Aireborough Supported Activities Scheme

PROVIDING LEISURE ACTIVITIES FOR CHILDREN WITH DISABILITIES

Policy title	Positive Behaviour Support
Policy number	CT - 003
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Date Approved by Management Committee	13 July 2017
Date First Issued	13 July 2017
Last Review Date	13 July 2019
Next Review Due	13 July 2021

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Policy Contents

1 Introduction

1.1 At ASAS the staff and management committee share common values, which include a commitment to assist our young people:

- To experience valued involvement within the play scheme and in the wider community,
- To develop skills necessary to make informed choices, which others will respect, and to communicate these choices to others,
- To make and maintain social relationships and friendships,
- To continue in the ongoing process of self-discovery,
- To reduce incidences of behaviour which adversely impact on one's own physical or emotional wellbeing, or on the emotional or physical wellbeing of others

1.2 ASAS has named staff members who have overall responsibility for issues concerning behaviour. These are:

- Jo Galasso (Project Manager)
- Liam Sanders (Scheme Nurse and Assistant Project Manager)
    - Trained behaviour specialist
- Team Leaders for each group

1.3 We require the named people to:

- Keep themselves up-to-date with legislation, research and thinking on the management of children's behaviour.
- Access relevant sources of expertise on handling children's behaviour; and
- Attend any relevant training that ASAS provides in recognition of the behaviours that some children and young people may present with.

1.4 This document is based upon the best available sources of information available at time of writing. Including legislation, local policy and other publications.

1.5 We believe that challenging behaviour is most often the result of an unmet need, or a difficulty in communicating that need to others. We are aware that many of our young people experience sensory issues and may find particular environments and experiences overstimulating, frightening or uncomfortable. Adults and peers can be sources of unpredictable actions and sensory sensations; transitions and demands which interrupt routines and repetitive activities (which a young person may rely on to give a sense of order and predictability to their day) can provoke anxieties which may be communicated to others through behaviours which are challenging in their nature.

1.6 By identifying difficult behaviours, considering physical and sensory issues, addressing mismatches in the environment and focusing on a person's highly individualised strengths and needs, we aim to provide more effective means of communication, more socially appropriate interactions with others, and greater tolerance of the different environments and demands which will be encountered in everyday life.

1.7 In line with the Equality Act 2010, we aim to enhance the life experiences of all of our young people so that no-one is unfairly disadvantaged as a result of their differing needs,

behavioural or otherwise. In order to fulfil this aim, we adopt the principles and practices of Positive Behaviour Support (PBS) to enable people to overcome behaviour challenges and ultimately live the life they want to live.

2 Positive Behaviour Support

2.1 Positive Behaviour Support (PBS) is widely acknowledged to be the most effective way to support people whose behaviour challenges the families, carers, schools and services that support them. From April 2014, this has been the required model for all learning disability, social care and health services to follow. In contrast to other models of behaviour change, the focus is not on eliminating behaviour by blocking reinforcing consequences and applying negative ones in their place. The use of punishment and sanctions therefore does not fit with this approach as the emphasis is instead on teaching alternative and replacement skills.

2.2 PBS focuses on a person's indisputable rights to be treated with dignity and compassion, to be valued, to be listened to, to be supported to have the best quality of life possible, and to be empowered to make choices and decide on how they want to live that life. A PBS approach makes use of the principles of applied behaviour analysis to observe, analyse and understand the messages which a person is communicating through their behaviour; it recognises that behaviours occur in part as a response to environmental triggers and demands, and seeks to create a better match between a person's needs and services offered. It acknowledges that reinforcement and reward strategies can be useful tools to employ when helping children to begin to use newly acquired skills and to employ self-control when this too is being developed; and it emphasises that adult responses when undesired behaviour occurs can make the situation either better or worse, and consequently focuses on ensuring staff develop skills in recognising warning signs that a child is having difficulty and take steps to reassure, redirect and calm a young person rather than confront, threaten or apply a sanction or punishment and provoke escalation of the situation.

