Organisational Restrictive Physical Intervention Policy

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Fair Ways Vision, Mission and Values (2024)

Our vision
To build a community that changes lives, makes a difference to society and leaves a legacy greater than ourselves and our contributions.

Our mission
To grow a compassionate, resilient, and trauma-informed community, that embraces learning, so that we improve the lives and outcomes of individuals.

Our values
Our values form the heart of the work we do, defined by Fair Ways people, for Fair Ways people. These are the values by which we operate, by which we are governed, and to which we are held accountable.

We therefore expect every individual within Fair Ways to *play their part*:

PROFESSIONAL	**A**CCEPTING	**R**EFLECTIVE	**T**RANSPARENT
· We do what we say we will. · We approach challenges with optimism and enthusiasm. · We don't judge, we notice. · We put the needs of the service before our own personal gains.	· We don't give up on people. · We value all individuals and are willing to challenge them. · We embrace each other's differences as much as our similarities. · We accept responsibility for our actions.	· We give feedback, we invite feedback, we listen to feedback. · We look inward before we look outward. · We learn as much from our mistakes as from our successes. · We listen to each other, learn from each other and grow together.	· We are always willing to explain why. · We have the courage to be open and honest. · We earn trust through our transparency. · We live by our values even when no-one is watching.

1 Introduction and Aim

1.1 Fair Ways provides regulated (Ofsted, CIW) social care and education services. This policy aims to provide a guidance for how *Restrictive Physical Intervention (RPI)* can be used to keep children and young people (individuals we care for) and staff safe from harm.

2 Scope

2.1 This policy applies to the following services in the organisation that may need to use a RPI:

- Fair Ways Education: Swanwick, Fort Wallington and GLADE School
- Residential Solent homes: Portchester Road, Manor Farm Cottage and Garden House
- Residential Wales: Ty Ros Bach, Birch Grove and Fair Ways Outdoor Adventures

2.2 All services have local policies and procedures for support their individuals with dysregulation and guidance in how to respond to behaviours of concern, that include ways of responding that do not include RPI. These documents should be used in conjunction with this policy.

3 Definition

3.1 It is likely that the individuals living or being educated in these services have trauma in their history, experience mental health, learning, or neurodevelopmental difficulties. Therefore, our individuals can struggle with regulating their emotions and behaviour which can lead to them finding everyday interactions or tasks distressing or confusing. Staff will frequently support individuals who are emotionally dysregulated, distressed, or angry and that individual may present with a behaviour of concern that could lead to serious harm or increase the likelihood of serious harm coming to themselves, or other people around them. All individuals have a right to be treated with respect and dignity, deserve to have their needs recognised and be given the right support. Each individual we support, will have in place, an Individualised Support Plan (ISP) or care plan and relevant risk assessments to support their individual needs. However, on occasions, Restrictive Physical Intervention (RPI) may be needed as a **last resort** to effectively **keep everyone safe.**

3.2 **Restrictive Physical Intervention can be defined as:**

"Any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement."

(Restraint Reduction Network 2019)

'An act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently, which should only occur to prevent harm of injury when necessary.'

(Welsh Government, 2016)

"Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- *Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken.*
- *End or significantly reduce the danger to the person or others.*
- *Contain or limit the person's freedom for no longer than necessary".*

(Department of Health 2014)

3.3 **The Use of Restraint**

The Children's Homes Regulations 2015, is very clear on the use of restraint for children's homes:

"Restraint in relation to a child is only permitted for the purpose of preventing injury to any person (including the child) and serious damage to property. Restraint in relation to a child, must be necessary and proportionate"

The Department for Education is also very clear on the use of restraint in schools, guidance states:

"There are circumstances when it is appropriate for staff in schools to use reasonable force to safeguard children. The term 'reasonable force' covers the broad range of actions used by staff that involve a degree of physical contact to control or restrain children. 'Reasonable' in these circumstances means 'using no more force than is needed'.

"Members of staff have the power to use reasonable force to prevent pupils committing an offence, injuring themselves or others, or damaging property and to maintain good order and discipline at the school or among pupils."

(Behaviour in Schools Guidance 2022)

The Department for Education, Use of Reasonable Force:

"Reasonable force can be used to prevent pupils from hurting themselves or others, from damaging property, or from causing disorder. In a school force is used for two main purposes – to control pupils or to restrain them."

(Use of reasonable force, Department of Education 2013)

HM Government advises that:

"*Restrictive intervention should only be used, when necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution,*

and we are particularly concerned about long-term or institutionalized uses of restrictive interventions."

(Reducing the Need for Restraint and Restrictive Intervention 2019)

4 Legal Framework

4.1 The use of all forms of restrictive physical intervention and physical contact are governed by criminal and civil law. The unwanted or inappropriate use of force may constitute an assault and may also infringe a child or young person's rights under the Human Rights Act 1998. The use of restraint can be justified for purposes set out in relevant legislation and different settings.

4.2 When implementing this organisational policy, the following legal, guidance frameworks have been taken into account:

- Behaviour in Schools Guidance (Department for Education 2022)
- 'Reducing Restrictive Practice Framework - Guidance on reducing restrictive practices in childcare, education, health and social care setting.' (Welsh Government 2022)
- Social Care Wales 'Positive approaches: reducing restrictive practices in social care', (version 2 November 2021)
- Reducing the Need for Restraint and Restrictive Intervention (HM Government 2019).
- Restraint Reduction Network Training Standards (RRN 2019).
- Positive environments where children can flourish - A guide for inspectors about physical intervention and restrictions of liberty (Ofsted March 2018).
- Residential Care in England – Report of Sir Martin Narey's independent review of children's residential care (July 2016).
- Guide to the children's homes regulations including the quality standards. (Department of Education 2015).
- Positive and Proactive Care: reducing the need for restrictive interventions. (Department of Health 2014).
- Use of reasonable force – advice for head teachers, staff, and governing bodies. (Department of Education 2013).
- Human Rights Framework for Restraint: principles for lawful use of physical, chemical, mechanical and coercive restrictive interventions (EHRC 2019).

5 Planned and Unplanned Interventions

5.1 In this policy the term 'planned restrictive physical intervention' means a restrictive intervention that has been discussed and agreed as a way of responding to a potential behaviour of concern and is documented as part an individual's support plan. An 'unplanned restrictive intervention' is when a restrictive intervention is used as a response to an

unexpected incident. The use of the restrictive intervention should be recorded and reviewed shortly afterwards.

5.2 A planned or unplanned interventions should never involve any coercion, pain compliance, be a punishment or seek to gain compliancy of any individual.

6 Deciding to use Physical Intervention

6.1 The decision on whether to physically intervene is down to the professional judgment of the team member involved and should always depend on the individual circumstances.

6.2 Any physical intervention should be considered only as a last resort, ensuring that all other avenues of supporting that individual have been exhausted or the only possible immediate action, are taken to prevent serious harm from happening to that individual or others around them.

6.3 Situations can rapidly change and will demand different responses; therefore, it is not possible to list which circumstances warrant physical intervention. However, the degree and duration of any force must be proportionate to the circumstances that are trying to prevent, and no more force than necessary should be used. This will be the minimum amount of force necessary to avert injury or serious damage to property applied for the shortest possible time.

6.4 Any attempt to physically hold another person carries risk including physical injury, positional asphyxiation, emotional or psychological disturbances and is known to be traumatic for both parties. In all situations, the use of restrictive physical intervention must be based on a dynamic risk assessment being carried out by the member(s) of staff making the decision. During dynamic risk assessments the following ought to be considered:

- The risks of not intervening
- What possible action is in the best interest of the individual or those around them
- The individual's previously sought views on what can help them de-escalate and regulate
- Have other strategies, that are outlined in their support plan been attempted?
- The size and age of the person being supported
- The level of understanding of the person being supported
- Any disability, health concern or medication of the person being supported
- The staff members knowledge of previous similar experiences and the outcomes learned from them
- Which method of physical intervention would likely be safest and most successful in the specific circumstances?
- The impact of the physical intervention, on the relationship between the individual and the team member(s) intervening.

6.5 It must be possible to demonstrate that, unless immediate physical intervention is taken, there are specific indicators that show injury is likely. This rational must be documented on the recording of any RPI.

Before using RPI, team members should consider the following questions to determine the lawful excuse and to assess if it may be reasonable to use physical intervention.

