Date of Last Review	2023
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POLICY ON POSITIVE BEHAVIOUR SUPPORT

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1. Aims of the Policy

1.1 To make clear to service users, parents and carers, staff and the public that Garvald Edinburgh is committed to the approach of Positive Behaviour Support to improve the quality of life for service-users.

1.2 To outline what PBS is, who it is for, and why it has been adopted by Garvald Edinburgh.

1.3 To describe how PBS is implemented at Garvald Edinburgh, including how staff are trained in the approach, how data will be gathered to contribute to the functional assessment of behaviour, and how behaviour support plans will be used.

1.4 To promote the approach of PBS to ensure its theory, values, and practice are embedded throughout the organisation

1.5 To link the policy on Positive Behaviour Support to other key policies at Garvald Edinburgh

2. Policy Statement

2.1 Garvald Edinburgh recognises that adults with learning disabilities may present behaviour that challenges. We believe that behaviour that challenges always happens for a reason and may be the person's only way of communicating an unmet need.

2.2 Garvald Edinburgh believes that PBS has a sound evidence base and provides the right support for a person, and those who care for them, to help people lead a meaningful life and learn new skills without unnecessary restrictions.

2.3 Garvald Edinburgh believes the theory, values, and practice of PBS are wholly compatible with the principles of Social Therapy that guide our work.

2.4 Garvald Edinburgh is therefore committed to the application of PBS to ensure its theory, values, and practice are embedded throughout the organisation.

3. What is Positive Behaviour Support?

Gore N J et al (2013) gave a definition and scope for positive behaviour support in the 'International Journal of Positive Behaviour Support (3(2), 14-23)' in the following way:

"Positive Behaviour Support (PBS) is a multi-component framework:

- For developing an understanding of challenging behaviour displayed by an individual based on an assessment of the social and physical environment and broader context in which it occurs
- With the inclusion of stakeholder perspective and involvement
- Using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support

- That enhances quality of life outcomes for the focal person and other stakeholders"

PBS is not a 'quick fix' for 'problem behaviour' and it doesn't happen overnight. Behavioural science tells us that we cannot successfully support people with behaviours that challenge without applying some core values or addressing the many factors that are known to influence behaviour. A PBS approach must therefore demonstrate certain key features:

- It is values based (these values include the commitment to providing support that promotes inclusion, choice, participation, and equality of opportunity)
- It assumes that behaviours of concern have a meaning/are a communication; it is our responsibility to find out that meaning and either alter the environment, or our behaviour, to teach less harmful alternatives, or to teach new skills or ways of communicating
- It involves working in partnership with individuals and their families/carers
- It is non-punishment based
- It is multi-component and evidence based (interventions are not based on personal opinions about what should happen)
- It is personalised and holistic – it relates to the whole person and their life, not just their behaviour
- It makes us challenge our assumptions
- Its ultimate goal is to enhance happiness, quality of life, and well-being
- It is a systems approach

BILD (British Institute of Learning Disabilities) have produced the following video to describe PBS:

https://www.youtube.com/watch?v=epjud2Of610

4. Terminology

This policy uses the term "behaviours that challenge" – you may also hear other terms, such as "challenging behaviours", "behaviours of concern", "distressed behaviours" or "risky behaviours". These terms are all used to describe behaviours that have a negative impact on a person's life and/or others around them. These behaviours may put them at risk of harm, exclusion or the use of restrictive practices.

5. Legislation and Evidence Based Research

The values underpinning PBS are entirely congruent with:

- The Scottish Social Social Services Council (SSSC) Codes of Practice:
- The National Care Standards
- Scottish national policy and frameworks for people with intellectual disabilities; the 2019 revision of the Scottish Government's Keys to Life Strategy places

strong emphasis on the principles of PBS and commissioning local authorities in Scotland have been instructed to facilitate PBS as a national standard.
- The Adults with Incapacity (Scotland) Act 2000
- Deprivation of Liberties Safeguards (May 2015)
- The Mental Health Act (1983)
- The Human Rights Act (1998)

There is strong evidence that PBS is effective in producing positive outcomes, such as increasing the person's skills and positive life opportunities. The approach is based on psychological theory, using processes of Applied Behaviour Analysis. PBS has been developed within a variety of settings in the UK over the past three decades, and there is a strong practice base for its use. It is recommended as best practice within professional practice documents (Royal College of Psychiatrists, British Psychological Society, and Royal College of Speech and language Therapists, 2007).

Evidence based research has demonstrated that outcomes for those allocated PBS have been significantly better and reduced stress in family and carers. Practitioner-researchers have been using single case experimental designs to evaluate intervention effectiveness for several decades. These have in turn been subject to review and meta-analyses (Campbell, 2003; Carr et al., 1990, 1999: Didden et al., 1997: 2006; Harvey et al., 2009; Marquis et al., 2000; Scotti et al, 1991). A more recent study (Heyvaert et al., 2010, 2012) included over 250 single case design studies and confirmed that behavioural interventions deliver positive outcomes for individuals whose behaviour challenges. There is also randomised controlled trial (RCT) evidence which attests to the efficacy of PBS.

6. How is PBS implemented?

The Management Team at Garvald Edinburgh completed the PBS coaches programme in April 2019 and developed an action plan to embed the approach throughout the organisation. This has involved systems development (such as the production of this policy and the improvement of procedures and paperwork related to incidents), communications with members, staff, the Board of Directors, and parents and carers, and the development of a staff training programme for PBS. Garvald Edinburgh has taken a three-tiered approach to the implementation of PBS (See Appendix 1 to see this in diagrammatic form). This is based on the notion that:

- all members should receive high quality person-centred support from skilled direct contact staff (i.e. Workshop Leaders and Workshop Support Workers) in high quality environments (Level 1 in the diagram).
- Some members will require more specialist support which will involve some functional assessments and personal plan development, and this will be coordinated by PBS Practice leaders (i.e. Line Managers, Level 2 in the diagram)

- A small number of service-users will require intensive individualised supports including full functional behaviour analysis and behaviour support plans and this will require coordination by an external Specialist PBS Practitioner (i.e. A Community Learning Disability PBS Consultant, Level 3 in the diagram)

The tasks, responsibilities, and knowledge related to each of the three levels in the organisational response to behaviour that challenges are listed and illustrated in a flow chart in Appendix 1. A case study to illustrate PBS in practice is provided in Appendix 4.

7. The PBS Competence Framework

This policy, and the staff training programme, is partly based on the PBS Coalition's PBS Competencies Framework 2015, this document can be found at:

http://pbscoalition.blogspot.com/

The PBS Coalition's PBS Competence Framework is a resource that provides a common and shared knowledge and associated actions necessary for the delivery of PBS to people with learning disabilities and behaviours that challenge. The objectives of the framework are that:

- More individuals with intellectual disabilities and behaviours that challenge will benefit from high-quality, evidence-based support delivered by competent professionals working as part of multi-disciplinary teams.
- Practitioners will benefit from professional development and occupational standards.

The framework details the competencies that define best practice and is a resource that provides a common a shared knowledge and associated actions necessary for the delivery of PBS.

The framework is divided into three main areas each of which details specific competencies that need to be achieved to deliver effective support:

- ***Creating high quality care and support environments*** aims to ensure that organisations, and those providing individual support, operate from a person-centred foundation. The purpose of person-centred support is to enable a high quality of life for all concerned, which includes mitigating risk factors for the development and maintenance of behaviour that challenges. The likelihood and impact of behaviour that challenges is likely to be reduced in supportive environments that meet a person’s social, physical and mental health needs, and that facilitate engagement, communication, choice and control. Many of the competencies described here, while having particular resonance in relation to supporting people with behavioural challenges, should be staple features of any high-quality service for people with intellectual disability.

