be consistent with our Child Protection policy.

Who can restrain? Under what circumstances can restraint be used?

Everyone has the right to use reasonable force to prevent actual or potential injury to people or damage to property (Common law power). Injury to people can include situations where a child's behaviour is putting him or herself at risk. In all situations, staff should always aim to use a less intrusive technique (such as issuing direct instructions, clearing the space of danger or seeking additional support) unless they judge that using such a technique is likely to make the situation worse.

Restraint should never be used as a substitute for good behaviour management, nor should it be employed in an angry, frustrated, threatening or punishing manner.

Although all staff have a duty of care to take appropriate steps in a dangerous situation, this does not mean that they have to use restraint if they judge that their attempts to do so are likely to escalate the situation. They may instead issue a direction to stop, call for additional assistance or take appropriate action to make the environment as safe as possible (e.g. by clearing the room of children).

Where it is anticipated that an individual child's behaviour makes it likely that they may be restrained, a risk assessment and intervention plan should be developed and implemented.

What type of restraint can be used?

Any use of restrictive physical intervention should be consistent with the principle of reasonable force. This means it needs to be in proportion to the risks of the situation,

and that as little force is used as possible, for as short a period of time, in order to restore safety. Staff should:

Before physical contact:

Use all reasonable efforts to avoid the use of physical intervention to manage children's behaviour. This includes issuing verbal instructions and a warning of an intention to intervene physically.

Try to summon additional support before intervening. Such support may simply be present as an observer, or may be ready to give additional physical support as necessary.

Be aware of personal space and the way that physical risks increase when a member of staff enters the personal space of a distressed or angry child. (Staff should also note that any uninvited interference with a child's property may be interpreted by them as an invasion of their personal space.) Staff should either stay well away, or close the gap between themselves and the child very rapidly, without leaving a "buffer zone" in which they can get punched or kicked.

Avoid using a "frontal", "squaring up" approach, which exposes the sensitive parts of the body, and which may be perceived as threatening. Instead, staff should adopt a sideways stance, with their feet in a wide, stable base. This keeps the head in a safer position, as well as turning the sensitive parts of the body away from punches or kicks. Hands should be kept visible, using open palms to communicate lack of threat.

Where physical contact is necessary:

Aim for side-by-side contact with the child. Staff should avoid positioning themselves in front of the child (to reduce the risk of being kicked) and should also avoid adopting a position from behind that might lead to allegations of sexual misconduct. In the side-by-side position, staff should aim to have no gap between the adult's and child's body. This minimises the risk of impact and damage.

Aim to keep the adult's back as straight and aligned (untwisted) as possible. We acknowledge that this is difficult, given that the children we work with are frequently smaller than us.

Beware in particular of head positioning, to avoid clashes of heads with the child.

Hold children by "long" bones, i.e. avoid grasping at joints where pain and damage are most likely. For example, staff should aim to hold on the forearm or upper arm rather than the hand, elbow or shoulder. 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.

Do all that they can to avoid lifting children.

Keep talking to the child (for example, “When you stop kicking me, I will release my hold”) unless it is judged that continuing communications is likely to make the situation worse.

Don’t expect the child to apologise or show remorse as many young children do not understand the difference between accidental and deliberate hurt.

Use as little restrictive force as is necessary in order to maintain safety and for as short a period of time as possible.

In very extreme circumstances 2 members of staff might be necessary to ensure safety.

After an incident:

It is distressing to be involved in a restrictive physical intervention, whether as the child being held, the person doing the holding, or someone observing or hearing about what has happened. All those involved in the incident should receive support to help them talk about what has happened and, where necessary, record their views.

Staff should inform the setting manager as soon as possible after an incident of restrictive physical intervention; parents/carers should also be informed. The physical intervention record sheet should be completed as soon as possible and in any event by 24 hours of the incident. There should also be a review following the incident so that lessons can be learned to reduce the likelihood of recurrence in the future.

Appendix 2

Writing a Behaviour Plan guidance & ABCC chart

Behaviour Plans ensure consistency when managing a child’s behaviour and help us to look at things we can change to support a child rather than trying to change the child.

We look at three areas. **environment, teaching new skills, praise and reward.**

Environment. The environment we provide has a direct impact on a child’s behaviour. We need to consider what can we do or change in the environment to support the child. E.g. How practitioners are deployed at possible trigger times, visual support, organisation of routines and or resources.

