The Red Door School

Positive Behaviour Support and the Use of Restrictive Practices

Approved by Board of Management:

Next Review date:

Signed: _____
(Chairperson of the Board of Management)

Positive Behaviour Support and the Use of Restrictive Practices

Introduction

This policy was originally drafted by the Principal and Clinical Supervisor. The Red Door School promotes restrictive free environments for all pupils and has a proactive and least restrictive approach to support behaviours of concern. This policy document should be read in conjunction with our 'School Continuum of Support' and 'Code of Behaviour 'Policy documents.

Policy Rationale & Relationship to School Ethos

The ethos of The Red Door School is to provide child-centred education through evidence based individualised programmes for each pupil underpinned by the child safe guarding risk assessment.

Legal Framework

The policy is based on guidance from the following:

- Education and Welfare Act 2000
- Safety, Health and Welfare At Work Act, 2005
- Safety, Health and Welfare at Work (General Application) (Amendment) Regulations 2007 (as well as other statutes and standards)
- Children First Guidelines 2011
- Department of Education Child Protection Procedures for Primary and Post Primary Schools 2017
- Guidelines for Schools on Supporting Students with Behavioural, Emotional and Social Difficulties - An information guide for Primary Schools: DES 2013
- UN Convention on the Rights of the Child
- UN Convention on the Rights of Persons with Disabilities
- NCSE (2015) Policy advice paper No. 5: Supporting children with ASD in schools
- Mental Health Commission (MHC, 2010) Code of Practice: Guidance for persons working in mentalhealth services with people with intellectual disabilities.
- Health Information and Quality Authority (HIQA) (2016). Guidance for designated centres onrestraint procedures (2014, updated 2016).

This policy should be read in conjunction with the following school policies and structures:

- Child Safeguarding Statement
- Anti-Bullying
- Code of Behaviour
- Safety Statement
- Admissions Policy
- Intimate Care and Toileting

- Parental Complaints Policy
- Supervision Policy
- Administration of Medication

Aims and Objectives

The primary aims / objectives of the policy are to:

- To provide clear guidelines to staff, pupils and parents/guardians regarding the use of restrictive practices in our school.
- To create a culture within the school of where there is minimal use of restrictive practices, where any restrictive practices used are: the least restrictive possible, used for the shortest duration possible and proportionate to the presenting risks.
- To promote the children's development of effective relationships, mood management and interpersonal skills.
- To develop individual proactive strategies (outlined in a pupil's Support Plan), where applicable, that reduce the likelihood of challenging behaviour occurring and manage its impact on the child/others if/when it does occur.
- To ensure that parent(s)/guardian(s) are consulted and consent to the ways in which their child's behaviour is supported while at school.
- To adopt and maintain a low arousal approach throughout the school, keeping the environment as calm as possible.
- To manage serious incidents if they occur.
- To reduce the risks associated with serious incidents such as injuries to pupils, staff or others or serious damage to property.

DEFINITIONS

Restrictive Practices

The term Restrictive Practices refer to the use of mechanical restraint, physical restraint, environmental restraint or chemical restraint for the purpose of requiring a child to refrain from behaviour that may cause damage or injury.

Restrictive Interventions are defined as deliberate acts on the part of the other person(s) that restrict a person'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, and or
- reduce significantly the danger to the person or others

(Restrictive Interventions Policy, NHS Foundation Trust)

Mechanical Restraint

Mechanical restraint involves the application and use of materials or devices on or close to a child's body that he/she cannot easily remove and that restrict freedom of movement of a part or all of their body or that restrict his/her normal access to the body or parts thereof. Some examples of mechanical restraints are: belts, straps, harnesses, modified seatbelts (guards/locks/harnesses), restrictive clothing, cuffs, splints, bed rails, recliner chairs and wheelchair trays.

Physical Restraint

Physical restraint is the use of physical interventions such as holding or guiding/blocking a child or part of his/her body, for the purpose of preventing his/her free movement (MHC, 2010). Examples of such interventions are: standing in the way of a child so as to block/guide them in another direction, and include certain restrictive PCM techniques.