1) Is it necessary to act immediately to prevent an individual from injuring themselves, others or from seriously damaging property, which would result in harm?
2) (a) Is the intervention the LAST **RESORT?** Have all other non-physical methods of de-escalation, been tried and have failed?
   (b) Is the intervention in the **BEST INTERESTS** of the child
   (c) How will **REASONABLE FORCE** be used?
   (d) Could **GREATER HARM** occur if the intervention is not initiated?
   (e) Is the intervention **PROPORTIONATE** to what you are trying to prevent happening?
   (f) Is it the team members **HONEST HELD BELIEF** that if they do not act then injury to any individual is likely to happen, taking into consideration their knowledge of the individual and the information they have in that moment.
3) If the answer to the questions from (a) and (f) is "yes", it may be reasonable to use physical intervention.

7 A Positive and proactive approach to Behaviour Support

7.1 We promote teams to work positively and confidently with the individuals they support and find the most compassionate and least intrusive way possible to support. Using techniques that can de-escalate behaviours of concern, and tackle the reasons for it at source, is the preferred approach. We are committed to reducing the need for restrictive interventions, with an emphasis of safety as the first priority. In keeping with guidance from Positive Environments where Children can Flourish March 2018 and Reducing Restrictive Practices Framework, 2000, we agree that the foundation of good practice in reducing RPI with our individuals includes:

- **Building Trusting Relationships**: Establishing trust and understanding with individuals.
- **Understanding Triggers**: Identifying triggers and finding effective solutions.
- **De-escalation**: Defusing situations and regulating the individual where possible.
- **Behaviour Reflection**: Understanding the meaning behind behaviours of concern and reflecting on team attitudes.
- **Person-Centered Planning**: Tailoring support to the individual, focusing on relationships and personal needs.
- **Skills Assessment**: Identifying communication through behaviours of concern and unmet needs.
- **Individual Support Plans (ISP)**: Developing plans to address challenges and support individuals' needs.
- **Training and Development**: Ongoing training for staff to ensure best practice.
- **Risk Assessment**: Identifying and managing potential risks.
- **Positive Lifestyle Outcomes**: Promoting strategies to enhance individuals' well-being.

- **Family and Professional Involvement**: Engaging families and networks in support planning.
- **Advocacy Access**: Ensuring individuals have access to advocacy services.
- **Governance and Oversight**: Ensuring effective leadership and monitoring of practices.
- **Legislative Compliance**: Adhering to policies and procedures based on relevant legislation.
- **Reporting and Recording**: Ensuring accurate and effective documentation.
- **Supervision and Debriefing**: Providing regular support and reflection for teams.
- **Human Rights**: Respecting human rights in the use of restrictive practices.
- **Trauma-Informed Practice**: Understanding and applying trauma-informed approaches.
- **Proactive Interventions**: Focusing on strategies that improve well-being and reduce restrictive practices.

8 Staff Training

8.1 Fair Ways have developed a certificated in-house trauma and attachment focused, behaviour support programme RiiSE (Relationship Inspired Ideas for Supportive Environments) which will be delivered to all staff. The RiiSE mission is to 'educate and inspire people to add value and positively contribute to improve the health and wellbeing of the lives of Fair Ways community every day.' RiiSE has eight core values, which are depicted as anchors, as follows:

1. We support Human Rights of all.
2. We aim for non-violence.
3. We stop and think before we act, to achieve the best outcome for everyone involved.
4. We help people to make sense of and manage emotions and feelings.
5. We recognise that everyone is different.
6. We focus on connection.
7. We look back and think forward.
8. We take the perspective of others.

8.2 RiiSE is certificated by the British Institute of Learning Disabilities Association of Certified Training (BILD ACT) and adheres to the Restraint Reduction Network (RRN) standards. RiiSE offers a range of physical techniques including breakaways, disengagement techniques, guiding and escorting, one and two person techniques, transitions, enhanced techniques.

8.3 It is mandatory for all team members working at the services specified in this policy attend RiiSE foundation training. Course delivery will differ in length of delivery to meet the varied needs of specific services for the purposes of this policy the team members all attend a five-day full foundation course. All RiiSE courses are delivered by a Senior RiiSE Coach and/or RiiSE inhouse Coaches. Theory is a core element of the content for the majority of curricular, with time frames indicating level of restrictive physical intervention delivered.

The RiiSE philosophy is that positive relationships are the key to healing, we seek to empower our employees to be compassionate, curious, reflective, relational, and inclusive. To then use these skills to be able to move from 'knowing' to 'doing' with confidence to become skilful trauma-responsive professionals. RiiSE emphasises the use of primary and secondary de-

escalation techniques focusing on building positive relationships to reduce the need for physical intervention.

8.4 Prior to attending a RiiSE Foundation course, all team members will be required to undertake a RiiSE Keep Yourself Safe (KYS) course with their in-house RiiSE Coach, where competency on a small selection of RPIs will be assessed. This KYS course should be completed within the first four weeks of employment, with attendance on a RiiSE foundation course to be completed within eight weeks of the KYS course. The KYS course is only a short introduction to the skills, knowledge and understanding required to physically keep individuals safe if they exhibit behaviours of concern that could result in harm to themselves or others. KYS in **no way** replaces the RiiSE foundation course. Limited physical interventions, and/or disengagement interventions will be assessed, and team members will only be able to *assist* a qualified RiiSE team member with these specific signed off physical techniques. In addition to completing the KYS course, the team member's line manager completes a RiiSE risk assessment.

8.5 All direct working team members must attend an annual two-day RiiSE refresher course. Team members can only use RiiSE techniques if they have been signed off as competent, this information is stored centrally by the training team and completion of refreshers is recorded on the services training matrix.

Failure to attend or gain the refresher will result in the requirement to attend a KYS course, which will be valid for 3 months, where only specific techniques will be signed off, until a refresher can be attended.

8.6 Only techniques that a team member has been 'signed off' as competent are permitted to use or assist in the use of Restrictive Physical Interventions. Physical techniques should only be used as a last resort, when other de-escalation approaches, not involving the use of force, have been tried and failed or are judged unlikely to succeed. RiiSE physical techniques must always be seen in the context of maintaining positive therapeutic, trauma informed relationships with individuals we care for whilst striving to meet positive outcomes for them.

8.7 RiiSE provides a framework, in line with the RRN, that actively supports the reduction of the use of physical interventions, individual's unique Individual Support Plans (ISP) should detail which RPI techniques are to be followed in line with this.

8.8 Fair Ways Restraint Reduction Plan (Appendix A) critically reviews the approaches available to reduce the use of restrictive interventions and considers how these approaches can be embedded within Fair Ways. It focusses on a whole-team approach in creating restraint free services, built on continuous learning and improvement.

8.9 Services that use physical interventions that are nonrestrictive will be taught RiiSE 'disengagement' techniques (non-restrictive physical interventions). When to use a nonrestrictive technique applies the same decision making and priority of safety for each

unique situation and information for these services are specified in their policies in responding to behaviours of concern.

9 RiiSE Enhanced Physical Techniques

9.1 There may be some services that may require RiiSE Enhanced Physical Techniques due to the risks being presented by an individual. RiiSE Enhanced physical techniques will only be taught as a bespoke workshop in response to an individualised situation with the intention of short-term solution on a 'case to case' basis and should only be implemented when all other RiiSE techniques are not deemed sufficient by the lead RiiSE coach after consultation. RiiSE Enhanced physical techniques can **ONLY** be used in supporting children and young people where the current RiiSE Techniques, when applied correctly, are not sufficient to keep everyone **SAFE**. This decision is made on an individual basis and any techniques taught to any staff member can only be used on the child or young person in discussion. There will always been a 'withdrawal plan' to support the reduction of enhanced techniques.

9.2 Unplanned RiiSE Enhanced Physical Techniques can be used once in an emergency situation. After this, due to there being a foreseeable risk the RiiSE Enhanced Protocol should be implemented.

10. Risk Assessment of RiiSE Physical Techniques

10.1 All RiiSE physical techniques have been risk assessed to consider the following:

- Risk of injury to staff using the technique within a training course (no resistance)
- Risk of injury to staff when used in the workplace (with resistance)
- Risk of injury to the person being physically held (with resistance)
- Resistance may result in a person experiencing pain.
- This technique uses a locking movement.
- Technique may cause pressure on throat, chest, abdomen and may restrict breathing.
- Trainability and complexity of the technique, including the level of skills, coordination and fitness required to conduct the technique correctly.
- Risk factors for medical conditions such as medical obesity, anorexia, physical disability, tactile defensiveness, ataxia, visual impairment, breathing problems, fragile bones, or issues specific to a named individual which may elevate risk.
- Risk of psychological or emotional harm or re-traumatisation
- Fragility of technique, which is the extent to which risks may be elevated and safety compromised by any margin of error in application.
- Compromises the dignity of the person.
- Compromises the principles of good moving and handling.