Teaching new skills. After identifying from the ABCC chart what the child is trying to communicate through their behaviour we can identify what new skills the child needs to learn. E.g. unable to listen to a whole large group story but through observations we know the child is able to listen to a story in a one to one situation. We can teach the child with small steps to listen to a group story. First small step is for the child to sit with one or two other children. When this is achieved slowly add more children to

the group. This way you are teaching the child a new skill but ensuring success. This may also be a target for the Individual Education Plan.

Praise and rewards. This ensures everyone is praising the child when they are working towards their new skills and reminds us to constantly look for the positive behaviours and not focus on the negatives. Rewards have to be motivating to the child so gather information about what the child likes. For some it is simply recognition from the practitioner through a smile or pat on the back. Others may need more tangible rewards e.g. time to play with a special toy or opportunity to do a special job. Ensure the reward remains motivating. This may need to be reviewed and changed over time. When giving praise be specific so the child knows the praise is for them and why you are pleased with them. E.g. rather than say ‘good boy’ say ‘Thank you Jack for tidying up the cars, that was very helpful’.

Reactive Strategies

If the child behaves inappropriately it is important to have a plan of how the practitioners will react in a consistent way to support the child. Plan together as a team including parents and carers and ensure everyone is comfortable with the plan and confident to carry it through.

The plan should be dated and signed by setting and parent/carer and a review date set.

Working closely with parents, seeking their views and gathering key information to plan the way forward is always easier if a good relationship is established from the beginning- sharing good news as well as bad. The ‘Good News’ sandwich is a sensitive way to share concerns with parents. Start by sharing a positive followed by the concern and finish with a positive. Even the most challenging children will do something positive during the session and it is essential that practitioners look for the positives rather than focus on the negatives and share these with parents.

Have a positive attitude, think about what is happening when the child behaves appropriately.

ABCC Chart
Name of Child ……...

Appendix 3 :Restrictive Intervention Record Form

Date/Time	A	B	C	C
	Antecedents	Behaviour	Consequences	Communicative Function
	What is going on beforehand?	What did the child do?	What was the result for the child?	What would the child have said?

Setting name …… EY Ofsted No ……

Name of child ……..……Age ……

Is this child a looked after child/SEN/vulnerability? ……

When did the incident occur?

Date	Day of week	Time	Where?

Staff involved

Name	Designation	Team Teach trained?	Involved: physically? (P) as observer? (O)	Staff signature

Please describe the incident and include:
1. What was happening before? 2. What do you think triggered this behaviour? 3. What de-escalating techniques were used prior to restrictive physical intervention (RPI) ? 4. Why was a RPI deemed necessary? 5. Any other information relevant to include.

Please give details below of how the child was held
……

How long was the child held?
……

What was the child's body position relative to the adult involved?
……..

Has the child been held on previous occasions?……

Good practice dictates that early years provisions should review what happened and consider what lessons can be learned, which may have implications for the future management of the child. These need not be added to this form but should be incorporated in the individual plans for the child.

A child should have an individual behaviour plan clearly detailing reactive strategies and physical intervention approaches if they have been involved in physical interventions on more than one occasion.

Does the behaviour plan need to be reviewed as a result of this incident? Yes/No

Does the risk assessment need to be reviewed as a result of this incident?
Yes/No

If yes, who will action and when? (less than four weeks)

Who was the incident reported to, and when?
……

……
……

Was there any medical intervention needed? Yes/No

Include names of any injured person and brief details of injuries
……

……
……

……
……

Please specify any related record forms

Accident Book ☐ Complaints record ☐

Skin Map ☐ Incident Record ☐

Other (please specify)
……

Life space interview

Was the child debriefed?	Yes/No
Were staff offered a debrief?	Yes/No
Was it taken up?	Yes/No

Parents/carers were informed

Date	Time	By whom?	By direct contact, telephone, letter?

Form completed by:	Name	Designation	Date and time

Manager's signature
……..

Appendix 4 : Support after an incident Life Space Interview

Physical intervention is distressing both for adults and the children and young people 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 and young people who are being supported.

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 setting 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

Share the adult view

Connect with other events

Alternatives – consider other possibilities

Plan how the alternatives might be put into place

Enter the normal routine

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.

Appendix 5 : Background to this policy guidance

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

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* LEA 0242/2002

Department for Education and Skills (2003) *Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties* LEA 0264/2003

Education and Inspections Act (2006)

Department for Education (August 2011) *Use of Reasonable Force*

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

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