- ***Functional, contextual and skill based assessments*** focuses more on emerging or established behavioural challenges and aims to ensure that the support outlined for each person is based on a thorough understanding of that person's needs, preferences, abilities, communication style, the function for them of any behaviour that challenges and how this is maintained, and the context and resources in which and with which such support may be given.
- ***Developing and implementing a Behaviour Support Plan*** **(BSP)** also focuses emerging or established challenging behaviours and aims to provide a detailed and personalised description of how best to support each person with developmental disabilities and their behaviours of concern. It will include prompts to guide the behaviour of those supporting them, strategies to redesign their environment and therefore reduce challenging behaviour, and a plan to develop their skills and appropriate behaviour. The competencies relating to evaluating intervention effects and on-going monitoring aim to ensure that a BSP continues to meet a person's needs and is systematically adjusted in response to any changes in those needs, the person's skills and his or her environment.

These three aspects relate closely to the three-fold picture of Thinking (Theory), Feeling (Values), and Willing (Practice) in Social Therapy, and the individual competencies detailed within each area also correspond to many of the principles and values within Social Therapy.

8. PBS Training

An introduction to PBS is delivered for all staff as part of our core induction programme. Following this, staff are required to complete a module based on the three competence areas detailed above with mentor support from a PBS Coach, and to attend a second half day training session which develops understanding of form and function in behaviour, theoretical models of behaviour, methods of data collection, and approaches to functional assessment and behaviour support plans. It is intended that this training will equip staff to fulfil their role at level 1 in the three-tiered approach referred to in the section on implementation.

9. The Function and Context of Behaviour

It is helpful to understand the nature of behaviour if we are aiming to support it in a positive way. Behavioural science tells us that:

- Behaviour is everything that we do – it is our actions, our movements, our facial expressions, and the things we say.
- Behaviour is a response to a stimulus
- All behaviour occurs in an environmental context.
- All behaviour (apart from reflex) is learned
- Behaviour is observable (seen and heard) and measurable (counted or timed)

These principles provide the foundation of Applied Behavioural Analysis which in turn is a foundation of PBS. Understanding behaviour requires us to recognise the distinction between form and function.

The **form** of behaviour is what it looks or sounds like (e.g. the person throws a mug on to the floor)

The **function** of behaviour is its purpose, that is, what it helps the person access or avoid (e.g. the person throws a mug on to the floor to get us to pay attention to the fact he is thirsty)

Behavioural science has also given us models to understand the way that behaviours that challenge may present. (see Appendix 2 and 3). These are discussed in more detail in the second half day of the PBS training.

Cooper et al identify five potential functions of behaviour:

1. To reduce the experience of pain or relief from internal discomfort
2. Attention or interaction
3. Escape from demands
4. Tangible reasons e.g. food or preferred items
5. Sensory or stimulation

David Pitonyak suggests behaviours that challenge result from unmet needs:

In a sense, these behaviours are messages which can tell us important things about a person and the quality of his or her life. Learning to listen to an individual's behaviours that challenge is the first step in helping the individual to find a new (and healthier) story.

People with behaviours that challenge are often missing:

- Meaningful relationships
- A sense of safety and well-being
- Power
- A thing to look forward to
- A sense of value and self-worth

(Pitonyak, 2015)

Hastings et al (2013) indicate that there are many factors that can influence behaviour. They divide these factors in to two broad areas:

- **Biological** – e.g. underlying sensory or health problems or genetic factors such as autism, Fragile x or Down's Syndrome
- **Psycho-social** – such as negative life events or trauma, communication difficulties, impoverished social networks, lack of meaningful activity, or psychiatric or mood problems such as schizophrenia or depression

As behaviour emerges in the context of these many potential factors there is a risk that the person can harm themselves, harm others, or become excluded. This can then feed in to their existing biological or psycho-social vulnerabilities resulting in further behaviour that challenges and the maintenance of a negative cycle. PBS provides a framework to attempt to understand the form and function of a person's behaviour in order to address this negative cycle and ultimately improve their quality of life.

10. Functional Assessment and Data Collection

Functional Assessment is a process for identifying the events that reliably predict and maintain behaviour. The Management team will complete training in this process in October 2019. If more detailed **functional analysis** is required, this would need to be carried out by a trained behaviour analyst (e.g. a member of the Community Learning Disability Positive Behaviour Support Team). In both processes the support, understanding, and input of direct contact staff is essential for the gathering of data about a behaviour in order to define it and hypothesise about where, when, and why the behaviour occurs. **Data collection** requires accurate, objective descriptions e.g. "the person slapped the left-hand side of his head for nine minutes" rather than subjective judgements e.g. "the person was kicking off to wind me up". There are many different ways and tools to assist the process of data collection – the incident recording process on the GMS is designed to gather objective information about the antecedents, the incident itself, and the response to an incident (see the Incident and Accident Reporting Policy and Procedure) but this may need to be supplemented by the use of additional tools where more specific data is needed about a behaviour. These need to be adapted to suit each specific case (See Appendix 4: "Positive Behaviour Support in Practice: A Case Study" and Appendix 5: Additional Tools for Data Collection)

11. Behaviour Support Plans

In "Positive and Proactive Care: Reducing the Need for Restrictive Practices" (2014) the Department of Health specified:

> *"Any person who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have an individualised behaviour support plan"*

As with the tools for data collection the form of a behaviour support plan can be tailored to a specific individual or situation, but the plan itself should always contain the following:

- Description of the behaviour/triggers/warning signs/presentation
- Evidence from a functional assessment completed by a qualified practitioner and/or data collected and analysed in-house

- Proactive preventative strategies
- Developmental strategies
- Reactive strategies
- Restraint reduction plan if restrictive practices are present
- Evidence that staff needs have been considered
- Details of the monitoring process, including the review dates and name of the responsible person
- Evidence of participation
- Opportunities for improving quality of life/well-being generally (not linked to behaviour of concern)

Garvald Edinburgh is committed to the creation and monitoring of Behaviour Support Plans in line with the Department of Health's standard indicated above. This is likely to involve the input of Specialist PBS practitioners (Level 3 on diagram in Appendix 1). The process of developing and implementing a behaviour support plan is covered in more detail in the 3rd competence area of the staff training module in PBS.

Responsive Practices and Strategies

Garvald Edinburgh recognises that behaviour that challenges can impact on others in many ways and can include acts of aggression and violence. In these situations, the organisation has a responsibility to keep everyone safe, to employ appropriate risk assessment processes, and to meet the needs of those people affected by the behaviour as well the person themselves. This may involve the use of restraint (such as medication), or physical intervention, such as breakaway techniques, in cases where this has clearly been identified as the least restrictive and most appropriate practice to support the individual and others to be as safe as possible. In these cases, guidance from an external health professional is essential and specific physical intervention training would be provided for the relevant staff. The organisation's approach to these situations, and the support offered to those affected is more directly addressed in the **Responding to Aggression and Violence Policy** and the **Restraint Policy**.

12. Links to other Garvald Edinburgh Policies

This PBS policy should be read in conjunction with the following Garvald Edinburgh policies that are available in the GMS Library:

- **Principles of Social Therapy**
- **Responding to Aggression and Violence**
- **Restraint**
- **Incident and Accident Reporting**
- **Keeping People Safe**
- **Critical Occurrences**
- **Police Involvement**