2.3 The behaviour policy which follows has a dual purpose: primarily, it is designed to give staff working at ASAS guidance on how to use a PBS approach to support young people whose behaviour may be described as challenging, to overcome these difficulties and develop skills that we hope will give them an enhanced quality of life as adults. Secondly, this policy is required to meet statutory requirements.

3 Safeguarding Children

3.1 The available evidence on the extent of abuse among disabled children suggests that they are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Staff need to be aware that changes in presenting behaviours could be an indication that a child has been subject to abuse.

3.2 Where a child has communication impairments or learning disabilities, attention should be paid to communication needs and to ascertaining the child's perception of events and his or her wishes and feelings. Staff should be aware of non-verbal communication methods. Professionals should not make assumptions about the inability of a child to share information about their concerns.

3.3 If staff believe that presenting behaviours might indicate that a child has been subject to abuse, then they should follow the process outlined in ASAS safeguarding policy. Particular attention should be paid to promoting high standards of practice and a high level of awareness of the risks of harm and strengthening the capacity of children and their families to help themselves.

4 Staff training

4.1 Many children with severe, profound or complex learning disabilities experience difficulties in monitoring and regulating their own behaviour, and staff who work in these environments require a range of skills in order to meet these everyday challenges. ASAS recognises the importance of continuing professional development and provides Team Teach and Positive Behaviuor Support training to all staff to support them to fulfil their professional duties effectively. ASAS recognises the need to have select staff who have trained to a higher level in the PBS approach to act as behaviour specialists within ASAS. Behaviour specialists have their own ongoing programme of training, outside of ASAS in their own professional capacity, and are able to provide training and support to all staff at ASAS to respond to the behavioural needs of their young people. They also have access to a range of documents (some of which are referred to below) to use in assessing childrens' needs and producing positive behaviour support plans if they are needed.

4.2 With their own professional training, and the additional support offered by behaviour specialists, most staff within ASAS will be able to meet the everyday behavioural challenges of their young people, without needing to produce prescriptive behavioural programmes. Where more specific actions and responses are needed, this may be accomplished by including guidance within a child's profile or positive behaviour support plan.

5 Guidance for producing a formal Positive Behaviour Support Plan

5.1 Stage 1 – Identification of behaviours that may challenge

- In the first instance that a child or young person who is not known to present with behaviors that challenge is identified to do so, a conversation shall be held by the behaviour specialist with the parent / carer to discuss in detail any known or perceived risks.
- The behaviour specialist may find he is able to give advice which precludes the need to take further action. Examples of this could be; use of PECS, allowing time to process requests, staff consistency,
- If first line advice is not felt by the behaviour specialist, parents, project manager and team leader to be sufficient in managing any associated risk, then a specific positive behaviour support plan must be devised.

5.2 Stage 2 – initiation of a positive behaviour support plan

- In partnership with the parents and where appropriate, other agencies such as CAMHS, school or social workers, the behaviour specialist shall undertake a holistic assessment of the young persons behavioural support needs.

- The behaviour specialist will ask parents and other agencies for sight of any supporting information, such as a pre existing behaviour support plan, which can form part of the young persons assessment of need.

5.3 Stage 3 – implementation of a positive behaviour support plan

- The behaviour specialist will produce a behaviour support plan specific for the young person in question when accessing ASAS provision. This will be implemented only after discussion from the child or young persons next of kin.
- The behaviour specialist will discuss it's contents with the staff team working with the child to ensure understanding of its contents.

5.4 Stage 4 – monitoring and evaluation of a positive behaviour support plan

- The behaviour specialist shall establish a monitoring programme, which may involve staff recording the target behaviour/s on a daily basis, using frequency, STAR and/or episodic severity charts. In addition, the behaviour coordinator should oversee the implementation of the Positive Behaviour Support Plan, meeting daily with all staff to review its progress. Parents/carers should be kept informed of the child's progress with information being shared on a regular basis.

