Saint John of God Community Services Limited

Positive Behaviour Support Policy

08

SJOGCS08 Positive Behaviour Support Policy
Document reference no. SJOGCS 08
Revision No 2 Approval Date: 25th June 2015 Positive Behaviour Support

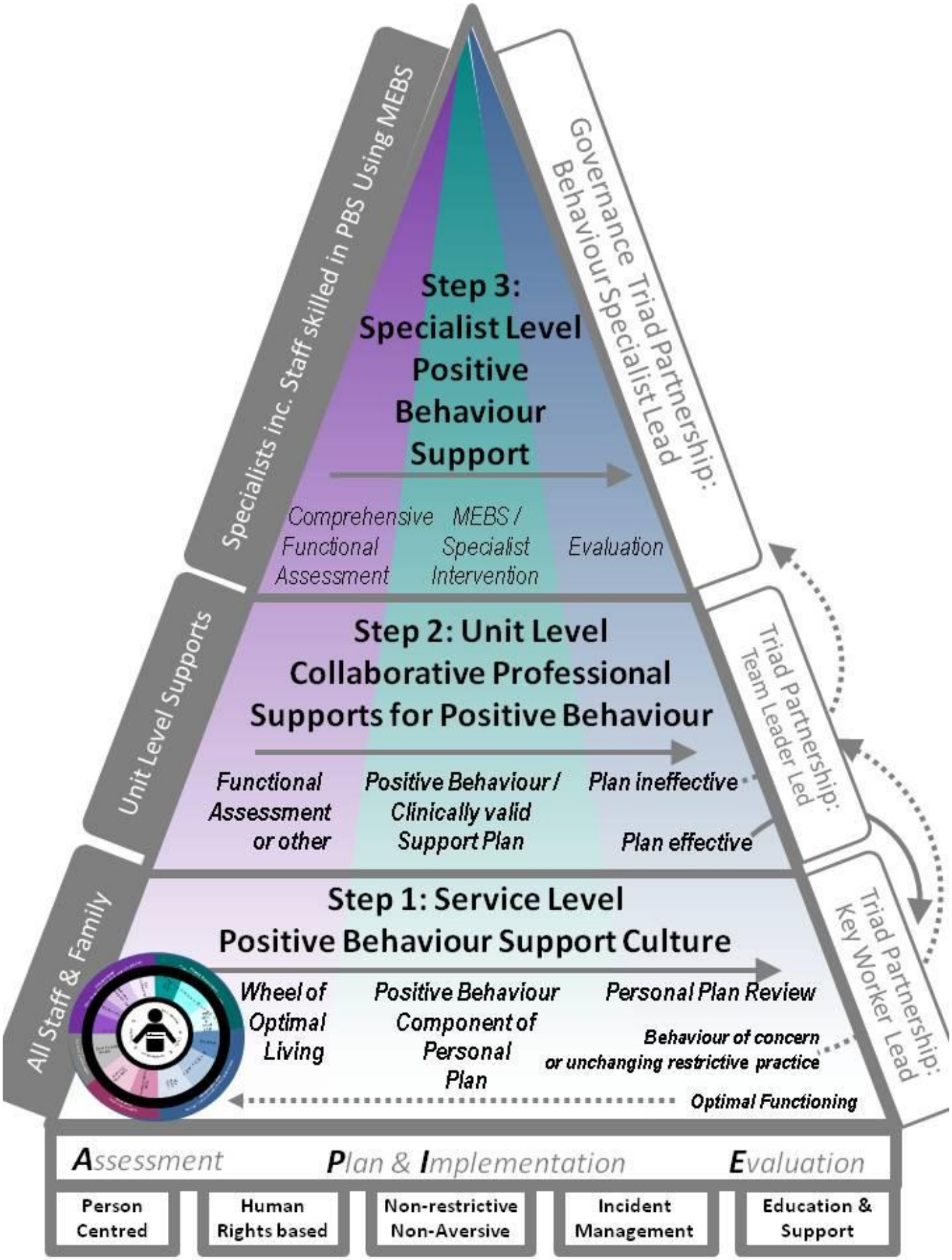
Document reference no. SJOGCS Restrictive Practices 08A 08B 08C
Revision No 1 Approval Date: October 2009