- Health and Safety at Work
- Adult Support and Protection

13. Additional Resources

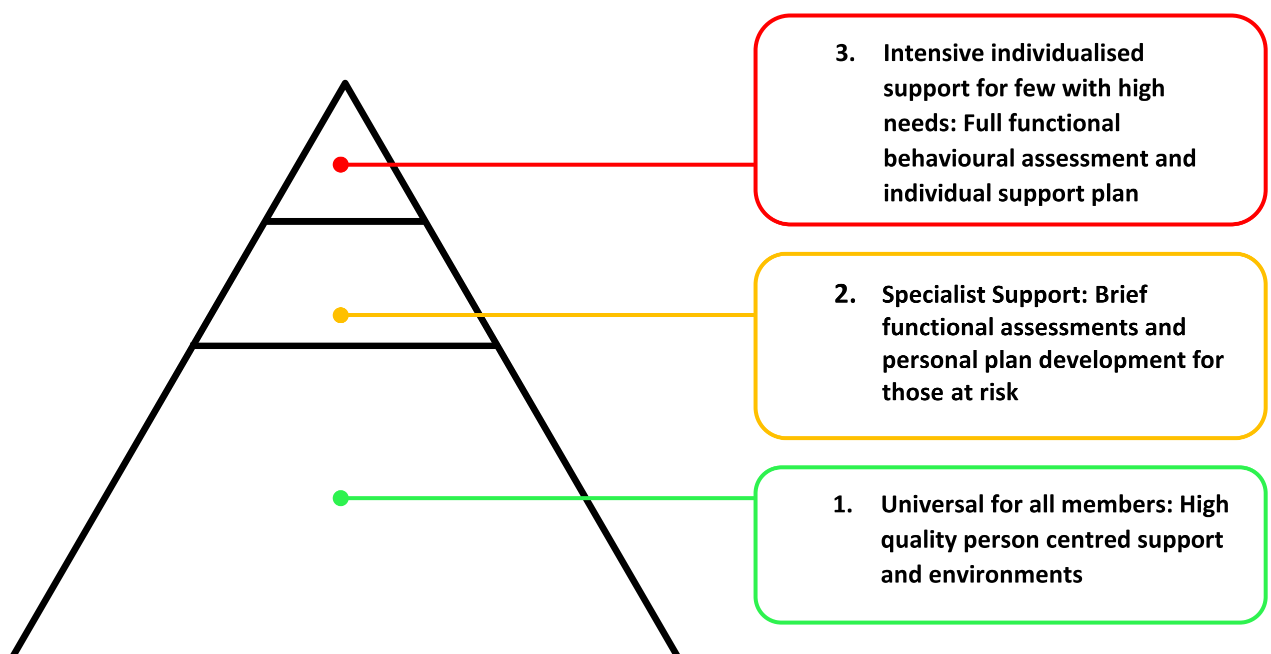
www.bild.org.uk/capbs

www.facebook.com/CentreforAdvancementofPositiveBehaviourSupport

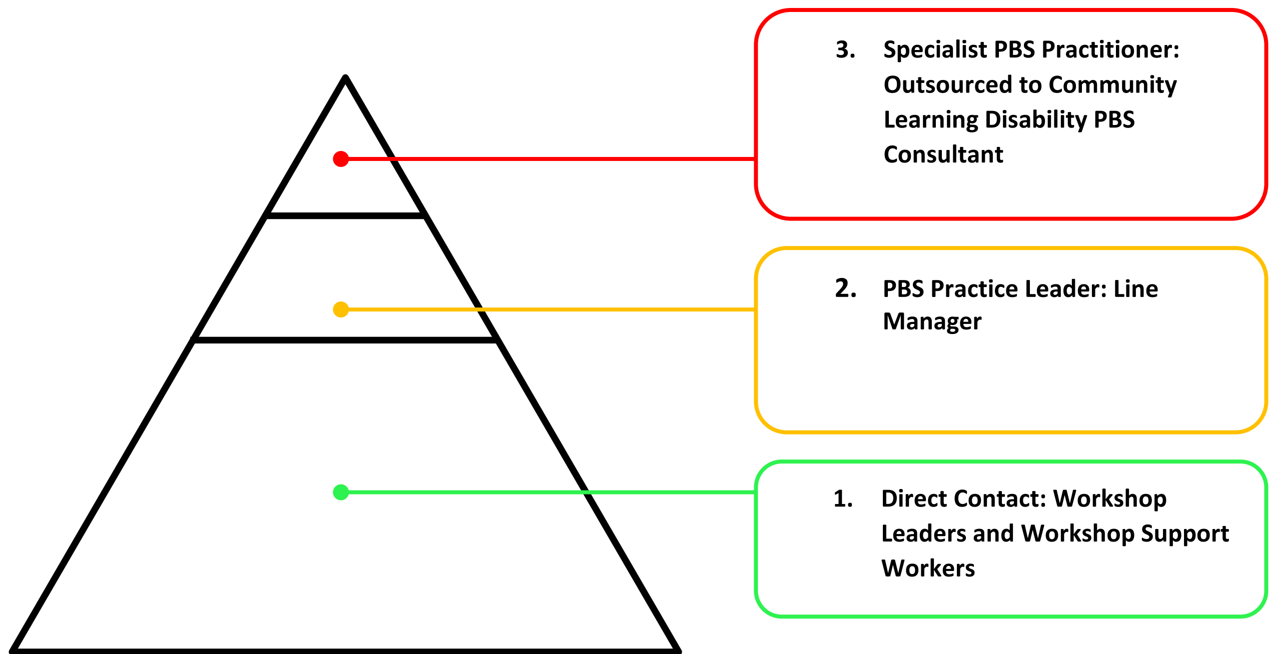
Appendix 1

The Three-Tiered Approach to PBS Implementation

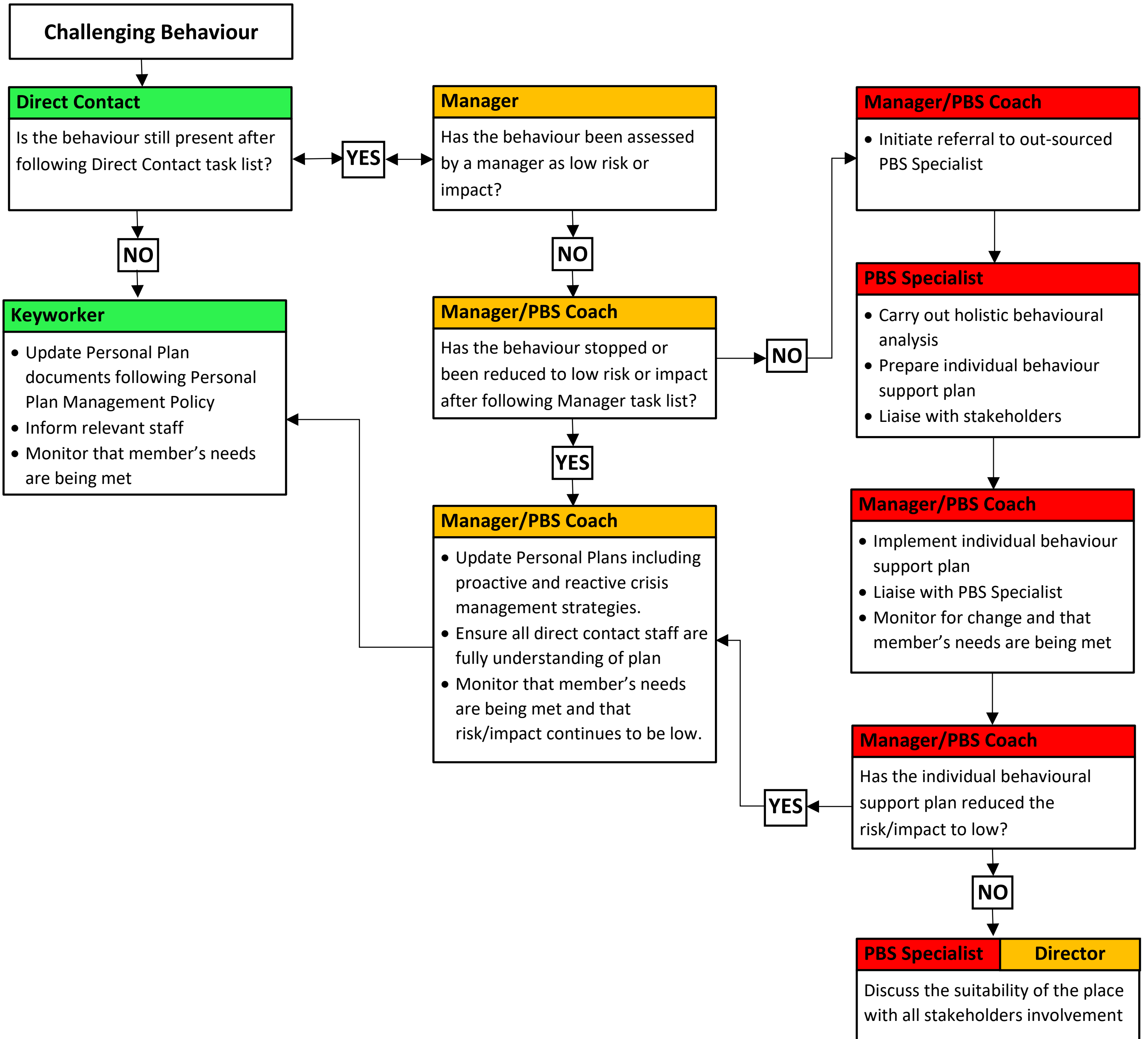
Levels of Positive Behaviour Support -



Practitioner levels -



Positive Behaviour Support Organisational Action Plan –



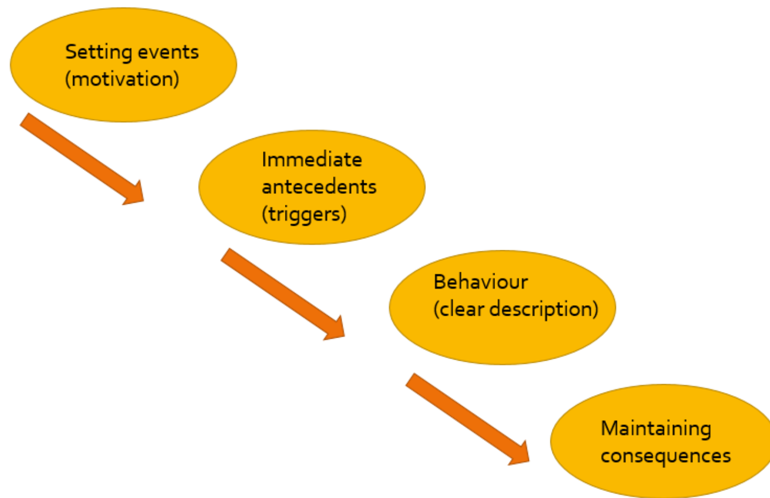
Role Task Lists –

Direct Contact: Workshop Leaders (WL), Key-Worker (KW) and Workshop Support Workers (WSW)
• WL + KW + WSW: Fully involve members in the development and delivery of their service • WL + KW + WSW: Be fully aware of current support plans and personal outcomes for members in their workshops • WL + KW + WSW: Ensure accurate and objective record keeping and reporting through GMS notes, incident reports and staff meetings when new or emerging challenging behaviour is present • WL + WSW: Liaise with Keyworker and ensure they are fully aware and involved to develop personal plan • KW: Involve individual member using their preferred method of communication • KW: If appropriate contact family/carers for any information regarding medical issues, family concerns, changes to routines, personal circumstances etc. • KW: Maintain and update personal plans in accordance with the Personal Plan Management Policy • KW: Liaise with Manager about any concerns and discuss any necessary multi-agency interventions necessary e.g. Social Worker, CLDT, GP etc. • Record any agreed data for basic behaviour analysis by manager

Manager/PBS Coach
• Be fully aware and responsive to concerns raised through GMS notes/records or staff meetings and ensure follow ups are completed including assessments of risk for all – the individual, other members and staff • Provide regular support and supervision time for staff to be aware of staff welfare and ensure staff have the necessary competencies, knowledge and training • Contact any external support agencies as required e.g. Social Workers, CLDT, GP, other Care Providers • Agree data gathering plans for staff to follow to aid in identifying the functions of behaviour • Recognise and agree when support plans need development and initiate specialist input • Monitor personal plans and implement necessary changes • Where higher level behaviour is present and where all attempts to reduce risk/impact have failed initiate referral to PBS Specialist • Notify and liaise with the Director when the risk/impact of a behaviour becomes a concern
PBS Specialist
• Agree data requirements with service manager and complete behaviour analysis • Develop individual Behaviour Support Plan including proactive and reactive crisis management plan • Provide holistic overview across all stakeholders and environments • Agree specific responsibilities and timelines • Provide independent appraisal of the needs and the suitability of services

Appendix 2

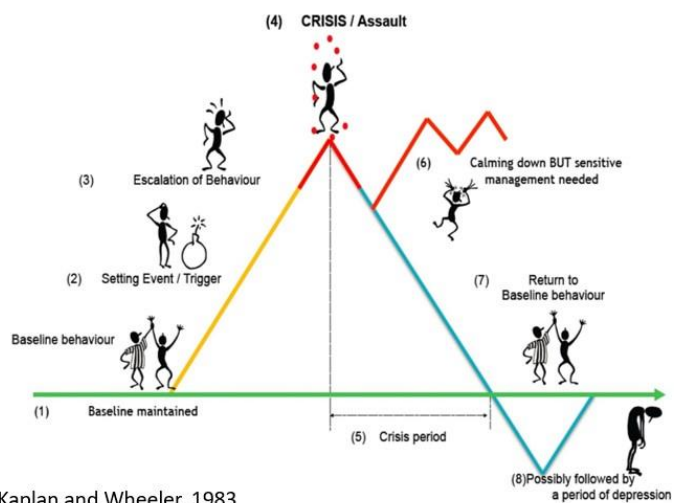
A model to understand behaviour



Anderson and Homer (2007)

Appendix 3

The Assault Cycle



Kaplan and Wheeler, 1983

Appendix 4

Positive Behaviour Support in Practice: A Case Study

This case study and the associated documents have been anonymised. It has been provided as an example of how some of the principles of PBS can be applied; it is not to be taken that all of the tools and systems described must always be used in every case of behaviour that challenges, as each situation will require courses of action and tools specific to the individual. However, it does demonstrate some typical PBS processes that staff are likely to encounter in their work.