- Circulation, including reference to any general potential risk factors such as limb position and body weight being used to hold someone, or issues specific to a named individual which may elevate risk.
- Joint functioning, as well as reference to any general potential risk factors such as the hyperextension and hyperflexion of joints and the unauthorised adaptation of techniques or issues specific to a named individual which may elevate risk.
- Potential for the techniques to intentionally inflict pain, with the use of pain compliance as a means of control.
- Potential involvement of sensitive areas of person's body (neck, chest, sexual areas)

10.2 If any individual has a change to their health status during an RPI or outside of an RPI but the health change could increase their risk of harm during an RPI the **Protocol for Temporary, Sudden, Unexpected Changes in Medical Status or Pre-Existing medical conditions and use of Restrictive Physical Intervention (RPI) must be followed. See Appendix D**

11. Monitoring and after Care Support for the individual, team members and witnesses involved in an incident of RPI

11.1 It is important to recognise, that any physical intervention or restrictive practice can be traumatising for everyone involved; the individual, the team supporting them and also any witnesses to the event. It is known that these practices can have long term negative consequences on health and wellbeing of individuals have a negative impact on the team members that carry them out. Even if an individual appears well following an intervention, they may be experiencing continued feelings of shame, anger, rejection, loss, or hopelessness. Support for team members should be available should they want to seek this from their line manager.

11.2 Individual Support Plans must state how they will be supported, and their safety and welfare monitored, following a physical intervention. For example, through further discussion about their feelings, distraction with an activity, some quiet time on their own, 1:1 time with trusted adults or a phone call to a family member.

11.3 Any individual should be monitored and observed above and beyond normal measures, following a physical intervention. Special consideration should be taken if a physical intervention has taken place in the evening. Communication between homes and schools should be a priority.

11.4 For an individual at risk of self-harm, the period following a physical intervention may be a particularly vulnerable one and attention should be made in monitoring the emotional wellbeing of these individuals.

11.5 Thorough and accurate communication between home and education settings, should describe any event of physical intervention and need for additional monitoring, during information handovers.

11.6 Following every incident, involving the use of RPI a re-attunement session must be completed as soon as is practicable. The goals of the re-attunement are to:

1. Continue supporting emotional wellbeing of the individual
2. Repairing any rupture to relationships
3. Listen to their perspective of what happened and share the team's experience
4. Support the individual to 'put things right' i.e., fix something they damaged, tidy up, show someone they are sorry
5. Explore with them what happened and help them to make links between their emotions, feelings, and actions
6. Identify alternative strategies for them to use
7. Develop a plan to re-enter them back into the setting
8. Learn from the experience and make plans to decrease the likelihood of the same situation happening again.

11.7 The re-attunement is paramount in re-establishing relationships with the individual with the intention of identifying strategies to reduce the need of RPI.

11.8 Any new strategies suggested in the re-attunement should be updated in the individual's support plans or risk assessment and shared with all team members.

11.9 Teams should also have an opportunity to discuss, defuse and debrief the incident as soon as practicable. This should provide opportunity to discuss teams' feelings about the incident, use this for team support, but also to look at underlying causes, how the techniques were used (and their effectiveness) and to develop a strategy for future incidents. Best practice is for you to use an After Incident Debrief (AID) (Appendix B).

11.10 Individual team members can talk directly to the Manager within 48 hours of an incident or request a 1:1 debrief from the Therapeutic Hub. Team members can also contact the EAP for additional support.

11.11 Good quality debriefing and follow-up action is essential after any incident requiring the use of RPI. The process can have a significant emotional impact on the staff and the young person involved and all should be given the opportunity to talk through the incident and deal with the feelings it may have aroused. Witnessing someone being held can have a significant impact on an individual and consideration should also be given to the needs of the individual and team members not directly involved in the RPI, but who may nonetheless have been affected by it.

11.12 The service's RiiSE coach can facilitate an in-depth additional reflection session if required and a RiiSE coach from another service can help support a formal debrief if necessary or helpful after a significant incident.

12 Recording the use of Restrictive Physical Intervention (RPI)

12.1 All incidents requiring the use of RPI strategies should be recorded in the individual's file in Clear Care on a 'Restrictive Physical Intervention' log or an 'Incident' log for any disengagement techniques. The record should be completed as soon as possible, but no later than 24 hours following the incident. Where appropriate, the individual must be actively encouraged to read, comment, and sign the record.

The description of the incident must include:

- Where it occurred
- Events leading up to the behaviour that required the use of RPI.
- Specific descriptions of the actual behaviour requiring intervention was (i.e. general descriptions like 'he became physically aggressive' are not descriptive enough)
- What the perceived or actual danger arising from the behaviour was
- What serious harm to self or others was being prevented
- Why any action taken was deemed necessary, reasonable, and proportionate.
- What other methods of intervention and de-escalation were tried or considered
- What techniques were used, by who and for how long, and in what location.
- Whether or not the intervention was pre-arranged as part of the child or young adult's support plans
- Who else was present and witnessed the incident or assisted with the RPI.
- What follow-up action was taken or is proposed in respect of counselling.
- Any injury that occurred to anyone involved
- What work was / will be done with the child or young adult as a result of the incident (including care planning / revision of individual risk management plan)
- The record should receive comment by the manager confirming oversight with any actions required.

11.2 If a staff member raises an issue after an RPI or incident and feels they need emotional support, then the manager or Head Teacher must make contact to offer support within one working day of the recording. The staff members will then be given the opportunity for a personalised debrief and to explore alternative support options, including access to employee support services.

11.3 RPI recording should be monitored by the Manager of the service or Head Teacher to identify any trends or recent developments. The record must also be made available to Ofsted during an inspection and any persons conducting independent persons visits.

11.4 Where necessary; all records of incidents should be sent to parents / carers and if the child or young person is under the care of the Local Authority, the nominated Social Worker.

11.5 All children and young people within regulated children's home should ensure they have access to an independent Advocacy. They have the right to access this on-going support to ensure their individual needs, feelings and perspectives are considered and listened to. It is the Manager's responsibility to ensure this service is available to all children and young people in his / her care.

13 Governance and Monitoring

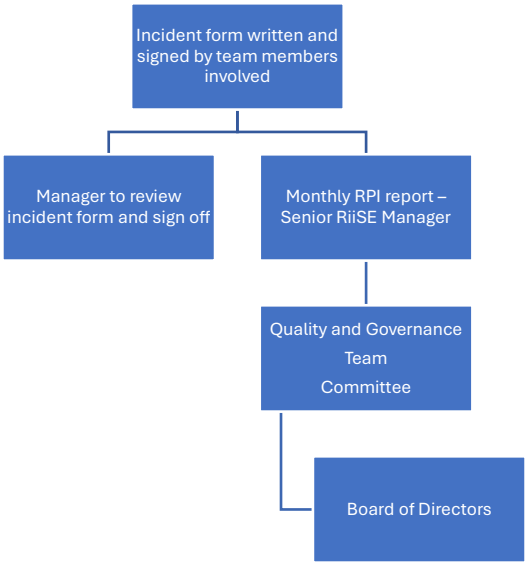
12.1 All incidents involving the use of RPI need to be monitored by the Manager, Head Teacher or appointed person and signed off *(refer to figure 1 below).* The Quality, and Governance Team will regularly monitor incidents.

12.2 The manager should make comment on all restrictive physical intervention that take place within 24 hours on ClearCare. They should ensure that all incidents of RPI are fair and conform to regulatory requirements and respond promptly if any concerns are found.

12.3 The manager should speak directly with the child and staff involved in the RPI after the incident to ensure their wellbeing.

12.3 Fair Ways also implements governance oversight each month for all RPI's being used within all departments. The RPI Lead produces a monthly and quarterly report to the Board monitoring serious incidents which involve the use of RPI in all services.

12.4 Clearcare should be used to identify trends and patterns in behaviour and incidents/RPIs to improve de-escalation effectiveness and supportive strategies that promote reduction in RPI use.



(Figure 1 – Incident Form Monitoring)

12.3 Once a RPI has been written, submitted and the service manager has commented on it, the RiiSE Senior Manager will read, monitor and analyse the RPI on a monthly basis. This includes discussing the RPI with managers/teams if clarification is needed, producing a report to the Quality, Safety and Governance Committee and tracking themes and trends for a continuous training needs analyse to inform the development of training. However, if the monthly report highlights concern in a specific provision / home on the high use of RPI, the Quality Assurance Lead may request a further response using the 3-stage process below (Table 1). On a quarterly basis all this information will be reported to the Board of Directors for oversight, scrutiny, and any key learning points for the organisation.