10 Components of Positive Behaviour Support

Responsibilities under this Policy

	Director *p.37*	Person-in-Charge *p.38*
Positive Behaviour Support Policy *This policy*	• Policy audit Reports are • Received & Reviewed • Shared	Ensure • Policy training , information and education for person, families & staff.
Positive Behaviour Support Committee *p. 39* Has responsibility for implementation of this policy: planning, training, implementing, evaluating, auditing and reporting.	• Establish each committee • Reports are Received ,Reviewed and Shared	• Ensure the PBCS is in place with clear terms of reference. • PBS mentoring group available
Restrictive Practices Review Process (or Committee) *p. 38* *Oversees all restrictive practices in services with a view to recommending PBS. Linked to the HRR & PBS committees.*		• Ensure the Restrictive Practices Review Process is in place with clear terms of reference.
Human Rights Review (HRR) Committee *p. 39* *Oversees all rights restrictions with a view to making recommendations.*		• Ensure HHRC is in place with clear terms of reference.
Quality & Safety Committee *p. 38*		• Ensure Quality and Safety Committee is in place, with clear terms of reference.
Services *p. 35*		Ensure availability of • Independent advocate & Legal representation • Callan Institute training • Policy Audit and feedback system

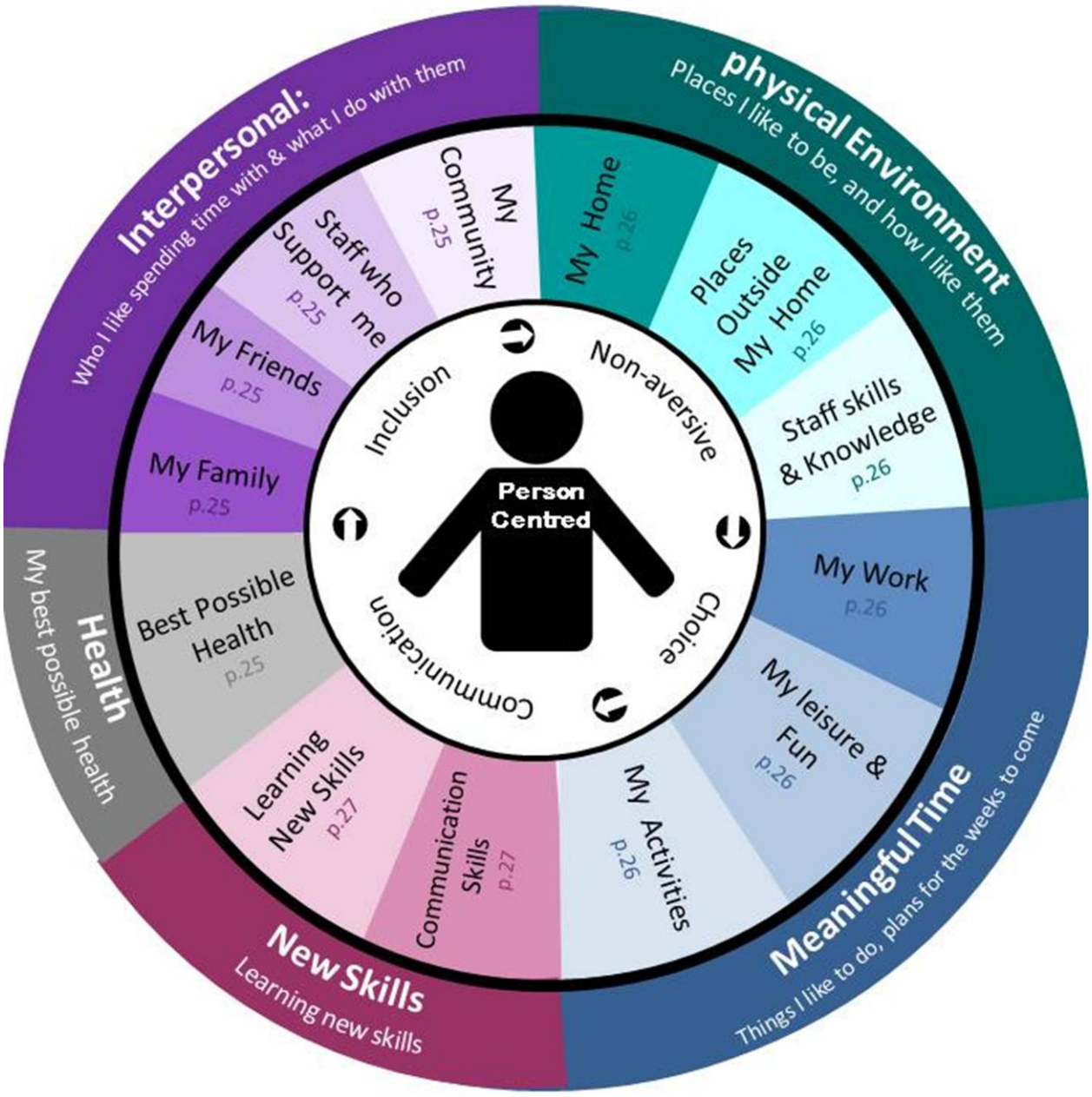
	A Positive Behaviour Support Culture	Assess A	Plan P	Implement I	Evaluate E	Skills Building	Aversive/ Restrictive (A/R) Strategies	Incident Management & Safeguarding
All Staff *p.31*						• Needs identified • Attend education	• Use non-aversive/ non-restrictive strategies • Record any use of an aversive/restrictive practice • Adhere to policies	Ensure • Safety, dignity & respect • Response & record • Adhere to policies
Frontline Staff *p.33*	• Implement PCP • Record behaviour of concern • Refer for PBS • Collaborate	• Participate • Record APIE • Ensure collaboration	• Contribute • Collaboration • Ensure Accessibility	• Develop strategies • Ensure collaboration • Implement plan	• Monitor • Evaluate • Record			
Assigned Staff *p.34*	• Promote PCP process • Recognise unmet needs- record. • Use the wheel of optimal living. • Refer for PBS supports	• Ensure consent • Assess • Participate	• Listen • Be creative • Plan • Proactive & reactive strategies Ensure • Collaboration • Accessibility	• Implement plan. • Record	• Evaluate outcomes • Monitor • Discuss at meetings • Record /Report			
Service Line Manager *p.35*	Ensure ... • Implementation of PCP . • Review incident reports	Ensure... • Completion • Review • ID supports • Refer for PBS	• Oversee • Ensure PCP plans	• Oversee	• Oversee Ensure... • Reports • Attention to A/R strategies • Coordinate & minute meetings re PBS	• Identify need • Support access • Provide PCP training • Support PBS training	• Oversee • Review A/R strategies • Refer to Professionals & committees • Report data	Ensure .... • Recording • Communicated • Managed • Adherence to policies • Review APIE • Access & support others
Practitioners with PBS Expertise *p.37*	• Contribute • Promote • Plan • PBS committee	• Active Caseload	• Active Caseload	• Active Caseload	• Active Caseload • Monitor • Evaluate	• Provide PBS training • Supervision • Mentoring	• Adhere to professional code of practice and policies.	• Adhere to professional code of practice and policies.
PBS Committee *P39*	• Plan for PBS Culture	• Collate & summarise data • Coordinate allocation of referrals	• Support access to PBS • Monitor assessment for clinical input	• Audit data on implement-ation	• Develop audit tool • Ensure audit of PBS • Reports on & audit policy	• Develop & Advise on training	• Audit use of A/R strategies	• Ensure clinical governance.