Background

K is a 23-year-old female with a learning disability who began attending our day service in 2014. She came with no additional diagnoses. K has no verbal language skills and she has no literacy, numeracy, or time recognition skills. She lives in her own flat supported by a local support agency. She attended a school for children with additional support needs from age 5 years to age 17 years and following that she attended a council day service on a full-time basis until she was referred to Garvald Edinburgh. During her time at school and the council day service she received some input from a Speech and Language Therapist. This had led to some recommendations such as the regular use of Signalong, a communication book, and a tech-aid, to support K with communication. During the referral to Garvald Edinburgh the Day Service Manager liaised with K, her family, her Social Worker, her school, her previous day service, and the Speech and Language Therapist to ensure as much information and understanding was gathered about K prior to the start of her placement. K presented as an enthusiastic but anxious individual with a particular interest in animals (she had been on a voluntary placement at Gorgie City Farm, has a cat, and goes horse-riding regularly). We were told she also enjoys music and dancing, cooking, crafts, and nail art. We were also told K had a previous history of nipping people/pulling people's hair but that this had rarely occurred since she had left school. The advice indicated this behaviour is more likely in situations where K is feeling anxious or unsure about what is happening. The information shared with us formed the basis of a support plan which has been developed throughout K's placement.

Incidents of Behaviour that Challenged

K has attended Garvald Edinburgh on Mondays and Fridays since 05/12/14. During this time there have been defined periods with multiple incidents and long periods of these behaviours not being present. Before an incident of physical aggression on October 2018 there had not been an incident since 07/07/17, the first incident at Garvald in this period of incidents occurred on 26/10/18 in the first week back since the October week break. Through communications with K's home support we were advised that the holiday week had seen at least one incident a day where K had grabbed, pinched, or pulled someone's hair. From 26/10/18 incidents of grabbing, pinching, hair-pulling or destructive behaviours occurred on a nearly daily basis at Garvald with 14 incidents of physical aggression and 2 incidents of destructive behaviour.

As we entered into November with daily incidents of physical aggression, staff anxiety understandably rose about the behaviours and some staff expressed frustration about the reactive strategies that were stated in the support plan and risk assessments. Part of the recommended reactive strategy is for staff to immediately give reassurance to K that the incident is over and can be forgotten about and that they were 'still friends'. Support staff repeatedly expressed a wish for the emotional and physical effects of the physical aggression to be communicated to K and either an apology or punitive response agreed.

Into mid-November, it was becoming questionable whether we would be able to sustain the service to K with risk to staff and members appearing to escalate. Using the knowledge gained in the PBS coaches training the Day Service Manager took a systematic approach to the situation with a hope to find the function of the behaviour and return to a baseline where K's needs were being met and incidents were no longer endangering her place or others' safety.