(Table 1 – 3 stage process)

Stage 1	Request to the Manager to provide a written explanation / rationale
Stage 2	RiiSE Senior Manager will further review the incident / RPI with clear action plan
Stage 3	QG Committee will invite HOD to committee to review incident / RPI with clear action plan

14 Associated Documentation and Legislation

- Behaviour in Schools Guidance (Department for Education 2022)
- 'Reducing Restrictive Practice Framework - Guidance on reducing restrictive practices in childcare, education, health and social care setting.' (Welsh Government 2022)
- Social Care Wales 'Positive approaches: reducing restrictive practices in social care', (version 2 November 2021)
- Reducing the Need for Restraint and Restrictive Intervention (HM Government 2019).
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- Use of reasonable force – advice for head teachers, staff, and governing bodies. (Department of Education 2013).
- Human Rights Framework for Restraint: principles for lawful use of physical, chemical, mechanical and coercive restrictive interventions (EHRC 2019).

Appendix A: Fair Ways Restraint Reduction Plan

Appendix A

Fair Ways Restraint Reduction Plan

Date: June 2025
Lead Author: Lucy Pearce
Review Date: June 2026

What is a Restraint Reduction Plan?

A restraint reduction plan outlines how we are committed to reducing the use of restraint on the individuals we care for and support. The plan also acknowledges the complexity of decision making, the necessity and the trickiness of using restraint.
At the heart of our work is a deep belief in the power of relationships to heal, to stabilise, and to offer hope. Every day, our direct- working teams at Fair Ways meet the individuals we care for and support, in moments of vulnerability, distress, and emotional dysregulation, sometimes this leads to a restrictive physical intervention. We know that every instance of restraint carries risk: of retraumatising a child, of harming trust, of someone getting physically hurt, and our teams step up to keep everybody safe, which can be scary for the individual and for the team members.

That is why our approach focuses not only on reducing the use of restraint but on transforming the culture that makes restraint less likely to be needed. This means recognising the stories behind behaviours, valuing emotional presence over control, and investing in environments and systems where our individuals and teams feel safe, understood and are supported in the right way.

This plan has been shaped by data, and more importantly, by Fair Ways people. It is informed by the lived experiences of children, by the reflections of staff who stay grounded through challenge, and by leaders who carry the weight of safeguarding with compassion. It is built on frameworks that resonate with our values. We hope this plan inspires, informs, and holds us to account because every individual we support, deserves care that sees them not as a risk to manage, but as a person to be understood. That is only possible through the collective people at Fair Ways and the systems we have in place.

1. Purpose of the Plan

To reduce the use of restrictive interventions across our charity in line with the RRN Training Standards, Human Rights Act, and the REsTRAIN Yourself toolkit. This plan outlines our multi-layered, proactive approach to reducing the frequency, duration, and severity of restraint, prioritising trauma-informed, relational care and support.

2. Our Ethos on Restraints and Restrictive Practice

Fair Ways supports individuals across children's residential homes, SEMH and autism specialist schools, supported living, and specialist services including family assessments, all of which use restrictive practices, but restraint is only used in our children's residential homes and schools.
This plan reflects our commitment to reducing the use of restraint through a trauma-informed, attachment-aware lens. We believe that safety and healing are only possible within relationships built on trust, empathy, and consistency. Guided by our therapeutic model of care, which integrates Scott Barry Kaufman's sailboat metaphor and Kim Golding's Pyramid of Need, this plan prioritises proactive support that meets individuals'

emotional needs before distress escalates. Restraint is viewed as a last resort, and our culture encourages curiosity, reflection, and relational repair in the event of incidents.
These principles are grounded in our ethos: that all behaviour is communication, and every individual we care for or support deserves to feel seen, heard, and valued. Our approach recognises the neurobiological impact of trauma and prioritises co-regulation, predictable routines, and emotionally available adults/staff. We aim to create safeness, build stability, develop quality relationships, explore emotions, learn skills and resilience, and ultimately help each individual to find purpose in their lives.

3. Key Principles – The RiiSE Anchors

Below are the eight RiiSE values, well call them anchors, highlighting the specific thinking around implementing safe and careful use of restrictive physical interventions (RPI) within our schools and children's homes.

1. WE support the Human Rights of all – which means we promote dignity, safety, and wellbeing and the views of that individual.
2. WE aim for non-violence – we take the least harmful, safest approach with care always and recognise the potential harm caused by restraint and the importance of alternatives.
3. WE stop and think before we act to achieve the best outcome for everyone involved. – We think about the role we (the carer/teacher/staff/adults) are playing in the interaction and how we can respond therapeutically to the distress of the individual in front of us, following the detailed plans they have contributed to.
4. WE help people to understand and healthily express emotions and feelings – we offer supportive & adaptive environments that are emotionally responsive, containing, and trauma-informed.
5. WE recognise that everyone is different – everyone has unique plans that they make in collaboration with the people caring for them. We aim to meet individuals where they are at.
6. WE look back and think forward – Using data and reflective practice to drive improvement and promote learning from our mistakes, as well as ensuring all voices are heard after any incident.
7. WE focus upon connection – by using PACE and having authentic connections where our individuals feel like they matter.
8. WE take the perspective of others – by embedding co-production, lived experience and and commit to really knowing the inner worlds of the individuals we support.

4. So what do we know about restraint at Fair Ways? Below is a current overview of restraint data from July 2024 – June 2025. (RRN Standard 1.4, 1.5)

Current Restraint Trends:

- The monthly average is 18 a month across the organisation.
- Schools have peaks leading up to the end of terms and the middle of the autumn term.
- Homes have peaks at the start of school holidays and new school terms.
- Most restraints happen on weekdays before 12 pm in schools and between 4 pm-9 pm in our children's homes.
- Most individuals who experience restraint after moving to our services have a reduction in the first 6 months. A handful of current individuals have a pattern of 'cluster' restraints around tricky times on for

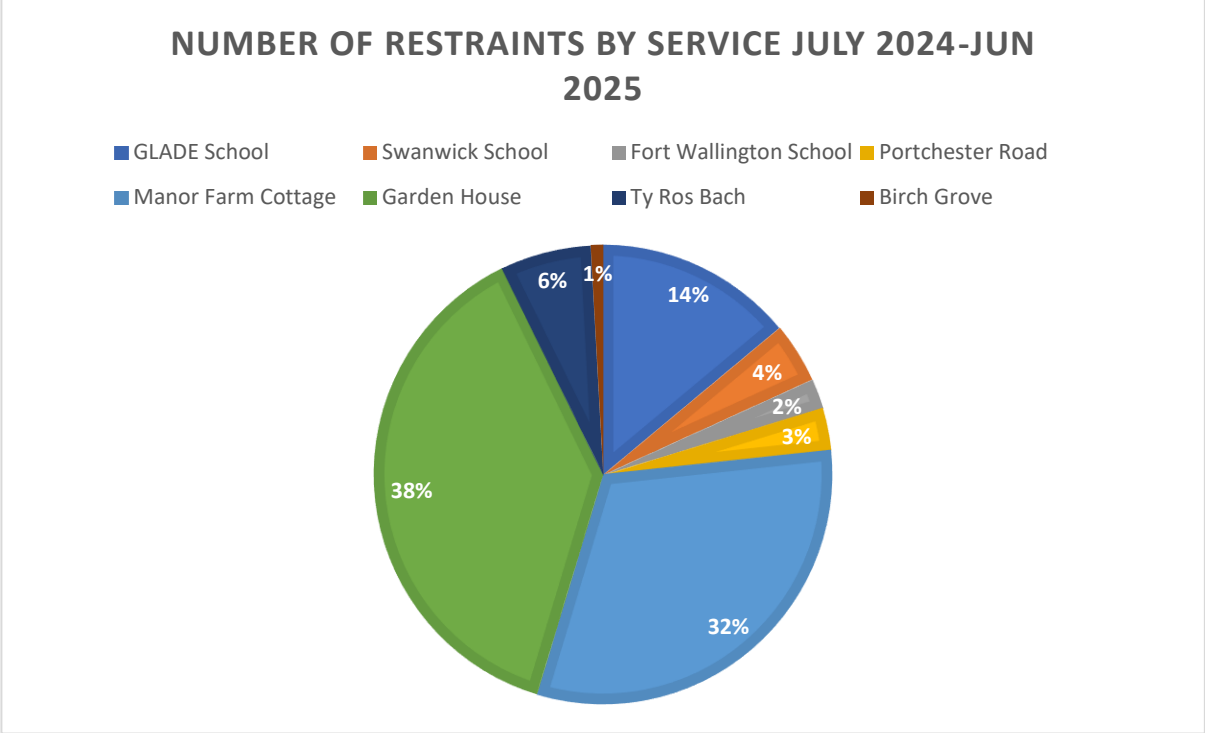
them e.g. family visit changes/sibling being born, but generally do not have any if they are not externally overwhelmed.