6 Specialist support for producing a positive behaviour support plan

6.1 For most young people who display challenging behaviour, the above measures should be successful in bringing about positive behaviour change. However, if the challenges are so severe that either the child him/herself, or others who share the child's environment, are at significant risk, ASAS shall request support from external professionals.

7 Promoting Positive Behaviour

7.1 ASAS believes that children flourish best when their personal, social and emotional needs are met in an environment where there are clear and appropriate expectations and when they know how they are expected to behave through interaction with caring adults who show them respect and value their individual personalities. We aim to work towards a situation in which children can develop self-discipline and self-esteem in an atmosphere of mutual respect and encouragement. Positive, caring and polite behaviour will be encouraged and praised at all times in an environment where children learn to respect themselves, other people and their surroundings and are able to learn from, and make mistakes without fear of any consequences.

7.2 Our aim is for children to feel safe, stimulated and happy and to feel secure and comfortable with all staff. ASAS recognise the importance of building strong attachments with children. All children are unique and we believe this is key to understanding, acknowledging and promoting positive behaviour in children. We commit to supporting and caring for children and their families based on their individual needs.

7.3 All children must be treated as individuals and staff are expected to adopt a consistent approach towards managing inappropriate behaviour. This ensures that the children have the security of knowing what constitutes acceptable behaviour and what does not. The

environment must always be conducive and relaxed, where children feel safe and welcome. In order to establish such an environment, staff must ensure that the children's play space is appropriate. Sufficient stimulating and challenging activities should be available to meet the children's individual needs. Staff must consistently thank and praise children for sharing, acts of kindness, helping others, playing co-operatively and for all their achievements.

7.4 We support the positive development of children's behaviour and all staff are encouraged to use positive language and behaviours.

Examples include:

- Say what you DO want, rather than what you DON''T want
- "I'd like you to walk in the nursery", rather than, "Don't run in nursery"
- Say Yes rather than No
- "Yes we can have story time, once we have tidied up" rather than "No, not yet, we have to tidy up first"
- Use when and then to encourage respectful bargaining and sharing goodwill, "When we've picked up the toys, then we can sit and have our snack"
- Proactive praise good behaviour, limit attention on negative behaviour
- "Who tidied up the toys? Great job!"

7.5 ASAS promotes treating children with the upmost respect and all staff are expected to lead by example. All staff must act in a caring way and considerate manner towards each other, demonstrating good role modelling to the children which will develop a positive caring attitude for their future.

7.6 We strive to ensure that the children feel safe and secure and know that they can rely on being cared for in a fair, non-judgemental way, where feelings expressed are acknowledged and taken seriously. Staff must develop trusting relationships with children and support their personal, emotional and social development through offering comfort.

7.7 Praise and encouragement and attention to the needs of the children as individuals, are fundamental aspects of the ethos of ASAS and must be readily given at all times. Through support of trusted adults, children will be nurtured and engaged in activities and learning opportunities that capture their interests and allow them to achieve to their fullest potential.

8 Responding to behaviour challenges

8.1 Within ASAS staff are supported to develop skills in understanding the messages behind behaviour and in identifying and reducing triggers which are causing the most distress and difficulty. Staff learn to spot warning signs that a child is having difficulty and take action to address the underlying message so that the child does not need to display more challenging behaviour to convey that message: requests are explained, environments are altered, transitions are forewarned, demands are reduced, emerging problems are solved. Within a PBS framework, all reactive responses (ie those responses which adults make when behaviour challenges begin to be displayed) are intended to reassure the child, to help them overcome the problem or reduce their emotional response to it: in short, the focus is on

keeping everyone safe by helping the child who is experiencing difficulty to calm and resettle as quickly and as effectively as possible.