Specifically, the Day Service Manager sought to:

- Assess and reduce the immediate risk to K. and others
- Collect and collate data around the behaviours.
- Widen the enquiry from our day service environment to gain a holistic overview through multi agency working; i.e. to identify if there was an associated link to a health issue or a change/issue in her life out with Garvald.
- Discuss the concept of behaviour as an unmet need with support staff and develop their understanding of a positive behaviour approach, moving away from concepts of blame or punishment.
- Liaise with family to understand their views
- Develop the support plan and the proactive and reactive strategies and monitor with staff how these are being implemented
- Ultimately improve welfare and outcomes for K

Risk Assessment

The Day Service Manager conducted a risk assessment involving all the relevant staff. This detailed the specific risks, immediate strategies to reduce those risks, and the likelihood, severity, and overall level of the risk with the strategies in place (see attached risk assessment)

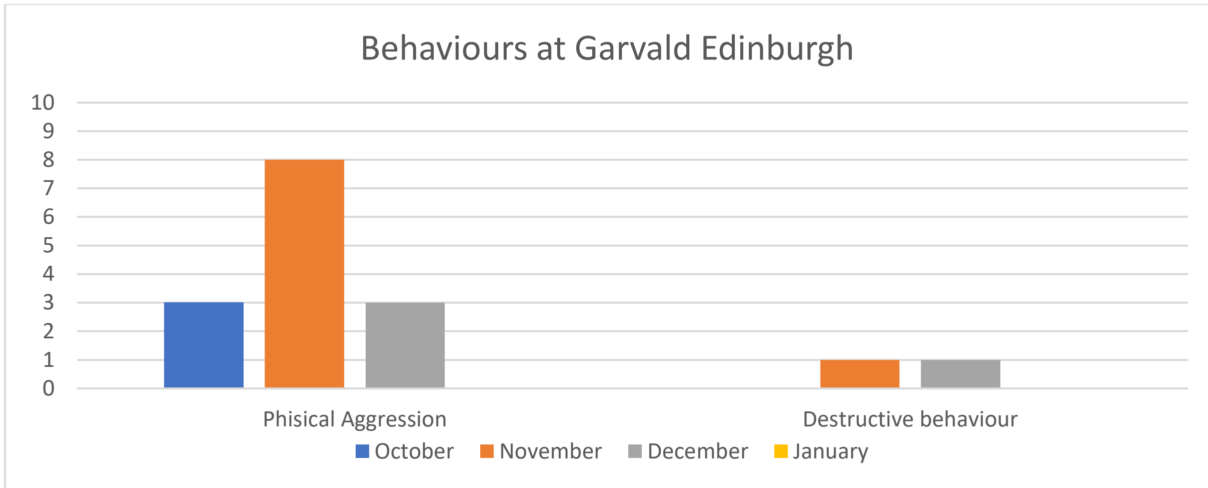
Behaviour Evidence

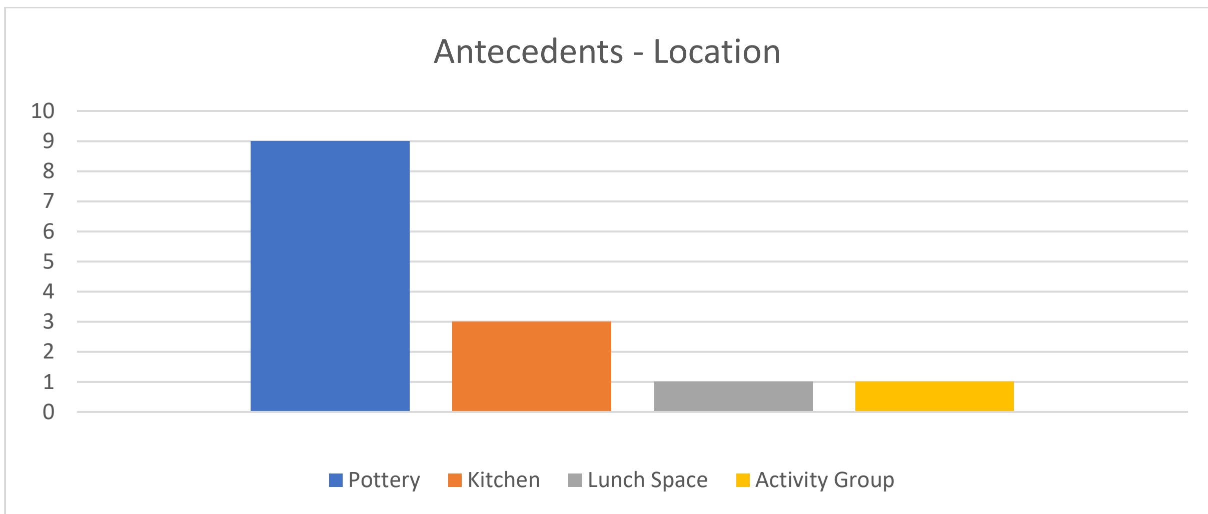
To understand the behaviour, the Day Service Manager looked at gaining evidence of key questions:

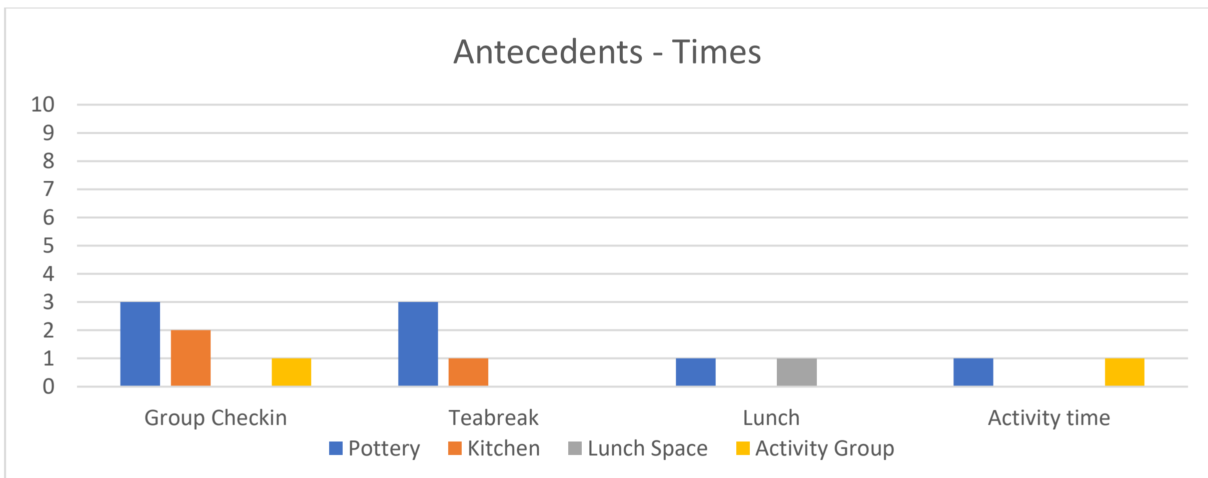
- When does it occur (most/least often)?
- During what activities is it most/least likely?
- Does it seem linked to certain events?
- In what environment is it most/least likely?

To supplement the incident recording system, the Day Service Manager asked staff to complete ABC charts and collated the information into graphs to see whether there were definite patterns to the behaviour. (See Appendix 5 for ABC chart template)

The graphs gathered evidence related to the nature of the behaviours, the antecedents in the different locations and the antecedents in terms of times. (see below)







Out of the 14 incidents 9 occurred in the pottery group, 3 in the kitchen group and 1 in the quiet lunch space and 1 in a large music group. In terms of times of incidents only 2 of the incidents occurred during workshop activity time; incidents cluster around transition times with 5 incidents during morning and afternoon check in times and 6 during tea-break or lunch time. Very quickly a

view that incidents were most likely to happen during transition times and in environments that were less controlled emerged: arrival time in the morning, tea break or lunch, and transition to afternoon group.