- The least restrictive two-person physical technique 'figure of four' is most frequently used.
- No services are trained in enhanced elevated risk techniques.
- The most frequent behaviours of concern leading to a restraint is physical aggression towards the adult, which could result in serious harm to another.
- The most frequent triggers that lead to
- Managers' oversight, re-attunements, and staff debriefs demonstrate an incredibly good understanding of the individual's we support, staff willingness to reflect on their own behaviours and analysis of the service as a whole.
- When an individual is frequently restrained, all services show a range of team members involved.
- There was one front ground hold which happened because a student was already lying on the ground.
- Since the start of 2025 9 injuries have been sustained by individuals during RPIs which are scratches and bruising from transitions getting into RPI, or accidently hurting themselves when hitting adults/ throwing items.
- 23 injuries had been sustained by the staff in carrying out RPIs, these have been minor injuries such as scratches, marks to the skins, bruising and aching muscles. Some bit injuries have caused broken skin.

Day of the week	Number of RPIs
Monday	31
Tuesday	34
Wednesday	39
Thursday	48
Friday	33
Saturday	26
Sunday	25

Below are the statistics demonstrating a continued decrease from one year to the next when looking at overall restraints, how many individuals are being restrained and the durations of restraints. Followed by restraints numbers demonstrated by service.

	July 2023-Jun 2024 Restraints	**July 2024-Jun 2025 Restraints**	**Overall % increase or decrease**	
All Services	296	238	19% decrease	
Number of individuals involved	33 out of a possible 97 CH = 18 S = 15	31 out of a possible 112 CH=15 S = 16	6% decrease	14 (45%) of which are the same children from the previous year
Number of total minutes in restraint	1789	1558	12% decrease	
The percentage of individuals being restrained	35%	27%	22% decrease	



5. How we use data to reduce the use of restraint on our individuals

Within Fair Ways services, restraint reduction must also be carefully measured on an individual basis. It would not be possible to monitor restraint reduction solely on a whole charity due to the huge volume of variables, including staff changes, opening of new services, change is the individuals we support, and ever-changing variables specific to each individual, to make data comparable over months or years.

Managers of each service have overall responsibility for ensuring recording, analysing and reduction of restraint is being carefully completed for the individuals within that service. The RiiSE senior manager completes a whole organisation's data collection and analysis, monthly, where relevant trends/themes or concerns are raised directly with managers and escalated to the Quality Safety and Governance committee (QSGC) who oversee overall data and trends for the whole charity. See appendix A for full details.

Once data is collected at the end of every month, a summary and key points are shared with QSGC, managers, and the heads of education and residential services. A summary of trends is shared quarterly with the RiiSE coaches during development days and shared with the clinical team. Details of any injuries that occurred each month are shared with the designated safeguarding lead for Fair Ways. From these places, the data is then used in the following ways:

- To inform risk assessments and support plans of the individuals we support
- To inform rota and ratio
- To highlight any team members that may need extra support or training
- To enhance strategies for individuals the individual in a future occurrence of distress
- To inform TAC, team around the child meetings, when creating formulations
- To support the emotional and physical well-being of the teams
- To raise safeguarding, health and safety concerns or issues
- To provide feedback to the RiiSE senior manager/lead coach to inform future trainings.

- To inform of policy updates or changes
- To support the clinical team running reflective sessions, help the team identify trends and the impact on them
- To adapt and update what is collated in the recording
- To identify gaps in training or resources

Quantitative data: Trends the RiiSE senior manager looks at when drawing data from our data base 'ClearCare':

- Number of RPIs per day/week/month
- Time and location of RPIs
- Setting events and triggers of the RPI
- Time in between RPI or incidents
- Other people involved in the incidents
- Duration of restraint
- What physical techniques are used

Qualitative data analysed:

- The individual's reflections on the RPI
- The triggers and 'window shrinkers' for the individual
- The co-regulation and de-escalation strategies used by the teams
- How the individual and team members reflected and reconnected
- What is discussed in team debriefs, including how the team reflected on the impact of their actions during the incident.
- Managers' oversight of the RPI, how much does this reflect their understanding of the individual, their team and service?

The RiiSE senior manager conducts data collection and analysis in more detail to support any setting that is having an increase in physical interventions. They or a senior coach can visit the service and assist in conducting workshops to support teams understanding, or therapeutic support strategies and combat skill fade by refreshing on physical skills. This is in collaboration with that service's inhouse RiiSE coach.

6. The role of Fair Ways in-house RiiSE Coaches

All our services offer the role of an in-house RiiSE Coach. A coach is selected through a recruitment process to have this role alongside the role they already have within their service. RiiSE coaches play a key role in embedding the RiiSE (Relationship Inspired Ideas for Supportive Environments) model of practice within their service. The RiiSE Coach support their teams to develop a trauma-informed, relational approach to care and education by modelling good practice, offering reflective support, and driving a shared culture of continuous learning by 'coaching in the moment' of incidents.

Key Responsibilities:

- **Coaching and Mentoring:** Provide regular 1:1 or group coaching sessions with their teams to support emotionally attuned, regulation and relational-focused practice.

- **Model Relational Practice:** Demonstrate the use of co-regulation strategies, attuned interactions, and strengths-based approaches in real time.
- **Embed RiiSE Values:** Ensure the principles of the RiiSE values are understood and integrated into daily routines, planning, and responses to behaviour.
- **Reflective Debrief Facilitation:** Support team members to reflect on incidents, relational dynamics, and their own regulation, using a non-blaming, learning-focused perspective.
- **Training Support:** Contribute to the delivery of ongoing professional development, including induction and refresher sessions on trauma-informed and relational care. Delivering at least two days of RiiSE training a year.
- **Link Between Theory and Practice:** Act as a bridge between therapeutic theory and direct application, helping teams understand the "why" behind the "what".
- **Collaborative Culture Building:** Work with everyone in their service to promote a culture of emotional safety, consistency, and child-centred care.
- **Own Development:** Attend development days and RiiSE refresher courses to deepen their own knowledge and coaching skills.
- **Feedback:** To provide feedback on their own learning, trends, issues, successes and strengths to the RiiSE senior manager to inform the development of the RiiSE content.

7. 2025-2026 Actions for Restraint Reduction (Huckshorns Six Core Strategies)

1. Leadership

Formal leadership within Fair Ways is a vital component in our successful restraint reduction plan, as these roles have the authority to make changes, implement successful strategies as a high priority, develop the reduction plan, reduce organisational barriers within policies and procedures and provide resources and hold people accountable.

The RiiSE senior manager, head of workforce development and director of talent and performance will continue overseeing the leadership and development of RiiSE by:

- Holding 6 weekly RiiSE Steering Group
- Hosting quarterly RiiSE Development Days
- Representing RiiSE ethos and restraint reduction in Board meetings
- Sharing data analysis with the Quality, Safety Governance Committee
- Accessing the right funding and resources
- Completing the training needs analysis and creating the training needed
- Tracking training compliance
- Developing and implementing the charity therapeutic model of care
- Having a continued commitment to gaining the latest knowledge and research in trauma-informed approaches
- Increasing understanding across departments
- Developing policies that back the trauma-informed approaches within RiiSE
- Collecting and analysing RPI data

Informal leadership is also essential to this plan, as they are the leaders who influence their teams and create positive cultures within their settings. Heads of service and service managers have the responsibility to ensure that data analysis is taking place, teams implement primary and secondary strategies, teams are collaborating with the clinical teams, and feedback is given to colleagues on good. They are also able to provide feedback to supervisors to improve practice.
Informal leadership includes the in-house RiiSE coaches who are the front runners in demonstrating the RiiSE values within the services and can offer extra support and guidance to teams and management relating to restrictive practice and trauma-informed care and education.