8.2 We recognise that traditional responses when unwanted behaviour is occurring, such as applying negative consequences (eg taking away a favourite toy or game, withholding a planned treat or favoured activity, removing the child from the group to an area of isolation [commonly referred to as "time out"]), or ignoring the behaviour (and by default, ignoring the message the child is trying to convey through it), often lead to an escalation in behaviour, since the child can become anxious, angry or upset, or feel the need to try harder to get their message acknowledged. Since the sole purpose of a reactive strategy is to keep people safe, a range of alternative positive strategies should be used to promote calming. These may include using active listening (to reassure a child that you are listening and understand their difficulty), distracting the child by initiating an unexpected but interesting occurrence or event, or redirecting the child by offering an alternative activity which s/he enjoys. If these types of positive strategies are used correctly (ie the right response, in the right way, at the right time), they can preclude the need for more "reactionary" responses which have the potential to escalate the situation further (for example, using physical contact to support a child to leave an anxiety-provoking or over-stimulating area and move to one where they will be better able to calm).

9 Time out, withdrawl or seclusion

9.1 Supporting or encouraging a child to move from one area to another, as a response to escalating behaviour, can take a number of forms: it is important that everyone at ASAS, as well as committee members and parents, are clear about the distinctions between these different forms and that parents in particular feel reassured that such actions are only ever initiated to keep their children safe or help them escape from a situation that is causing them over-arousal, anxiety or distress.

9.2 Many people will be familiar with the term: "Time Out" which is sometimes used to describe the action of moving children away from one area to another. However, this is a punishment strategy which is intended to teach a child to stop misbehaving before they will be allowed to return to the activity they were previously enjoying. At ASAS, we do not believe that children or young people should be punished for trying to communicate to us that they have a problem with the current situation, whether that is a result of anxiety, over-excitement, boredom or frustration, and using punishment strategies like "time out" have no place in our model of Positive Behaviour Support.

9.3 However, there may be times when a child finds the environment they are in difficult for a number of reasons – perhaps it is too loud, too crowded, too bright, or the activity has become too easy, too hard or gone on for too long. If these types of things are difficult for a child to handle, they should have been identified, with the aim being to empower children to be able to take the appropriate action to deal with these challenges independently (so they can cope with the situation for longer, or take action to reduce the anxiety eg by practising a self-calming strategy or leaving the room in a controlled manner). When such a challenge arises and staff can see that a child is becoming anxious, upset or over-aroused in one setting, they may feel the best thing to help the child reduce their arousal level would be to

leave the room and go and do an alternative activity with them in a different environment (perhaps the reading corner, or sensory room, or outside on the playground – whichever area would best help the child to resettle). This action of "withdrawing" a child from an over-stimulating environment, to one that is better suited to provide an activity that will help to reduce their current arousal level, should be seen as a positive action related to redirection. If a child's rising arousal levels are being well monitored then it should be possible to invite a child to willingly leave one area to accompany a member of staff to engage in a different activity elsewhere, without producing an escalation in the presenting behaviour.

9.4 "Seclusion" is a term which is often misused and the action it describes is therefore sometimes confused with other responses. The most recent guidance from the Department of Health defines seclusion as:

"The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving….Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others."

(Positive and Proactive Care, 2014, pg 28)

9.5 By preventing a person from leaving a room, seclusion is effectively a deprivation of liberty. Seclusion is therefore only permissible with a person who has either been detained under the Mental Health Act 1983, or is subject to a criminal order. Consequently it is not a practice to which we ascribe at ASAS.

9.6 However, there is a difference between deprivation of liberty and restriction of liberty and it is also acknowledged that there may be occasions when a child's anxiety level rises quickly and dramatically (perhaps as a response to a sudden action or noise by another child) and in this heightened state of agitation, the child may find it hard to see the invitation to leave the area (as in "withdrawal") as something designed to help them. In these circumstances, if staff feel that moving to another area is essential to enable the child to resettle, then they may feel it necessary to use physical contact to support the child to leave the room.