In response to identifying that most incidents occur during these transitional events, the DSM identified other possible maintaining functions of the behaviours recorded in the ABC records; there were four key areas:

- Change to Routine: Holidays from the service; changes to timetable or not knowing what is happening or expected of K; changes to staffing.
- Environment: Not being fully aware of what and who are around; people moving or standing too close or out of vision; lack of defined personal space; too much noise or external stimulation.
- Communication: Not being understood or feeling listened to; diary being used as service tool with records of incidents.
- Mental Health: Low mood and motivation; anxiety related to previous incidents and needs not being met out with Garvald.

Multi Agency Working –

Previous multi agency enquiries and working with CLDT specialist identified individual support needs. In reviewing these within the support plan the DSM discovered that communication protocols were not being followed by the supported living agency. The DSM initiated discussions specifically about incidents being related to a personal diary being used as a service tool to communicate incidents between services. Unable to find an agreement to the previous CLDT protocols the DSM escalated the matter by referring back to the appointed social worker and CLDT. Additionally, the DSM initiated health checks.

Proactive Responses-

In response to discovering links between the behaviour and transitional events and the four areas of maintaining functions the DSM implemented several changes:

- That K should have a defined place to sit that faced on to everyone and in a position that would prevent others moving behind her sight of vision or close proximity.
- That those entering the space should be limited and the environments are kept as consistent as possible for K – incidents had happened during times where people not part of K's group appeared in the environment.
- That K had consistent staff who she knew well and who were fully aware of her support needs and communication methods – sign along and symbols. That staff used simple, short and accessible language and limit choice to two options.
- That a very structured and know routine was in place at these transition times using symbol timetable so that K knew exactly what was happening now and next.
- That K is fully involved in her choices and no pressure or judgement made should she not wish to participate in set activities/projects- giving space when asked for etc.
- That activities and environments are considered to not over stimulate K

These strategies were added as a protocol to K's support plan (see Appendix 6: K Support plan and attached protocols)

We are currently awaiting a Behaviour Support Plan document that is being prepared by a member of the Positive Behaviour Support Team.

Staff Supervision and Training-

As mentioned above, as incidents increased so did the anxiety of staff and the DSM was increasingly questioned over the reactive part of K's support plan around not seeking an apology or there being any punitive response to incidents of physical aggression. The DSM used staff team meetings, group supervision and intensive individual supervision to:

- Develop support staff understanding of behaviour functions, needs not being met and ensure blame was not being attached to K.
- To ensure staff had the competencies and knowledge necessary for K's support needs.
- To maintain staff welfare and understand the impact/risk and respond accordingly.
- Implement, monitor and review the support being given and any changes to behaviours as a result of adjustments to plans.
- Keep staff aware of current situation.
- Challenge staff who maintained a reluctance to follow the support plan.

Involvement of Family-

To ensure K's family were as fully involved and considered the DSM initiated further multi agency meeting with their involvement. During this time, the DSM was able to develop their understanding of K's support needs and the influence of mental health – low mood and anxiety. During one of the meetings, K's mother raised a concern that a weekend routine was impacting on her mental health and an agreement with her supported living agency to end this routine was agreed.

Outcome-

Since collecting behaviour data, evidencing antecedents/maintaining functions and implementing a holistic development of support plans, including new proactive and reactive strategies the incidents have ceased. Since K returned to our service 11/01/19 we have not had any incidents, additionally K appears happier and motivation and social interaction has increased.

Reflection-

During the period of incidents, the DSM encountered a reluctance to engage within the process of enquiry from the Supported Living provider. On reflection, the DSM would not take so long to counter such a barrier in the future as there was a very real risk of K's place being suspended because of this delay. The systematic approach the PBS in leading an enquiry into the functions of behaviour has given the DSM and the staff team added confidence in the process and of making these types of decisions.

September 2019: Recently there was a brief reoccurrence of the behaviours after having a period of no incidents for around 8 months. In doing the follow up the DSM contacted home support, K's mum and the social worker and discovered K was anxious and angry about a decision for her to move from her single occupancy home to a shared accommodation. The DSM also looked at the areas that had contributed to these behaviours in the past: the environment, communication and routines. In all these three areas there had been inconsistency in the way support was being delivered. The DSM met with the staff involved and reviewed all of these areas and received feedback that as things had been so good many of the proactive measures had been 'relaxed'. The DSM reiterated the need for these support plan measures to be consistent standards in meeting K.'s needs. The DSM also advised

the social worker that the evidence of the multi-agency work completed pointed to K. requiring as controlled environments as possible and that in view of this shared accommodation would likely not meet her needs. Since the return to the proactive support plan measures and then latterly the suspending of the housing decision there has been a return to no incidents of physical aggression.

K - Risk Assessment

Risks

Detail the Risk being assessed ('Risk is the likelihood that a person may be harmed or suffers adverse health effects if exposed to a hazard.'). The Risk is the overall event such as 1. travelling independently by bus for the first time or 2. Acting aggressively (dangerous behaviour) towards self or others.

Risk of nipping, grabbing, scratching and hair pulling primarily directed at support staff, but on limited occasions towards other members

Who

Detail who is at risk i.e. members, staff, visitors, etc.

Supporting staff are at risk and others including visitors who may be perceived as members of staff. risk to other members however it is rare for K to direct these behaviours towards other members again this may be related to where K is unsure of the person's role.

Benefits

List any potential benefits of the actions that will create the risk. i.e. 1. Increased independence for a member after learning to travel on their own. 2. Continuing to engage in a service in an activity.

Social interaction and forming of good friendships and relationships.
Engagement in a range of activities leading to increasing confidence, well-being and skills.

Clear structure and routine that helps with K'S anxieties.

Hazard

'A Hazard is a potential source of harm or adverse health effect on a person or persons'. What are the individual Hazards that increase the overall risk presented for example 1. getting on the wrong bus 2. throwing objects. A Hazard (there might be a number of hazards identified) is one of the factors that may cause harm and contributes to the overall risk.

In the past there have been incidents of physical aggression in cars towards the driver.

Variables

List any variables, known or potential triggers, any history or diagnosis, which may increase or change the hazards occurring.

- Feeling anxious of worried.
- Feeling unwell which can be related to her anxieties.
- Mood fluctuations due to her hormones/menstrual cycle.
- Unsure of what is happening or what she needs to do.
- Overwhelmed or experiencing sensory overload or over stimulation.
- Frustration from being unable to communicate her needs or emotions or feeling that she is not being listened too.
- Feeling threatened, could be linked to staff body language e.g. Crouching below or leaning over.
- Isn't getting enough attention.

- Doesn't want to do a certain activity or is bored or tired.
- Isn't getting something she wants/needs.
- Having to finish something she is enjoying.
- Being anxious, upset or sorry about a previous incident.
- Certain topics/subjects - personal hygiene, well-being, safety.
- Personal space not adhered too, particularly when K has communicated she is anxious or upset.

Risk Reduction

What strategies or interventions can be put in place to reduce the likelihood of the hazard occurring or the impact if it does occur?

- Positive and confident staff.
- Using minimal, clear and simple language when talking to K.
- Use of signs and symbols to help with communication.
- Being aware and vigilant about K'S mood.
- Reassurance and guidance from those around.
- Letting K know what is happening and what she is doing now and next. Timetables can help and sticking to routines is important.
- Giving praise and encouragement at any opportunity.
- Distraction and redirection at the right times.
- Ignore difficult behaviour, but don't ignore K.
- Don't ask lots of questions about what is wrong or why she did something, this can increase anxiety.
- Dont focus on why K is feeling unwell at certain times.
- If there is an incident, don't dwell on it and reassure K that everything is okay and you are friends.
- K likes to have her soft toys and this can comfort her.
- Giving quiet time alone and a break from routine. Sometimes to have a lie down in a quiet space.
- Giving K enough time and accepting her decision on whether this continues.
- Holding K.'s hands.
- Taking a step away from K when grabbing or pinching can be anticipated and checking in with K from a distance out of the range of physical contact.
- Tie long hair to avoid possibility of hair pulling
- While K is agitated and presenting behaviours towards others it is advisable not to enter small confined space like a workshop office with K.
- Sandwich negative behaviours or worries in between positives when recording in K'S diary; do not recount incidents, use phrases like 'was anxious for a little while' or 'was feeling unsettled'.