2. **RiiSE Training**

Our teams will continue to be trained in RiiSE. All direct working team members will attend a 3.5 or 5-day training, dependent on where they work, and will have an annual 1 or 2-day refresher training for the entirety of their employment. Any team member working in the services but not directly with the individuals will attend the theory elements of the course and central support teams attend a 2-day introduction to the RiiSE ethos course.
Every Fair Way's employee working directly with our individuals are required to attend the three or five-day RiiSE Foundation Training programme during their induction process. The training is tailored to the dedicated teams caring for the individuals, to equip them with an understanding of the impact that past trauma or neglect/abuse experiences have on the individuals and the behaviours of concern they may present and how to support them. Aiming to provide the teams with the necessary skills, knowledge, and confidence to successfully respond to the young people's needs.
The training course is underpinned by research from Kim Golding and Dan Hughes, leading psychologists who specialise in working with individuals who have experienced trauma and attachment difficulties. This is further supported by our training needs analysis, in-house RiiSE coaches, our full-time Lead RiiSE Coaches and our in-house clinical teams (The Hub) who focus on reflective practice with the teams.
In the course; research, exercises, case studies, visual representation, and the psychological and physical impact of trauma on individuals is explored. This allows participants to understand that the behaviours of concern they may see, occurs for a reason. Alongside the underpinning of trauma and attachment-informed practice, the training focuses on individualised support plans, preventative strategies, secondary and de-escalation strategies, and physical interventions that support therapeutic tertiary strategies.
Other training that staff can complete that supports continued learning and promotes restraint reduction:

- Foundations of Attachment
- Non-Violence Resistance
- Level 3 Diploma for Residential Childcare
- Level 1 Dyadic Development Psychotherapy (DDP)
- Level 5 for Leadership and Management for Residential Childcare, Health and Social Care
- *Other qualifications for other services

3. **Person-Centred Care**

The individuals who are supported and cared for are at the centre of any decisions that are made about them; they are uniquely known, seen and understood by the teams looking after them. Teams working directly with our individuals will ensure each individual has a personalised risk assessment and a current individual support plan. These documents must:

- **Reflect the individual's voice, preferences, hopes and goals** – not just their risks or behaviours

- **Consider communication needs**, including non-verbal preferences, communication aids, or accessible formats
- **Include a clear plan for emotional regulation support**, including co-regulation strategies and known triggers, sensory profiles.
- **Be grounded in trauma-informed principles**, recognising past experiences that may influence current needs and behaviours
- **Be integrated into daily routines and team practice**, not just a document for compliance
- **Be regularly reviewed through multi-disciplinary input**, ensuring ongoing relevance and effectiveness, and updated as changes happen
- **Promote strengths-based language**, focusing on what the individual can do and how they thrive
- **Include preventative and post incident strategies –** not just strategies for responding to an incident
- **Clearly outline the individual's legal and safeguarding needs**, including consent, advocacy, and decision-making capacity where relevant
- **Involve contributions** from families and advocates where appropriate.

Post-Incident Support

Fair Ways emphasises, through RiiSE, effective debriefs for the team and intelligent, nurturing reflection with the individuals involved, called a re-attunement. These do and must take place after any incident or restraint. The discussions that happen in these debriefs and re-attunements are essential for emotional wellbeing, understanding, enhancing practice and learning. Teams must ensure that:

- An informal team debrief happens as soon as possible after any incident – this initial debrief or 'defuse' is focused on emotional wellbeing and support.
- A formal team debrief is held and recorded with any team member involved in the incident, where lessons learned from it are recorded and new strategies are implemented into plans and practice.
- Team members are sign-posted to the Employee Assistance Programme or offered further debriefs if needed through their line manager, in-house RiiSE coach, the Hub team or RiiSE senior coaches.
- A re-attunment conversation is held with the individual involved as soon as possible, and a record of this is submitted in ClearCare within seven days of the incident.

Debriefing goals

- To reverse or minimise the negative effects of the use of restraint on the individual and the team
- To prevent the future use of restraint and inform future practice
- Reflect on successful and non-successful strategies
- To ensure overall wellbeing of everyone involved
- To support teams in understanding how trauma and attachment can be expressed in behaviours that concern
- To encourage open and honest communication between the staff team
- To deepen the understanding of how to successfully support this individual when they are distressed
- To expand knowledge RiiSE key concepts, linking them directly to practice.

Other debrief spaces for teams and individuals include:

- Keyworker session

- Advocacy support
- Daily debriefs at the end of each day
- Informal debrief with each member of staff after an incident
- A specific debrief with a manager for the individual
- Reflective Practice space
- Supervision
-

During RiiSE training, the importance of staff debriefs after an incident is highlighted and practiced throughout the course as a key part of supporting the young people and the reduction of restrictive use.
See Appendix B – After Incident Debrief,

4. Involving people with lived experience

Fair Ways recognises the unique insight and value that people with lived experience—particularly those who have experienced care, education, or therapeutic support—can bring to improving practices and reducing the need for physical restraint. Over the next year, Fair Ways can harness these voices to shape a more relational, trauma-informed, and compassionate approach to care by aiming to involve individuals with lived experience:

- In reviewing behaviour support plans, de-escalation strategies, and training materials.
- By asking their insights to identify language, approaches, or environments that may unintentionally escalate distress or reduce emotional safety.
- By using their reflections to inform policy development
- In asking for their contributions to training content
- By sharing anonymised stories or case studies to spark reflection and learning in team meetings, supervision, or reflective spaces.
- By piloting peer support roles where individuals with lived experience can connect with young people in care
- By ensuring that lived experience voices are embedded in the evaluation of restraint incidents, contributing to learning reviews or post-incident reflections.

Two individuals have been identified to work alongside Fair Ways in the development of RiiSE and the therapeutic model of care. This is an ongoing process which is still in development stages.

6. Monitoring and Review

Monitoring is not just about compliance; it is about learning, improving, and staying accountable to our primary task. We aim to create a culture where restraint data is used not to blame, but to understand, support, and grow. The progress of this restraint reduction plan will be overseen by the Director of Talent and Performance, Head of Workforce Development and the RiiSE Senior Manager.
The following will be monitored:

1. Any changes to policies or procedures around restrictive practice or restriction to liberty, attending relevant meetings where appropriate.
2. Service managers continuing to create positive cultures within their settings around restraint reduction through reading manager oversight of RPIs.
3. Data is collated, analysed and shared with QSGC
4. Everyone in our services has an individualised support plan to which they have contributed.

5. All direct working staff to attend a 3.5- or 5-day foundation RiiSE training programme during their induction process or as soon as possible after the start of employment
6. Staff debriefs and re-attunement conversations take place after any RPI or incident and are documented.
7. Progress on involving people with lived experience targets

Quarterly meetings are held between the Senior RiiSE coach and the QSGC director. Before each meeting, the Lead RiiSE coach will conduct overall data analysis of the services and combine this with the quarterly report QSGC team which will be presented in Board meetings where any new decisions will be made, fed back to the RiiSE steering group and coaches, and then distributed to all services.

Key Resources & Frameworks

- RRN Training Standards (2021)
- REsTRAIN Yourself Toolkit (NHS England)
- Restraint Reduction Network resources
- Trauma-Informed Practice resources

Each action reflects the whole-system commitment required for restraint reduction and reflects a core principle of our ethos: creating environments where restraint becomes increasingly rare because our individuals are understood and known. Our objectives is designed to ensure that trauma-informed practices are embedded in everyday interactions, teams are supported to respond compassionately, and the individuals we care for and support are actively involved in shaping their experience with us. Our ambition is not only to reduce restraint but to foster cultures of safety, trust, and connection.

Appendix B: RiiSE After Incident Debrief

APPENDIX B RiiSE After Incident Debrief

Staff members involved:	**Date of incident:**
Child's initial:	**Time of incident:**
(to be completed with all staff members involved)	**Location of incident:**
Brief overview of the incident:	
What went well? (How were individual support strategies used? PACE?)	
Possible alternative actions/interventions that could have improved the situation?	
Reflection on understanding the behaviour displayed/ hidden needs of the child….. *(consider any trigger, arousal continuum etc)*	
Any reattunement or emotional/physical wellbeing needs for the YP? *(Who will ensure this is completed?)*	
How was everyone feeling during and now after? •	
Courageous conversations: *any concerns to raise about any action taken by any member of staff?* *any confusion about any action taken by any member of staff?* *Any concerns around duty of care or duty of candour?* *Did everyone involved feel they were supported?*	
Looking after yourself: What has/will each staff member done to look after emotional or physical wellbeing since the incident?	
Any updates needed to Support Plans or Risk Assessments? ***Does anyone else need to be informed of this incident/RPI?*** *Who will be responsible for completing this?* ***What actions have been decided, who is responsible for them? By when?***	

Staff Name	Staff Sign	Date:

APPENDIX C RiiSE Safety Advice for Incidents in Vehicles

Safety Guidance in Vehicles

This guidance has been put together in response to questions being asked about how to work with dysregulated children while in vehicles. This is to support your RiiSE training. It also falls in line with ***Appendix 24 of the RRN Training Standards.***

You have already learnt about how the **Law, Lawful Excuse Components** and **Lawful Excuse Criteria** will inform the decisions you make in the moment when faced with a child who is dysregulated and presenting in an unsafe manner.