Specialists inc. Staff skilled in PBS Using MEBS
Governance Triad Partnership: Behaviour Specialist Lead
Step 3: Specialist Level Positive Behaviour Support
Comprehensive Functional Assessment
MEBS / Specialist Intervention
Evaluation
Unit Level Supports
Triad Partnership: Team Leader Led
Step 2: Unit Level Collaborative Professional Supports for Positive Behaviour
Functional Assessment or other
Positive Behaviour / Clinically valid Support Plan
Plan ineffective
Plan effective
All Staff & Family
Triad Partnership: Key Worker Lead
Step 1: Service Level Positive Behaviour Support Culture
Wheel of Optimal Living
Positive Behaviour Component of Personal Plan
Personal Plan Review
Behaviour of concern or unchanging restrictive practice
Optimal Functioning
Assessment
Plan & Implementation
Evaluation
Person Centred
Human Rights based
Non-restrictive Non-Aversive
Incident Management
Education & Support

Wheel of Optimal Living:

What makes life good?

& where to look if there is a behaviour of concern



Policy on Positive Behaviour Support

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Contents

1. Introduction

The Saint John of God values of Hospitality, Care, Compassion, Dignity, Excellence, Justice, Respect, and Trust underpin all activities related to service provision and individual support. All Saint John of God Community Services Ltd. policies aim to promote the philosophy of person centred practices, empowerment, capacity building and the realisation of individual rights and place each individual in the context of their family life, their natural support network and their community.

1.

1.1. Policy Statement

Saint John of God Community Services Limited (SJOGCS) is committed to providing positive approaches within a Positive Behaviour Support framework and Human Rights Based Approach (HRBA) to individuals with intellectual disability and behaviours of concern in order to enable optimal lifestyles and to respond to behaviours of concern using non-aversive and non-restrictive strategies. This policy advocates for the use of Positive Behaviour Support (PBS) and the Multi-Element Behaviour Support (MEBS) Model.

1.2. Purpose

The purpose of this policy is to ensure a collaborative, integrative and consistent approach in supporting individuals with behaviours of concern within Saint John of God Community Services Limited.