10 Non-Restrictive Physical Contact

10.1 "Physical contact" refers to direct physical contact between one person and another and can therefore include contact which gives guidance or support, or which serves an important emotional purpose. Examples of physical contact made within these contexts include: holding a child's hand to walk down the corridor, supporting a child to stand or sit, supporting the head of a child who has poor muscle tone to enable them to take a drink, , placing a hand on a shoulder to congratulate a child, or to offer empathy when upset, or touching a child's limb to apply first aid. Contact of these sorts is recognised as both proper and important within a caring role and is not considered to be restrictive unless a child actively resists such contact and the adult perseveres with the contact in spite of this.

11 Restrictive practices

11.1 In contrast to using physical contact to support teaching as described above, using physical contact to interrupt behaviour (eg to block self-injury or to prevent a child hitting out at a peer) or to lead a child out of a room, is a temporary restrictive practice, which the Department of Health's workforce guidelines document (2014) defines as: "Making someone do something they don't want to do or stopping someone doing something they want to do" (A Positive and Proactive Workforce, 2014, pg. 9)

11.2 The guidance acknowledges that there may be times when, in order to keep people safe, it may be necessary to ask children or young people to do something they would prefer not to do, or to prevent them from continuing to do something that might be harmful to themselves or others, pointing out that: "When people are distressed, ill, angry, confused or lack understanding of their situation they may need some degree of restriction to keep them or other people safe." (A Positive and Proactive Workforce, 2014, pg 13)

Examples of when such restrictive practices may be necessary include holding a child's hand to prevent them from running on ahead when crossing a road, insisting a child stays seated and wears a seatbelt when they would like to move about freely in a vehicle, holding a child's hand and perhaps placing and holding a favourite soft toy in it that they can squeeze, to interrupt their attempts to bite their fingers when they are upset, holding a hand and moving it down to a child's side if they are trying to hit or grab hold of another child, and in more extreme circumstances, holding a child's hand or arm to lead them out of a room when to stay there would increase their agitation and put them or others at risk.

11.3 When, as in some of the above examples, a restrictive practice involves making physical contact with a child to interrupt a behavioural response, it is considered to be a "restrictive physical intervention". DOH (2014) defines restrictive physical intervention as: "Interventions that restrict an individual's movement, liberty and/or freedom to act independently, in order to:

- take immediate control of a dangerous situation; and
- end or reduce significantly the danger to the person or others; and
- contain or limit the (person's) freedom for no longer than is necessary"

(A Positive and Proactive Workforce, 2014, pg 11)

11.4 In April 2014, the Department of Health launched a new two year initiative: "Positive and Safe" with the aim of radically reducing all restrictive practice. At ASAS, we endorse and fully embrace this initiative and, in line with DOH guidance would only ever consider using physical intervention when to not intervene in this manner would place a person in our care at risk. Using force involves making physical contact with a person to control, or in more extreme circumstances, restrain them. It can only be deemed to be reasonable if the amount of force used is the least amount required to bring about a desired outcome to keep people safe, and it is used for no longer than is absolutely necessary.

12 Definitions of physical contact and physical intervention

12.1 Physical Contact

12.2 Physical contact is an important part of support in a specialist setting such as ASAS, where it is sometimes necessary to prompt, guide, support, comfort or reassure a child. However, there may also be times when physical contact may be needed to interrupt behaviour. Under these circumstances ASAS defines "Physical Contact" as: "the interruption of a behaviour by means of 1 member of staff making physical contact with a child".

12.3 Examples of physical contact which may be necessary under these circumstances include:

- Holding a child's hand
- Leading a child by the hand or arm to another area
- Placing one or two hands (if the child is using both hands to initiate the behaviour) on a child's forearms, or holding both hands, to block repeated attempts at self-injury
- Using one or two hands to move a child's hand/s away from making contact with and hitting another child or young person

12.4 Under some exceptional circumstances, and with due consideration given to child protection, age-appropriateness and gender issues, physical contact might also involve:

- Placing an arm around a child' shoulder
- Embracing a child to give empathy, comfort or an opportunity to calm

12.5 Any physical contact which is used with a child as a planned strategy to interrupt a behaviour should be listed in their child profile document, or PBSP (Positive Behaivour Support Plan), and as such, should be discussed with parents/carers each time that the support plan is regularly reviewed. Although consent to use physical contact with a child is not required in law, it is important to ensure that parents/carers understand why any planned use of physical contact forms part of their child's support plan and that it is is only used to keep their child safe when either they, or someone else who shares their environment, may present a temporary risk to that safety.