Chemical Restraint

The use of medication to control or modify a child's behaviour when no medically identified condition is being treated (HIQA, 2016). This form of restraint is also known as 'psychotropic medication as restraint', which is defined as the use of sedative or tranquilising drugs for thetreatment of problem behaviours (MHC, 2010), where this use extends beyond a short-term measure of up to 3 months. Chemical restraint is only considered as a last resort and on prescription of a medical practitioner.

Note: Drug treatments for any underlying medical or psychiatric conditions that a person may have are not included in this category. Treatment for anticipatory anxiety prior to procedures such as phlebotomy, medical/dental examination and/or treatments are also not considered to be restrictive practices.

Environmental Restraint

The use of environmental design or barriers to intentionally restrict a child's movement in, use of or leaving of an area. Such measures include, but are not limited to: locked doors, close tables that prevent a mobile child from leaving a chair, removing powered mobility or alternative communication devices, handles/catches out of reach and strategies that involve the withdrawal or separation of the person from others.

In schools, because of the developing safety awareness of children and the necessity to maintain a safe environment for them, it is necessary to restrict the children's access to certain areas and their unsupervised exit from the building. In this school, the following restrictions apply as standard practice, in order to provide a safe and calm learning environment for pupils:

- locked/fobbed/coded doors: school entrances
- Thumb lock on classroom doors
- Handles/catches out of reach on some presses and classroom doors
- Locked presses (e.g. for chemicals, cleaning products, sharp objects etc.)
- Window restrictors and locks

Various terms can be used to describe environmental restraint strategies that involve separating or withdrawing a child from others e.g. time out, time away, withdrawal, use of quiet space, single separation, seclusion etc.

In the interest of clarity, 4 categories of separation strategy are defined here:

- **Access to a Separate Area**: When a child goes into a separate unlocked area by choice. This

may be scheduled, as part of their routine, or in particular circumstances e.g. through use of a break card or communication book. Access to a separate unlocked area is not a restrictive strategy.

- **Withdrawal**: When a child is encouraged into a separate unlocked area or others are moved out of the area he/she is in. This is not considered a restrictive strategy.

- **Single Separation**: When a child is alone in a separate locked area. Single separation is a highly restrictive strategy of last resort. It should only be considered when all other less or non-restrictive strategies have been ruled out. Any use of single separation must be recorded (reasons for, duration, persons involved in the decision). The child must be continuously monitored and supervised during any period of single separation and the strategy must be discontinued at the earliest possible safe time.

- **Seclusion**: Seclusion is unsupervised single separation in a locked area. This is a prohibited practice in this school.

Note: The Department of Education and Skills (as cited in NCSE, 2015) provides for "small safe spaces" in schools that teach children with special educational needs. These rooms are used by children who choose to access it as a "separate area" (non-restrictive) and/or for the small number of children whose individualised School Support Plan includes the strategies of withdrawal or single separation.

Note: Access to a Separate Area and Withdrawal are not restrictive strategies in and of themselves, but they become restrictive if physical restraint (as defined above) is used when bringing the childto a separate area or when removing others from the area. It is important to note that blocking or physical guiding are forms of physical restraint when they are used to control or direct a child's movement.

Non-Restrictive Physical and Healthcare Interventions

Some interventions used to support children's physical or healthcare needs may appear similar in design or approach to restraints, but are not restrictive. Such interventions include:

- Supporting/holding limbs during personal care or therapy sessions/exercises and transitions

- Providing a child with physical prompts/guiding through an activity, including physical reassurance where appropriate e.g. in busy/dangerous environments.

- Protective helmets worn due to seizures/recurrent falls

- Wheelchairs/ buggies (for mobility reasons or reduced exercise tolerance/stamina)

- Shower/bath/toileting aids, standing/walking frames, sleeping/lying positioning systems

- Straps/harnesses/trays used for postural purposes

- Arm splints, body suits and harnesses that are prescribed for orthopaedic or tone management purposes

The above interventions are not considered to be mechanical or physical restraints or restrictive practices **provided** they are required for the purpose of improving or maintaining a child's health or comfort and not used with the intension of restricting the child's freedom of movement.