Likelihood

Please estimate the likelihood of the hazards occurring with strategies/interventions in place. Rate the likelihood from 1 - 5, where 1 = unlikely to happen, 2 = may happen, 3 = Likely, 4 = very likely, and 5 = certain (e.g. not if it will happen but when)

2

Severity

Please rate the severity of injury or impact if the hazard/s do/es occur. Rate the severity ranging from from 1 - 5 where 1 = minor injury, 2 = minor injury but requiring First aid, 3 = significant (A&E), 4 = significant life changing injury and 5 = fatal injury

2

Risk Level

Estimate the level of risk remaining with the actions to minimise the risk in place. Multiply the likelihood value by the severity value. i.e. Likelihood = 2 and Severity = 2 would produce a risk level of 4, therefore the risk would be Low. 1-4 = LOW, 5-10 = MEDIUM, 11 - 25 = HIGH If the risk is towards the upper end of medium or high you must discuss / review this with a manager.

Low

Comments detail any comments / actions related to ongoing review of risk- particularly risks that are assessed as High or towards the upper end of medium

People involved in creating the Risk Assessment

Add the names of staff and professionals who were involved in creating the Risk Assessment

Risk assessment was created from working experience with K and using the supporting information from the NHS learning disability team. Further consultation with K'S mother.

K Support Plan

This document has been anonymised and the symbols and help text have been removed to reduce the size of the document for the purposes of this policy

This document includes the following attachments

Supporting_K pdf
Diary_CommunicationProtocol.docx
Speech_Language_Therapy_Report.pdf

Things you should know about me

I like to be called : K

Address

Supported accommodation with (support agency) K lives on her own in her house supported by staff. Her neighbour in the house next door is also supported by (support agency) and sometimes they have dinner together.

Birthday

September Likes to celebrate with a party, dancing and chocolate Cake

I Like

Animals, dancing, cooking, pottery, crafts, music, She has a cat called Jake. K likes animals and used to go horse riding. K likes to have her teddy bears with her for comfort. K really enjoys joking and playing games like knocking on the table to pretend there's someone at the door or telling people that they are cheeky. K likes to be social and the opportunity to say hello and see different friends. K has a timetable in each workshop and likes to know what is next. K likes to know who will be supporting her and people she knows well and trusts.

I Don't Like

See attached behaviour strategies K doesn't like to talk about previous incidents. This can upset her and can be the cause of further incidents. It is very important to tell K 'It's over',that everyone is friends and sign friends as confirmation. K does not like to be challenged or pushed into action and needs time and space when she is feeling anxious and allowed to make her own decision about when she is able to return to an activity. K is very hard working but sometimes needs time out and a rest with a cushion. When this happens the timetable can be put to one side. It is good to acknowledge that she is a hard worker but needs time out. K does not like unexpected changes as this makes her very anxious.

Important People

K’s Mum – A, and her dad. She also has a sister M, who is important to her.
She also likes her sister's partner .

Important For Me

In each workshop K has a visual timetable and likes to keep it so that she knows what is happening next.
Being understood is important for K. K has a symbol book which she is happy to use if you donlt understand a sign she is using. She sometimes has them on a cord necklace also.
K is very hard working; K really enjoys working and being part of the team but sometimes needs time out and a rest with a cushion. When this happens the timetable can be put to one side. Checking in with K is important at these times and listening to when she wants time and space and when she wants company or to return to her timetable. K’s teddies, diary, symbol book, magazines and toys are very comforting and important to K. K likes to lay them out on the table at the beginning of each session so that she knows where they are.
K likes her diary to be written to tell others how her day has been, it is important for her to hear what has been written in her diary - with the exception being the details of an incident that should instead be distilled to statements like “ had an anxious time “ or “was worried for a while ”.

Religion & Culture

Not Set

My Health

Diagnosis

Learning Difficulties/Global delay

Medication

K uses paracetamol as a pain killer for example for tooth ache. If she brings medication with her it needs to be checked in at reception and kept in the medication cupboard. K cannot take medication independently.
In the past K has sometimes got into a routine of taking pain killers regularly and for example pointing at her neck indicating she needed pain relief.
Her Mum said that this is about an event that happened a long time ago. It is good to try to find out if K does need pain relief and what for. A phone call to the support agency to clarify can also be helpful.

My Ideal Support Person

Shared Interests

Someone with a good sense of humour, someone to joke with. It is important for K' S support workers to be confident, positive, enthusiastic and reassuring. Someone who likes animals and teddy bears.

Gender

Male or Female

Support Personal Qualities

Calm, patient, kind, funny and upbeat.

Actions Staff Should Avoid

K shouldn't be asked to join in the work if she needs time out. K will generally tell you when she 's ready. You can gently ask occasionally if she is OK and if she 'd like to come back but be careful not to overwhelm her. You can make this inquiry from an appropriate distance outwith an area of where physical contact could easily take place at times where K is expressing she is anxious and wants space.

If she has grabbed, pinched or pulled hair, this should be moved on from as quickly as possible as dwelling on it even for a short time will stress K out and it may happen again. Talking an incident through is usually not helpful for K. K seems very aware of what is not ok to do but if she does pull hair or scratch someone she feels so anxious about it that this might lead her to do it again.

Do not make unexpected changes to routines or expectations this can lead to confusion and anxiety.

Specific training needed to support me.

Positive behaviour support. Signalong. Social Stories. Talking Mats.

Communication

Communication Aids

K uses signalong and symbols to help her communicate. If you can’t understand what she's saying she is very happy to use her symbol book if prompted.
Talking Mats are helpful, although symbols surrounding well-being can be triggers to challenging behaviour.

K has a diary to communicate with home.
K'S diary should be predominantly used to record achievements and good things to remember and to talk about. The diary is also a place to record handover information for K'S home support, so a brief report of any incidents should be written here as well. If there has been an incident, sandwich this 'bad news' in between two pieces of positive/upbeat news. If K asks for you to read an entry back to her that contains bad news, just summarize that section e.g. “K was for a short time a little anxious “ or “ K was little uptight for a while today.”
Draw cartoons, smiley faces, silly drawings, thumbs up etc. as well as this helps in giving K a sense that the entry is a positive one.

Verbal Interactions

Clear, simple, calm, short and direct sentences.

Non-Verbal Communication

Signalong and symbols. K also indicates thumbs up and initiates a touching of her and another person’s thumb as a kind of ˝minihug”. K likes it when other people indicate that they are fine by smiling and she sometimes draws a smile with her thumb to show that she is fine.

Personal Space

When K is anxious and she has taken to a head down and arms folded position she needs lots of space. The rest of the time she needs lots of company and short friendly interactions.

Making Choices

Take time to present choices to make sure K has understood. K may say 'Aye' with a definite tone when she has understood and is happy. She may also say 'NO!' when she is not. Reassure K that you have understood when you feel you have had a clear answer.

My Support Needs

My Personal Care Needs

K can manage to go to the toilet by herself.
During her period she may need help from a female member of staff. She may need help to maintain a tidy appearance from a food spillage etc.

Routine

Routine is very important for K. Please see her broken down timetables for each workshop.

Eating and Drinking/Dietary Requirements

K is lactose intolerant. She can only tolerate very small amounts of milk.

Travel and Mobility

K is escorted to and from Garvald in a social work taxi. There are no other service users in her taxi.

Reading, Writing, Time and Money

K can't read, write or tell the time. She has no numeracy skills.

Risks and Agreements

K has a history of nipping/pulling hair; she gets very upset after these incidents. Staff with long hair should tie it back as hair down is a big temptation for K to pull. Incidents seem to be prominent when K is anxious and if she is worrying about a recent incident. When an incident happens K's anxiety normally triggers more incidents so it is important to move on from the incident ASAP and let K know it is over and that everyone is ok, safe and are friends. Generally, K needs to feel that people around her are ok. If other people and especially staff display anxiety or worry, she gets anxious as well. A calm, positive, friendly, competent and well-organised atmosphere is therefore an important pro-active approach to avoiding incidents.