12.6 Physical Intervention

12.7 At ASAS, the term "Physical Intervention" is used to describe contact made with a child when a behaviour that is being presented poses a greater risk to themselves or others and needs more than one member of staff to intervene to keep everyone safe from potential harm. "Physical Intervention" is defined as: the interruption of a behaviour by means of 2 members of staff making simultaneous physical contact with a child

12.8 "Team-Teach techniques seek to avoid injury to the young person, but it is possible that bruising or scratching may occur accidentally, and these are not to be seen necessarily as a failure of professional technique, but a regrettable and infrequent "side-effect" of ensuring that the young person remains safe." George Matthews, Team-Teach Director, 2017.

12.9 When using physical intervention as described above, staff should adhere to the basic principles of physical intervention in ensuring that any contact made:

- Does not cause pain
- Does not use excessive force
- Does not restrict breathing
- Does not involve holding joints

- Does not involve holding limbs out of body alignment
- Does not involve holding a child face down

12.10 Physical Intervention would not normally form part of a child's PBSP as such contact has the potential to escalate a situation. If it is used in an emergency as an unplanned response with any child, staff should carry out a dynamic risk assessment of the situation and consider what measures can be put in place to prevent the emergency situation recurring in the future.

13 Minimising the need for physical intervention

13.1 Physical Intervention involving 2 members of staff would not normally be used as a 'planned response' however, if in exceptional circumstances, ASAS shall consider that a child might need this level of support on an occasional basis, the following procedures should be followed:

1) A risk assessment should be completed in relation to the child, to identify the level of risk and a range of control measures that may be introduced to reduce the risks

2) If the risk assessment indicates that, even with some control measures in place, there may still be a need to use physical intervention, they should arrange for a Brief Functional Assessment to be carried out, and a Positive Behaviour Support Plan produced in relation to this child. This may be done by the behaviour specialist (who may wish to liaise with other professionals eg Educational Psychology services or LD CAMHS, for additional support with this process).

4) Parents/carers should be actively involved in the assessment process and if ASAS concludes that a physical intervention needs to be included in a child's PBSP then parents need to feel reassured that such actions are only ever taken as a last resort and to keep their child safe.

14 Monitoring, recording and reporting

14.1 The purpose of having a PBSP (Positive Behaviour Support Plan) is to help a child to overcome the challenges they face in dealing with everyday life. In order to know whether the PBSP put in place is having the desired positive impact, it is necessary to monitor and record behavioural incidences to judge whether or not they are reducing in frequency, duration or severity. This monitoring and recording may take several forms, and may include logging incidents of behaviour within a child's PBSP documentation folder or physical intervention log book.

14.2 Where physical contact is made with a child as a behavioural response, this is likely to be recorded within a child's PBSP folder. Information regarding these occurrences will be shared with parents at regular intervals, or more frequently if specifically requested.

14.3 Where physical intervention is used with a child as a behavioural response, this would always be recorded in the Physical Intervention log book. Parents would be informed the same day that such an incident had taken place, and provided with details of the incident, including a copy of the log if required. Parents should also feel reassured that ASAS considers such

incidents exceptional and will always review practice and responses following such an occurrence, to find alternative ways forward to better support their child.

14.4 In addition to the above, there will be times when significant behavioural incidents occur during ASAS provision, in which a child becomes anxious, angry, upset or distressed and which are resolved without staff using physical contact. If such an incident occurs, an incident log will be made, and information will be shared with parents, so that they will be aware that their child has experienced some difficulty that day. Staff at ASAS will reflect critically on such incidents to consider whether the child has any underlying unmet needs which have to be addressed, and will work to identify and respond to these in liaison with parents/carers and if required, additional multidisciplinary professionals.