Two important exceptional circumstances are:

- if the child resists, refuses or appears distressed by the physical/healthcare intervention, or
- if the child presents with a mixture of behavioural and postural/medical needs, to the extentthat the intervention could be perceived by the child or by others as restrictive in nature.

Note: If either of the above exceptional circumstances occurs, the intervention must be considered to have a restrictive element and must be discontinued while advice is sought from the Clinician prescribing use of such supports and the matter is further referred to the Board of Management.

Prohibited Practices

The following practices are expressly prohibited for all school staff working with pupils in all situations:

- Any use of a restrictive practice, meeting any of the above definitions for a mechanical, physical, environmental, or chemical restraint, which has not been given the appropriate level of approval (see table under Restrictive Practices below for the level of approval required for different levels and types of restrictive practice), except in emergency circumstances (as outlined in policy)
- Any abusive use of physical, mechanical, environmental, or chemical restraint
- Any infliction of pain, discomfort, negative consequences, punishment or humiliation on a pupil or threats thereof
- Any use of seclusion (unsupervised single separation)

N.B. Should a staff member observe or suspect the conduct of a prohibited practice, this should be treated as a safeguarding concern and the Child Safeguarding Statement of the Red Door School should be followed.

Professional Crisis Management (PCM) Training

The code of crisis management researched and approved by our Board of Management is that of the Professional Crisis Management Association (PCMA). PCM is a complete and fully integrated system that allows trained staff to manage crisis situations effectively, safely and with dignity. It is approved by the British Institute for Disabilities.

Three modes of response may be put into operation:

- Transportation – physically moving a student from one area to another.
- Vertical immobilisations – physically suspending the movement of a student in a standing position.
- Horizontal immobilisations – physically suspending the movement of a student on an approved mat.

The school will have a member of staff who will be fully trained in PCM and will also be a fully qualified PCM

Trainer. All staff implementing PCM will be fully trained and will be subject to annual recertification in order to continue practicing PCM. Procedures for use of PCM Professional Crisis Management (PCM) procedures are reactive strategies and will be used only in specific and planned crisis situations.

Whole School Positive Behaviour Support Approaches

Whole school Positive Behaviour Support approaches are non-restrictive and are appropriate in a context of a school setting. They are included in the Policies and Procedures of the School relatingto: Code of Behaviour and The School Continuum of support Policy.

Training:

- PCM training.
- In house Positive behaviour support training.
- Training available to schools from Middletown, National Council for Special Education, clinicians, etc.

Education Based:

- Proactive strategies (non-restrictive) e.g. Sensory breaks, visual schedules, use of rewards, verbal supports, visual schedules, praise, reassurance, positive reminders, offering choices, short tasks only, calm stance and facial expression of staff, careful use of tone of voice and choice of words by staff, planned ignoring, change of staff, distraction/diversion, use of humour, negotiation, outlining limits/boundaries, selective attention, time given to process/cool down, close supervision, relaxation music, chewy tubes, hand or foot massage, deep pressure, messy play, movement breaks.
- Reinforcement Strategies e.g. token systems, First/ then boards.
- Physical touch and hugs for the purpose of comforting a pupil when upset.
- Physical touch for the purpose of sensory programmes, P.E., oral motor programmes.
- High fives, pats on the arm, hand-over-hand support for encouragement/reward/prompting
- Wellbeing and low arousal strategies.
- Access for pupil's to a separate area, or comfort areas, sensory and soft play rooms, areas to increase access to exercise.
- Access to 1:1 teaching areas, individual workstations, timetables.
- Removal of possessions from a pupil during the school day (if required to help the pupil with focus and attention).
- Access to increased pupil staff ratio's, specialist staff, preferred staff if and where possible.
- Use of a break card by a pupil to indicate the need for a break from normal school activity to a less demanding task either inside or outside the classroom, as indicated on a choice board, or previously agreed.
- Use of more time card by a pupil to request additional time with a preferred item or activity.
- De- escalation strategies, i.e. what staff do in response to the early warning signs to help intervene as early as possible. This will be individual to the child and should be outlined in their Support plan.