Our overarching guidance would be **not to hold children in cars unless the risk is immediate** and to intervene would prevent greater harm from occurring.
Additional risks of physically holding anyone in vehicles include overheating and injury by car fixtures and/or due to restricted space for movement. Increased risk of breathing restrictions due to a sitting position.
The key factor when facing this situation is about what proactive approaches you take to reduce the likelihood of having to do this. A child-centred approach is essential.

Primary Prevention Planning

• Is the child able to travel in cars safely under normal circumstances?
• What does a safe and calm journey feel like for the child; and how can it be achieved?
• What things has the child historically done in cars? i.e. opening doors of moving vehicles
• What 'window shrinkers' pre-dispose the child to an increased likelihood of becoming distressed? Some examples could include Not given enough time to be prepared, not understanding where they are going or what will happen when they get there.

- If the Risk assessment suggests the risk is low enough to allow travelling in vehicle, what things make those journeys successful?
- Where is the child sitting?
- If child is directly behind the driver, then must sit on passenger side
- Do you have/need child locks?
- Breaking journey down into manageable chunks
- Factoring in rest / comfort breaks / toilet stops
- Do you have suitable in-car entertainment – colouring books, electronics, sensory toys, blankets etc
- Who is travelling with them?
- Who will be seated with them?
- Are staff aware of the need to be mindful of tone and content of any conversations taking place which may be overheard by the child?

- Do they have the skills to work with the child should they become dysregulated? Can they respond to the need for physical intervention effectively without the need to open car doors?
- The route you will take (do you need to avoid busy roads, dual carriageways, motorways or bridges?)

Secondary Prevention Planning

- What is the protocol should an incident start to happen?
- Would it be safer to pull over? Or
- Simple script for driver eg; "stop, stop, stop" which means stop the vehicle as quickly as is safe to do so.
- At point when vehicle stops, driver should undo seatbelt.
- Should the child get out of the vehicle once stopped, ensure all staff are aware of protocols for that child in line with their Support Plans/Risk Assessment.
- Unplanned, emergency interventions may be required to prevent a greater harm under circumstances such as:
  - *The child lashing out at driver*
  - *The child pulling on driver seat belt/clothing*
  - *The child opening door of moving vehicle*
  - *The child grabbing hand break*
  - *The child grabbing steering wheel*
  - *The child presenting in ways that are immediate risk to self/others*
  - *The child attempting to get out of moving vehicle via open window*
  - *The child Repeatedly kicking the back of the driver's seat*

Activity Risk Assessment considerations

- Is the young person safe to be transported by car? - This decision will inform their activity planner/programme
- What places young person can manage
- What activities to avoid (increasing dysregulation and potentially making return journey unsafe) E.g. noisy or crowded places
- Any transition requirements to prepare the child before and after both activity and transportation.

A child who regularly becomes dysregulated in a car – Service Manager or person of seniority must sign off activity planner or make clear if to be transported for essential journeys only.

This document is offered as general guidance only, all final decisions about what will be in the best interests of an individual child must lie with senior manager involved in the child's overall care and/or education.

If a risk assessment for an individual child has identified that there is potential for restrictive physical intervention being needed during transportation, this must be discussed in full with the RiiSE Senior Manager so that a suitable plan can be drawn up.

APPENDIX D RiiSE Protocol for Medical Conditions

Protocol for Temporary, Sudden, Unexpected Changes in Medical Status or Pre-Existing medical conditions and use of Restrictive Physical Intervention (RPI)

1. Purpose of this protocol

1.1 This protocol provides staff with guidance on how to proceed if any individual we support at Fair Ways, has a sudden, unexpected or temporary change in their health status and are likely to be restrained by use of a restrictive physical intervention (RPI).

1.2 This protocol aims to ensure the safety and well-being of the individual and the staff, while complying with safeguarding, medical, and legal requirements.

1.3 This aims to ensure that the use of RPI is always conducted with the utmost regard for the safety and health of the individuals in our care, particularly in the event of unexpected medical changes.

1.4 For pre-existing or known long term medical issues please see Appendix A and C for further guidance.

2. Understanding the risk of restrictive physical interventions

2.1 All restrictive physical interventions carry a level of risk. This risk can be elevated when a medical condition is present. RiiSE training and RiiSE physical technique risk assessment state that RiiSE physical techniques should never be adapted by any employee. Therefore, if there needs to be a change to a technique due to a medical condition, professional medical advice is required.

3. Temporary, sudden and unexpected medical conditions

3.1 These can include (but not limited to):

3.1(a) **Seizure activity**
3.1(b) **Musculoskeletal injuries e.g. Factures, sprains, strains or muscular injuries –** any injury affecting bones, muscles or joints
3.1 (c) **Concussions or head injuries**
3.1 (d) **Recovering from surgery or medical procedures –** surgical wounds, stitches or bruising
3.1(e)**Asthma attacks**
3.1 (f) **Temporary Cognitive or physical Impairment** - due to substance use
3.1 (g) **A sudden decline in mental health** – resulting in episodes of panic attacks or psychosis
3.1 (g) **Any new medical diagnoses**

3.2 In any of these cases, staff should apply the protocol, ensure that medical advice is obtained, and update the care plan accordingly. This approach helps to avoid exacerbating any temporary health condition and ensures that RPI is only used when safe and appropriate.

4. Immediate Action- once a medical condition has been detected:

A - if occurrence happening during RPI If a sudden and unexpected medical condition arises during the use of RPI staff must:	**B – Change occurs but not during RPI** but RPI generally likely to be needed to support this individual
• **Cease use of Intervention:** Immediately and safely release the restraint if there is any sign of medical distress. Ensure that the individual is in a safe position to prevent further harm.	• **Cease use of future interventions as long as safety isn't compromised:** Avoid using RPI if there is an unknown risk to their health until further medical advice is sought.
• **Call for Medical Assistance** **Emergency Situations:** For seizures, suspected broken bones, concussions, or other critical conditions, call emergency services (999). **Administer First Aid:** If trained, administer appropriate first aid while waiting for medical assistance.	• **Medical Assistance** **Non-Emergency Situations:** Follow first aid guidance and any existing support plan/risk assessment for that individual.

After any initial incident is managed, or following an initial assessment of a health need staff must follow these procedures to assess whether it is safe to continue using RPI with the individual in the future.

5. Seek Medical Assessment: Risk assessment changes

5.1 A qualified medical professional or specialist consultant must assess the individual

5.2 If the individual is taken to a hospital or seen by a paramedic, request a discharge summary or written medical report that provides specific guidance on whether RPI can be continued or if alternative strategies should be used. Seek this at every appointment with a medical professional.

5.3 The individual must receive medical clearance before RPI can be used again. This clearance should confirm:

- Whether RPI poses any additional risk to the individual's health.
- Any restrictions or modifications to standard RPI techniques that should be applied.
- Documentation of the clearance must be filed in the individual's medical record and linked to their individual support plan (ISP) and risk assessment.

5.4 RiiSE technique risk assessments can be requested from lucy.pearce@fairways.co along with pictures of the techniques. These can be shared with medical professional to support their guidance and understanding of the restrictive physical interventions we use at Fair Ways.

6. Risk Assessment and Care/Support Plan Review:

6.1 The individual's personalised risk assessment and any support plans must be immediately updated to reflect the medical advice.

6.2 If the medical condition affects the individual's ability to tolerate or safely undergo RPI, alternative intervention strategies should be explored and included in the plan.

6.3 A meeting must be held with the individual's network, (including medical and others professionals, caregivers, teachers, key workers and/or parents) to revise intervention strategies based on the individual's updated medical needs.

7. Communication with teams supporting individual

7.1 All staff members involved in the individual's care or education must be informed of the medical incident, any changes to their risk assessments, support or care plan, and any restrictions or adjustments to the use of RPI. *See appendix B.*

7.2 Additional RPI/RiiSE training may be required for staff to address new medical considerations when intervening with the individual.

8. Notifying Individual's Network:

8.1 Follow appropriate communication processes with the individual's network of professionals and key people including social worker and their family where necessary, to inform them of the changes to their support.

8.2 Consent from the social worker, parents or guardian may need to be obtained if any significant changes to care planning or intervention strategies are made.

9. Documentation and Reporting:

9.1 Ensure that all relevant ClearCare reports are completed to reflect all medical appointments, medical condition or injury changes and timely recording of any new plans or adjustments to intervention strategies.

10. Health and Safety and Safeguarding reporting

10.1 If the medical condition involves a serious injury or hospitalisation, it may need to be reported to Fair Ways Safeguarding Officer and follow safeguarding policies, internal and external health and safety protocols (e.g., RIDDOR).