15 Responding to accusations

15.1 Staff, children or young people who are involved in an incident where force is used will be given whatever appropriate medical and pastoral support is required. Where an accusation of the use of excessive force is made against a member of staff, this will be investigated without prejudice. Suspension of the member of staff while the investigation is undertaken is not automatic, however, pastoral support will be provided as required. If any allegations are proven to be false, disciplinary procedures against the person bringing the complaint may be instigated if considered appropriate.

16 Bullying and hurtful behaviour

16.1 Bullying involves the persistent physical or verbal abuse of another child or children. It is characterised by intent to hurt, often planned and accompanied by an awareness of the impact of bullying behaviour. A child who bullies has reached a stage of cognitive development where he or she is able to plan to carry out premeditated intent to cause distress. We will act upon any concerns that may be raised.

16.2 If a child hurts another child, staff will model compassionate behaviours, and encourage the other child to help and learn positive behaviour. In a positive environment children are generally eager to please, and often they will feel remorseful and will want to apologise if they feel that their behaviour has hurt or disappointed someone.

16.3 We will not allow and will deal with the following inappropriate behaviour:

bullying, hitting, punching, spitting, biting, pinching, pushing, negative body gestures, name calling, racist remarks, shouting, swearing, intimidation, lack of respect for people and property, invasion of privacy. This list is not exhaustive.

This applies to children, staff, parents and all visitors to ASAS.

16.4 Physical or humiliating punishment such as smacking, shouting and shaking will not be used or threatened. We believe that aggression breeds aggression and if children witness adults behaving in this way they will think that this is an acceptable way to interact with others. All discipline must have a positive effect on a child's development.

16.5 All the management techniques, outlined above, apply equally to management of bullying behaviour

17 Review arrangements

17.1 This policy will be reviewed bi-annually unless required sooner to reflect changes in legislation or completion of a post incident investigation.

18 References

18.1

- "Physical Interventions: A Policy Framework" (BILD, 1999)
- "Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder" (DES/DoH, July 2002)
- "Challenging Behaviour: A Unified Approach" (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, March 2007)
- Equality Act 2010
- "Ensuring Quality Services: core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges" (Local Government Association, February 2014)
- "Positive and Proactive Care: Reducing the Need for Restrictive Interventions" (Department of Health, April 2014)
- "A Positive and Proactive Workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health" (DH/Skills for Care/Skills for Health, April 2014

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Physical Intervention Form

Name of Child:		D.O.B:	
Date:		Group:	
Time:		Location:	
Names of staff involved:			
Names of witnesses:			

Lead up to the intervention					
Disruptive behaviour		Hurting other children		Hurting themselves	
Hurting staff		Absconding		Verbal abuse	
Damage to property		Argumentative		Refusal to do as asked	
In distress		Threatening behaviour to staff		Threatening behaviour to other child	
Throwing equipment		Overly stimulated / excited		Change of routine	
Transition time		Unsettled arrival		Opting out	
Strategies used before physical intervention					
Humour		Verbal advice and support		Firm clear directions	
Negotiation		Limited choices		Distraction	
Diversion		Reassurance		Planned ignoring	
Calm talking and stance		Swap adult		Reminders of consequences	
Withdrawal offered*		Time out**		Success reminders	
Withdrawal directed*					
Reason for intervention					
Risk to self – physical harm		Risk to others – physical harm		Risk of damage to property	
Risk to emotional safety					
other					
Form of physical intervention used following Team Teach principles					
THE RESTRAINTS BELOW MUST BE RECORED IN THE BOUND AND NUMBERED BOOK				One person - escort	
T-Wrap – standing – RESTRAINT		Two person – figure of four – RESTRAINT		One person – half shield	
T-Wrap – seated – RESTRAINT		Two person – single elbow – RESTRAINT		Two person – friendly escort	
T-Wrap – ground - RESTRAINT		Two person – Double elbow – RESTRAINT		Other	
If other please state:					