Environmental:

- In all school settings, some environmental restrictions are necessary for the safe operation of the school and for the safety and wellbeing of the children. The environmental strategies used in this school are listed under point 5 (Definitions) above. These are undertaken to safeguard vulnerable pupils from leaving the school building unsupervised or to prevent access to unsafe areas or equipment.
- The non-restrictive strategies of separate areas and/or withdrawal strategies are used with individual children on occasion, as/if appropriate and when necessary, in order to support them to regulate and to maintain their safety and wellbeing and that of others. (see Point 5. Definitions above).

Restrictive Practices

These practices are restrictive in nature and therefore must be discussed with the Principal and/or Clinical Supervisor in the first instance. They require team discussion, parental consent and approval of the School Principal, and, in certain instances, the Board of Management (see table below for details of how the various levels of restrictive practices are decided, documented and approved):

Note: The Principal may approve an intervention provisionally and agreed with parents and in some instances with relevant multi-disciplinary staff, while waiting on approval from the Board of Management.

Whole-School Restrictive Practices		
Approach	**Documentation**	**Persons Responsible**
Some environmental strategies are used as part of the whole-school positive behaviour support approach (listed under Environmental restraint definition above).	If any new or additional general environmental restrictions not already listed in the school policy are proposed, these must be considered by the BOM as an amendment to this policy.	Any policy amendments are submitted to the Board of Management for approval.

Individualised Restrictive Practices		
Approach	**Documentation**	**Persons Responsible**

Angel clip or seatbelt guard.	'Modification to Seatbelt on Transport' form, signed by parent(s)/guardian(s).	Plan is developed by Teacher & Clinical Supervisor, in conjunction with the Principal, with advice of additional clinicians as available/appropriate. Plan has signed consent of Parent(s)/Guardian(s).
Individualised Restrictive Practices Requiring Approval		
Approach	**Documentation & Reporting**	**Persons Responsible**
PCM Response • Transportation: physically moving a student from one area to another. • Vertical: • Immobilisations: physically suspending the movement of a student in a standing position. • Horizontal immobilisations: physically suspending the movement of a student on an approved mat.	Detailed in the pupil's School Support Plan & signed by parents/guardians. PCM Post-Incident Report' form is completed after any/each use of strategy. Request for Approval (with copy of School Support Plan attached).	Plan is developed by team: teacher, Clinical Supervisor, relevant clinician(s), in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Form/Plan is submitted to Principal.
Transport harness/vest	Detailed in clinical report or guidelines, as appropriate. 'Modification to Seatbelt on Transport' Form is completed and signed by parent(s)/guardian(s). Request for Approval Form.	Plan is developed by team: teacher, Clinical Supervisor, relevant clinician(s), in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Form/Plan is submitted to Principal.

Wheelchair or buggy use with an otherwise ambulant pupil (other than for physical/ healthcare reasons)	Detailed in pupil's Support Plan Request for Approval Form (with copy of Support plan attached).	Plan is developed by team: teacher, Clinical Supervisor, relevant clinician(s), in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Form/Plan is submitted to Principal.
Straps/trays/reins to keep a pupil from standing up or to otherwise control his/her movement	Detailed in pupil's Support Plan Request for Approval Form (with copy of Support plan attached).	Plan is developed by team: teacher, Clinical Supervisor, relevant clinician(s), in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Form/Plan is submitted to Principal.
Gloves, splints, helmets, all-in- one clothing to manage a pupil's self-injurious or injurious behaviour or to maintain their dignity.	Detailed in pupil's Support Plan Request for Approval Form (with copy of Support plan attached).	Plan is developed by team: teacher, Clinical Supervisor, relevant clinician(s), in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Form/Plan is submitted to Principal.
Single Separation (see definition above)	Detailed in pupil's School PBSP (see above). Recorded on 'Use of Single Separation' record sheet (reason for use, times, duration, etc) Request for Approval (with copy of School PBSP attached).	Plan is developed by team: teacher, relevant clinician(s), parent/guardian, in consultation with the School Principal. Plan has signed consent of Parent(s)/Guardian(s). Principal reports to next BOM meeting (no identifying details given).