Support Plan Completion

Service User Input

K had some involvement with the help of staff to write this review.

How we all need to support K

General strategies to promote positive behaviour and avoid difficult behaviour

- Use minimal clear, simple language with K when talking to her
- Always supplement instructions with signs/symbols
- Let K know the plan for the session/trip/day using symbols.
- repeat this using symbols throughout the session/trip/day.
- Ask her to sign what she has to do to check she has understood.
- Use enthusiasm when explaining things
- always be positive about what you will be doing.
- Praise K at any opportunity, especially where she is taking part in activities, joining the group, helpful. friendly, listening well.
- Ignore any difficult behaviour but don't ignore K — i.e. do not give K eye contact and do not comment on the behaviour or say anything about it, even afterwards.
- Distraction and redirection at the right points work very well with K

In the absence of these strategies, the following behaviours may occur

- Nipping, hitting, grabbing hair, or indicating that she is about to do so
- Targeting others
- Not moving on from something she wants
- Not doing something you want her to do

Why this behaviour happens and what K is trying to tell me

- She doesn't understand what she needs to do or what is happening next
- She is overwhelmed or experiencing sensory overload, sensitivity or overstimulation
- She doesn't want to do an activity, or is bored or tired
- She isn't getting enough attention
- She isn't getting something she wants
- She has to to finish an activity she is enjoying
- She is expressing distress or trying to communicate her emotions
- She is experiencing mood fluctuations due to her hormones/menstrual cycle

Strategies for specific behaviours

Behaviour	What you need to do	Why responding in this way is important
Nipping, hitting, pulling hair	Move away from K if safe for both of you Pull over if driving. Redirect by talking about what is going on outside, putting the radio on or something else that K likes. Hold K s hand close to your head so she can't pull your hair and hurt you or If it isn't safe to move away, keep K and yourself as safe as possible and say once 'hands down' and 'K friends' and wait Once K is calm enough, redirect her to another activity For important/necessary activities, complete the task in some form, use "I finished" if resistant Praise her for completing the task and do not comment on the behaviour.	To keep you & K safe and avoid injury To let K know what you want her to do To move on from the incident, it doesn't help to dwell on it To let K know that when you say something wiil happen, it actually does happen, you must follow through on things you say or K Will not trust you It is crucial to give attention and praise when K does what you want her to do, no matter how small the behaviour (e.g.ᶜgood waiting/sitting/listening/sharing K!) Whatever you give your attention to — you will reinforce and get more of, this is why it is important not to comment at all on behaviour you don't want more of
Targeting others	Be vigilant to K 's mood and who is around her. Ensure an adult is engaged with K. at all times if vulnerable others are around Where possible, remove K or the other people until K is calm again Never leave K unsupervised for long periods In transport, have an adult sit next to K not others who are vulnerable.	K may target other people if she feels attention is focused on someone else. K remains more settled when kept busy/distracted by an adult. K likes adult contact and will get bored and seek interaction from adults if left alone for too long Keeping a close eye on K at all times minimises/removes the opportunity for her to be able to target others.
Not moving on from something she wants	Give K. a plan of what you are doing beforehand and throughout an activity and use symbols at all times Always give a count down of at least 3 goes in any activity, the activity must end after these 3 goes, give no extra goes. Redirect to what you will do next when she does not move on from an area where there is something she wants. Redirect with symbols, keep language and eye contact to a minimum. Patience and persistence is needed.	This helps K understand what she needs to do Ending the activity when you said it would reinforces that when you say something will happen, it actually does happen and that there is no point trying to get more goes Don't get involved jn a debate, this only escalates things Moving K On to another activity she likes helps focus her attention on something else and she is more likely to forget about the original activity. K needs firm boundaries so do not give in-

Speech & Language Therapy Report

Background

K was referred to speech and language therapy in January 2014 following her transition from school to adult services. At this time K was living with her parents and receiving her day services at (day service name): supported by (Support Agency).
I have continued to have input throughout the time of K.'s move to her new home and her subsequent changes in day service.

K has a significant learning disability and specific difficulties with all aspects of communication, including both her understanding and use of language. This affects the following communication skills:

- Her ability to listen process and understand all information . Her ability to understand spoken information.
- Her understanding of social situations and non-verbal communications e.g. recognising facial expressions and knowing how other people are feeling .
- Her ability to communicate her needs, wants. feelings etc
- Her ability to make choices. K can make some simple choices about concrete everyday things. but would struggle to make choices about more complex, abstract things.
- Speech — K has a few single words only and can produce only a very limited range of speech sounds.
- Signing; uses Signalong signing system at a single sign or 2 combination sign level to communicate. Her limited motor skills make it difficult for her to produce some of the signs accurately, although she knows a good number of signs.

K's limited communication means she that often uses her behaviour to communicate — particularly when she is anxious or upset or confused about what is happening. This can result in some difficult behaviours and refusal to do things.

K can become upset and finds these behaviours difficult to manage She has needed support to manage changes to her day to day activities as well as bigger life changes such as moving into a new house.

My input has included:

- Signing training for staff
- Provision of a symbol and photo communication book for day to day use and also has some symbols on a lanyard for quick use.
- Demonstrating use of the "Sounding Board" app on K's iPad which uses photos and recorded messages to support communication.
- "Feel better" strategies on a symbolised sheet, that staff can help Fi to choose from when she starts to get upset.

- Use of social stories around a variety of topics.
- Recommendation of a symbol timetable and use of staff photos to help make K's day more predictable.

- Choice making - K- needs help to make choices. She will tend to say "Yes" or agree when she is not sure. This can often lead to confusion and the use of more difficult behaviours to get out of situations. She needs adults supporting her to present simple choices in a meaningful way, using pictures, symbols and signing to help her understanding.
- Use of visual strips for different tasks. K needs additional support from adults to complete many tasks. She benefits from the use of visual task strips to help her learn and remember what she has to do.

K needs consistent and skilled communication partners who can continue to implement the above strategies. She benefits from the use of visual timetables and planners to help her know what is going to be happening. K can easily become anxious when plans are not clear or are changed.

Following K's recent review meeting on 9 August 2016: I met with L from (Support Agency) and JP, CLDN, to look at further social stories around staff changes and how she feels when she has her period.

K now has a number of successful communication strategies in place and does not need further speech and language therapy involvement at this time. I have therefore discharged her from my caseload.

Please do not hesitate to contact me if you would like to discuss this report or have any further questions.

I wish K well with all her future plans.

ED
Speech and language Therapist

Appendix 5: Additional Tools for Data Analysis and Behaviour Support

The templates in this section are provided as examples of tools that can be helpful for gathering evidence of behaviours that challenge. There are many other tools and in each case it is likely the tool would need to be adapted to suit the individual case and capture the detail required to assess the behaviour's function.

Scatterplots

This is a very simple way to record the pattern of incidents of behaviour and helps to establish whether it occurs around specific times. Recordings are made on a simple grid with columns for several days, possibly even a month. Each day column is divided into hour or half-hour cells. Each time the person's target behaviour occurs, the staff member shades in the appropriate time cell for the relevant day. If there is more than one target behaviour being recorded, this can be indicated by a code or a different type of shading.

Name

Date started:

Target behaviour:

Time/Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon

S T.A.R Recording form- Private and Confidential

This tool is designed to gather more detail in relation to the setting events, triggers and nature of the behaviour, based on Anderson and Homer's behaviour model illustrated in Appendix 2)

Focus person's name:

Date: Time:	Setting(s)	Trigger(s)	Action(s)	Result(s)

Proactive Strategies timetable

This simple tool is designed to focus attention on positive and proactive strategies across the week. It is useful in cases where an individual does not have a well-structured timetable of meaningful activities or where specific strategies at specific times have been identified as helpful.

Weekly timetable of proactive strategies for:

Week starting:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
AM							
PM							
PM							

ABC Recording form- Private and Confidential

Focus person's name:

Date: Time:	Antecedent	Behaviour	Consequence	Signature