**Physical Handling Policy**

All staff at the AYA 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 handling:

*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 *Safeguarding Children Policy*). 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.

**Principles for the use of restrictive physical intervention**

Restrictive physical handling should be used in the context of positive behaviour management approaches.

In our setting, we would only use restrictive physical intervention in extreme circumstances. It is not our preferred way of managing children's behaviour. In our setting we recognise that physical intervention should only be used in the context of a well established and well implemented positive framework. In our setting, we promote positive behaviour as is described in our behaviour management policy.

Our setting 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".

In our setting, restrictive physical intervention will only be used when staff believe its use is in the child's best interests: their needs are paramount.In our setting, all staff have a duty of care towards the children. 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.

In our setting, 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 will use as little restrictive force as necessary in order to maintain safety. Staff will use this for as short a period as possible.

Physical intervention can be used 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.

Duty of care means that staff might also use restrictive physical intervention if a child is trying to leave the setting and it is judged that the child would be at risk. However, other positive measures, such as securing the setting and ensuring adequate staffing levels are also used. This duty of care is also extended to trips.

In our setting, staff would firstly issue an instruction to stop, seek help, or make the area safe, consistent with their duty of care, before using restrictive physical intervention.

Our aim in using restrictive physical intervention is to restore safety, both for the child and those around him or her. Restrictive physical intervention is never 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?**

In our setting 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 our setting's policy.

Where individual children's behaviour means that they are likely to require restrictive physical intervention, staff will identify members who are most appropriate to be involved. We will ensure that 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 our setting will be consistent with the principle of reasonable minimal force. Where it is judged that restrictive physical intervention is necessary, staff will:

* 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.

In our setting, staff do not use seclusion (which is where children are forced to spend time alone in a locked room). Restrictive physical intervention is not used to bring children to, or hold them in, time-ou

**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).

In our setting, staff pay particular attention to responsive strategies and use a range of approaches such as humour, distraction, relocation, and offering choices which are direct alternatives to using restrictive physical intervention. 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

Our setting 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 SENCOs, Educational Psychologists, Portage Plus workers, the Behaviour Support Team, Speech and Language Therapists and Social Workers). The outcome from these planning meetings will be recorded and 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**

In our setting, it is important that any use of restrictive physical intervention is recorded in the Incident Book. The records will show: who was involved (child and staff, including observers); the reasons physical intervention was considered appropriate; how the child was held, when it happened (date and time) and for how long; any injuries or subsequent distress, and what was done in relation to this. 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.

After using restrictive physical intervention, our setting will inform the parents by phone and on collection. The head of the setting and the local authority (where required) should also be informed.

**Supporting and reviewing**

In our setting, we are aware 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. 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. Where appropriate, staff may have the same sort of conversations with other children who observed what happened. In all cases, staff will 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 will 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**

The policy is reviewed at least every two years and more often if needed. 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.

**Complaints**

Where anyone (child, carer, staff member or visitor) has a concern, this should be dealt with through the setting's usual complaints procedure.

| This policy was adopted by: AYA | Date: 01/09/23 |
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| To be reviewed: 01/09/24 | Signed |