Emergency Use of Restrictive Practices		
Approach	**Documentation & Reporting**	**Persons Responsible**
Best practice guides that restrictive practices should only be used as part of a planned approach, with appropriate documentation, recording and governance (approval). On occasion, however, emergency situations arise which require an immediate decision to be made by those caring for or supporting the pupil to use a restrictive practice in order to safeguard the safety and wellbeing of the pupil or others.	Record the use of the strategy in contemporaneous notes to include notes on: *what led to the decision to use the practice *what non-restrictive strategies were first tried/considered and why these did not suffice in the situation *when and for how long the strategy was used *how the pupil reacted to its use *any adverse effects noted Request for Approval (with copy of above notes/record attached).	If restrictive strategies are used in an emergency situation, with a pupil for whom they are not detailed in a written Support plan: *the parent/guardian must be notified (on the day). *Reported by Principal at next BOM meeting. *Seek interim approval from Principal.

Post Incident Support

Following an incident the priority is to look after the pupils and staff involved before reports are filled out and reviews held.

Debriefing/ Recovery

Pupils are assisted to recover from an incident by staff. Useful strategies to support a pupil to recover should be identified in the pupil's Risk Assessment and Support Plan. Staff may need to take a break from the site of the incident to recover. This time is afforded to them, particularly when dealing with a very stressfulsituation, by calling on support from an adjacent class. Ideally time should also be set aside at a later stage to carry out an Incident Review.

Incident Reports

Incident reports should be filled out by the staff after an incident. The following is a guide to what form

to fill out and criteria for recording. School management can also be contacted for guidance.

FORM	CRITERIA
General Data Collection Recording Forms	Filled out and kept in class file for recording low level behaviours that do not result in any injury to staff or damage to property but are worthy of recording. These may be designed by class teacher or Clinical Supervisor based on the child.
Use of Single Separation Form	When Single Separation is used following all the guidelines outlined above.
Use of PCM Form	When a PCM technique is used following all the guidelines outlined above.
ABC Forms	Filled out as assessment tool for behaviours of concern to identify patterns/functionsof behaviour. Used for analysis purposes only.
Incident Form	This is filled out when someone has received an injury as a direct result of challenging behaviour, when there has been a near miss of a significant incident that has the potential to be a risk to safety and/or significant damage to property. This form is filled out by staff and approved by the Principal. It is kept on file as per school guidelines for recording and keeping of information. The school refers it to HSA if the injured person is out of work for 3 or more consecutive days as a result of the injury.

The best time to fill out an incident report is when the situation has settled and the pupil and staff have had time to recover. The report is signed by the Principal or Deputy Principal who will review the interventions used by staff, decide if any further action is required, to provide any further careor reassurance to pupils or staff, and to inform any future recommendations.

Risk Assessment review

Following incidents where physical intervention has been used, the teacher and SNAs involved in the incident will meet with the Principal / Clinical Supervisor as appropriate to review any existing Risk Assessments. Input from any external clinicians will be sought where required. Any changes to risk assessments will be discussed with parents and, where a higher level of intervention is being sought, this must be approved by BOM.

Using a PCM Physical Restraint

If a PCM Physical restraint is used staff must ask themselves the following questions:

- Am I trained? If not is there a trained member of staff nearby who can help?
- Am I using the minimum force for the shortest time?
- Is the intervention I'm using correct?

- Can I reduce the amount of pressure?
- How best can I communicate with the pupil and with other staff?
- Can I manage this? Should I ask someone else to take over?
- Did I test for compliance at regular intervals?

REVIEW AND MONITORING

The Principal and Clinical Supervisor will conduct termly reviews and the Principal will provide feedback in the Principal's Report to the BOM.

ROLES AND RESPONSIBILITIES

All stakeholders in the education of the pupils will take responsibility for implementing this policy.

Ratification & Review

The Board of Management ratified this policy on ---------- .

Review

This policy will be reviewed in 2 years time and amended as necessary.

Signed: _____ Date: _____
(Chairperson of Board of Management)

Signed: _____ Date: _____
(Principal)