Length of restraint (mins):					
Injury to child / staff involved:	Yes / No	Accident form completed:		Yes / No	
Post incident support offered:	Yes / No	By who:			
Parents informed:	Yes / No	By who:			
Completed by:		Role:		Date:	
Signed (Team Leader)				Date:	
Signed (Assistant PM)				Date:	
Signed (Project Manager)				Date:	

*Withdrawal – removing a child from a situation which causes anxiety or distress to an environment where they can be continually observed and supported until they are ready to resume their usual activities. This can mean removing a child from a group to allow them time to calm down or to prevent a situation from escalating. They may need time away from the situation to break the pattern of their behaviour or to reduce their level of anxiety. This "calm time" could be time in the playground, a quiet room, or sitting in another quiet area of the building, they are fully supported by an adult always and **never in a room / area alone.**

** Time out – restricting a child's access to positive reinforcements as part of the PBS plan, in a room or area which they may freely leave. It is a specific behaviour management technique and does not necessarily literally mean time spent out of the group, but rather refers to a withdrawal of attention and/or things they find rewarding (it could be as simple as turning away from a child who is attention seeking, or positioning a child away from the group).

Positive Behaviour Support Plan

Part A – Childs Details

Child's Full Name

Gender Female ☐ Male ☐ Date of Birth ___/_____/_____ (DD/MM/YYYY)

Part B – Target Behaviours

YES / NO	Type of behaviour	Description of what this behaviour looks like? Please write as much detail as possible
	Verbal aggression	
	Physical aggression	
	Inappropriate removal of clothing	
	Smearing of faeces	
	Absconding	
	Environmental damage	
	Self-injurious behaviours	

Part C – Proactive strategies

Type of behaviour	For each behaviour listed in Part B, please describe what you do to help prevent the behaviour occurring in the first place.	How successful is this in preventing the behaviour occurring?

Part D – Reactive strategies

Type of behaviour	If a behaviour does occur, what do you and others do to prevent injury to your child and others?	How successful is this in stopping the behaviour?

Part C – Consent and agreement

Should any of the behaviours outlined in this plan occur, staff will always attempt to use, the strategies described in this plan first.

If your child displays a new behaviour, or one that is not outlined in this plan, staff will react accordingly, using the least restrictive option that is proportionate to the behaviour being displayed, and the risk posed to your child's self and others around them.

All incidents of behaviour that occur whilst your child is with ASAS will be documented and communicated with you upon collection of your child or sooner if necessary.

1. I confirm that the information provided above is a true account of my child's needs at the time of completion.
2. Should any of the information change, I will inform ASAS before they next support my child.

Signature [This signature applies to point 1 and 2.] Date [___/_____/_____ (DD/MM/YYYY)]

Relationship to child [ ]

Aireborough Supported Activities Scheme

PROVIDING LEISURE ACTIVITIES FOR CHILDREN WITH DISABILITIES

Positive Handling Plan	**Name:**
	Group:
Triggers:	**Medical Information:** (that need taking into account before physically intervening)

Stage of Crisis	**Topography of behaviour** (Describe what the behaviour looks/sounds like)	**Preferred supportive/intervention** (Describe strategies that should be attempted at each stage, including critical friends)
Anxiety	(Describe common behaviours/situations which are known to have led to positive handling being required)	
Defensive/Escalation		
Crisis		
Recovery		
Depression		
Follow Up		

Additional information/Preferred handling: (Describe preferred holds, standing, sitting stating numbers and names of preferred staff and useful 'get outs' that can be used when holding)
Notification required: (in discussion with parents)

Plan agreed by

Name (child)_____ **Signed**_____
If appropriate

Name (parent/carer)_____ **Signed**_____

Name (ASAS staff)_____ **Signed**_____