10.2 Staff should follow the charity's reporting policies

11. Ongoing Monitoring and discontinuing the use of any medical advice

11.1 The manager of the service responsible for the individual should monitor the effectiveness of the implemented plan. Changes to the plan may include updates or ending the advice in consultation with the medical professionals involved and agreeing this change. If the plan is updated or ends, the manager must remove the plan from the individual's risk assessment and support plans ensuring all staff are informed. The time frames and channels for sharing information will be service specific but the information changes must be 'live' and shared in any handover or team meetings.

Appendix E: Additional Health Changes

Below is a list of additional health changes/illnesses that if present could increase the vulnerability of a child or adult when a restrictive physical intervention is being used on them.

It may be advised to seek medical advice from the individual's GP if the team caring for the individual thinks that any condition/illness below present with:

- Breathing difficulties – including coughing or sinus congestion
- General weakness
- Dehydration
- Fatigue
- Dizziness
- Balance issues
- Impaired judgment
- Vomiting, nausea, or stomach pain
- Skin irritations or cuts

1. **Acute Illness (e.g., Flu, Respiratory Infections)**
2. **Fever or High Body Temperature**
3. **Dehydration or Heat Exhaustion**
4. **Mild allergic reactions**
5. **Ear, nose or throat infections**
6. **Sleep deprivation**
7. **Medication side effects**
8. **Stomach or Digestive Issues (e.g., Gastroenteritis)**
9. **Eye infections (e.g., conjunctivitis)**
10. **Hayfever**
11. **Rashes or eczema**
12. **Chicken pox, hand foot and mouth or other skin related illnesses**
13. **Injuries from self-injurious cutting**

Appendix F: Temporary, Unexpected or Sudden Medical Changes Plan

Team signing sheet

Individual with medical change:	*(Enter name)*
Advice given:	*(Enter advice for staff to follow)*
Advice received from:	*(Enter medical professional name and contact details)*
Plan implemented by:	*(Enter management/SLT members that have implemented/agreed plan)*
Date plan is active from:	*(Include start and end dates where possible)*
Review date:	*(Time frame to be agreed by meeting)*
End of plan date:	*(In put in end date is known or when plan does end)*

By signing below, I confirm that I have read and understand the procedures outlined in this protocol and agree to follow them in any situations involving restrictive physical interventions.

Team member name:	Sign to agree to plan:	Date read and signed:

Appendix G: Long term medical conditions that may need additional medical guidance

If an individual is being cared for, supported or educated by Fair Ways and they have a preexisting medical condition (or a newly diagnosed one) it may not be covered by our current restrictive physical intervention risk assessments. Therefore, the above policy may need to be followed to gain the correct guidance and advice to support that individual if RPI is required. This should be highlighted during the referral process and considerations to meeting their needs and agreement from medical specialists in the network, be made before offering a placement.

The RiiSE Physical Technique Risk Assessment consider the risk factors of the following medical conditions:

- Obesity
- Anorexia
- Physical disability
- Tactile defensiveness
- Ataxia
- Visual impairments
- Breathing problems such as asthma
- Fragile bones

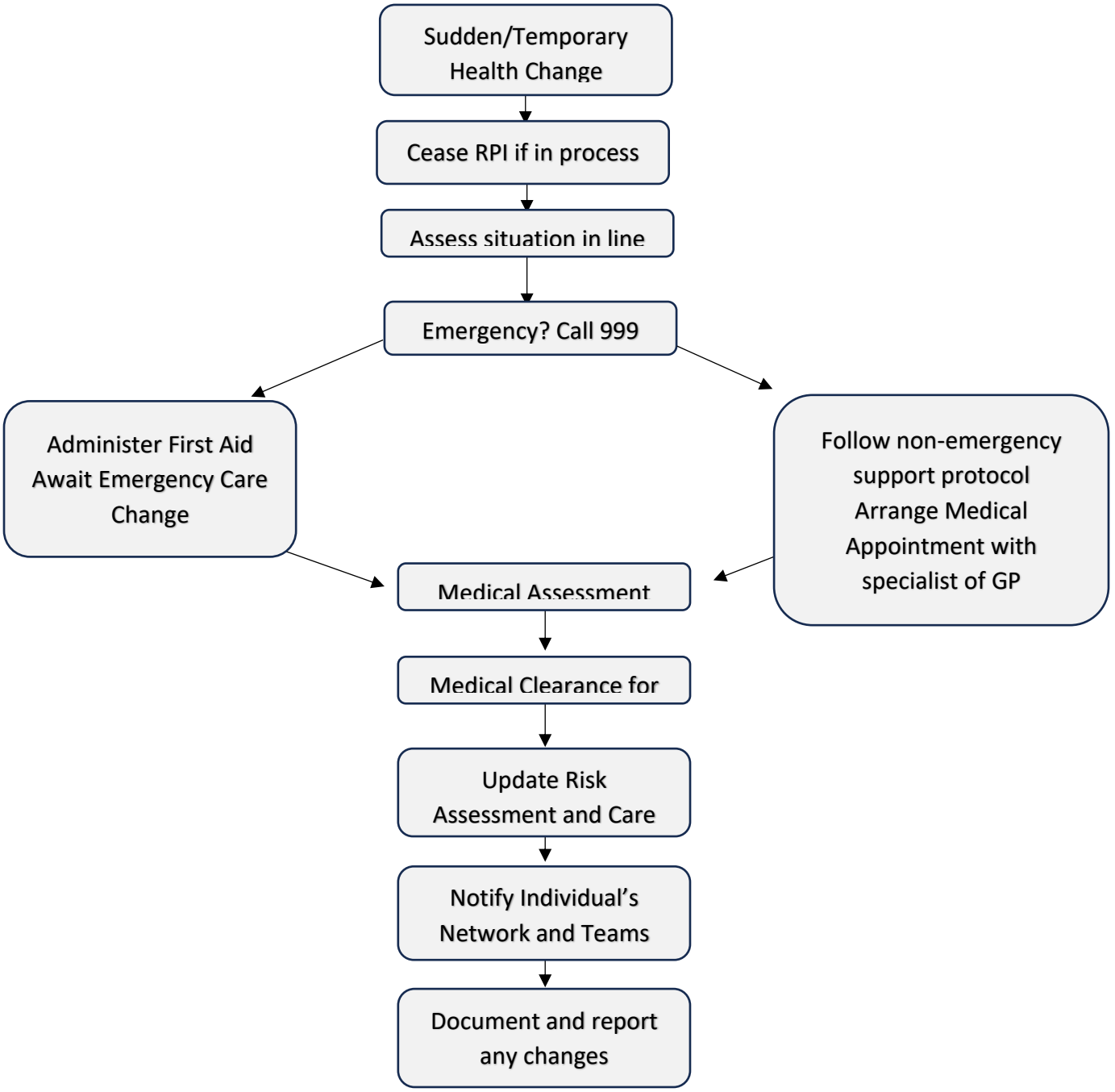
The medical risk assessment grade for these elevated risks for each foundation technique are as follows:

NAME OF PHYSICAL TECHNIQUE	MEDICAL RISK ASSESSMENT GRADING
Walk and Talk	Extremely unlikely
Side Embrace	Extremely unlikely
Adapted Embrace	Extremely unlikely
Small person shepherding	Extremely unlikely
Side hug	Unlikely
Adapted side hug	Unlikely
Seated Side hug on chair/sofa*	Unlikely
Half shield	Unlikely
Figure of 4	Unlikely
Double embrace	Unlikely
Cupped hand	Unlikely
Seated cupped hand against a wall*	Unlikely
Seated cupped hand against a wall – Straight Arm Response*	Unlikely
Straight Arm Transition standing	Unlikely
Dropping of body Weight level 1	Unlikely

Dropping of body Weight level 2	Unlikely
Seated adapted embrace with leg support (bean bag)*	Unlikely
Seated adapted side hug with leg support*	Unlikely

Further medical guidance for use of RPI should be sought from a medical professional if an individual has the following medical conditions:

- *Severe asthma*
- *Epilepsy*
- *Severe Cuts/abrasions*
- *Heart related conditions*
- *Functional Neurological Disorder (FND)*
- *Chronic diseases*
- *Blood disorders*
- *Lung conditions*
- *Brittle Bone*
- *Diabetes*
- Physiological conditions (e.g. PDSD)
- Eating disorders
- Low weight
- POTS -

This is not an exhaustive list – should an individual you support have a medical health status that could be considered as a risk during RPI please contact lucy.pearce@fairways.co for guidance.

Appendix H : Flow Chart for Sudden/Temporary Health Changes and Use of Restrictive Physical Intervention