This policy is based on the following statements of good practice:

a. A behaviour of concern can arise when there is an unmet need. It is expected that a person centred planning (PCP) process (e.g. Positive Futures Planning, PATH, Lifestyle Planning, Personal Outcomes Measures etc.) together with a personal plan will be used to achieve the desired lifestyle or optimal functioning level. If this is inadequate or unresponsive, a behaviour of concern may arise.

b. This policy advocates that Positive Behaviour Support principles and practices are used for interventions and supports for a behaviour of concern; which are always informed by a clinically valid assessment and are evidence-based.

c. This policy also seeks to ensure a proper balance between an individual's needs and the needs of others either sharing their environment including those responsible for supporting them. It does this while ensuring best practice within the current legislative and regulatory requirements.

1.3 Scope

This policy is for all staff working in services for adults with intellectual disabilities in Saint John of God Community Services Limited.

2. Glossary of Terms, Definitions & Abbreviations

Person Centred Planning: 'Person centred planning' may be defined as a way of discovering:

- how a person wants to live their life and
- what is required to make that possible.

The overall aim of person centred planning is "good planning leading to positive changes in people's lives and services" (Ritchie et al, 2003, cited in NDA, 2006:12).

Optimal Living: This is best understood as the most favourable or desirable life as identified by and with the individual.

Disability: The Convention on the Rights of Persons with Disabilities adopts a social model of disability, and defines disability as:

> *'Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others'.*
>
> (United Nations, 2006)

In adopting this definition this policy conforms to the social model of disability recognising the interaction and responsiveness of the environment to the needs of the person.

A Behaviour of Concern: Behaviour can be described as being 'of concern' when it is of such intensity, frequency or duration as to threaten the quality of life/optimal functioning and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (Adapted from Royal College of Psychiatrists *et al*, 2007, Chan et al 2012).

Positive Behaviour Support: Positive Behaviour Support (PBS) uses behavioural technology and person centred values to understand the function or cause of a behaviour of concern. Once the function or cause is identified, a Positive Behaviour

Support Plan is developed and implemented, 'to first enhance the individual's quality of life and second to minimise his or her problem behaviour' (Carr *et al,* 2002:4). The uniqueness of PBS lies in the fact that it integrates 10 key components into a cohesive whole:

10 Key Components of PBS (Gore *et al,* 2013)	
Values	*1. Prevention and reduction in the context of quality of life, inclusion, participation & valued social roles.*
	2. Constructional approaches; intervention, skills and deliberately avoid restrictive practices.
	3. Stakeholder participation.
Theory	*4. Behaviour is functional.*
	5. Primary use of Applied Behaviour Analysis (ABA).
	6. Secondary use of other evidence-based approaches.
Process	*7. Data driven approach.*
	8. Functional assessment to inform function based interventions.
	9. Multi-component interventions (proactive and reactive).
	10. Implementation, monitoring and evaluation long-term.

Multi-Element Behaviour Support: Multi-Element Behaviour Support (MEBS) is a structured and formal model of Positive Behaviour Support which incorporates the above 10 key components. The uniqueness of this model rests in the use of functionally based and/or non-functionally based, non-aversive and non-restrictive reactive strategies.

Restrictive Practice: Restrictive practices can be broadly defined as the intentional restriction of a person's movements or behaviour. Restrictive practices include: *Physical or mechanical restraint*, in which a person or a mechanical device restricts someone's freedom of movement or access to their own body; *Chemical restraint*, which is the intentional use of medication to control or modify a person's behaviour or to ensure a patient is compliant or not capable of resistance, where the treatment is not necessary for a condition; *Environmental restraint,* which is the intentional restricting of a person's normal access or mobility within their environment; it also includes denying a person their normal means of independent mobility, means of communicating or the intentional taking away of ability to exercise civil and religious liberties. *(HIQA, 2013a).* ***(see Section 4.2 below)***

2.1 Abbreviations

AAC: Alternative and Augmentative Communication
APIE: Assessment, Planning, Implementation and Evaluation
HIQA: Health Information and Quality Authority
HRBA: Human Rights Based Approach
HSE: Health Service Executive
PCP: Person Centred Planning
PBS: Positive Behaviour Support
POMs: Personal Outcome Measures
MEBS: Multi-Element Behaviour Support
NDA: National Disability Authority
SJOGCS: Saint John of God Community Services Limited
SJOGHM: Saint John of God Hospitaller Ministries
UN: United Nations

3 Legislation/Other Related Policies:

This policy is informed by Health Act 2007 (Care and Support of Residents in Designated Centres for persons - Children and Adults - with Disabilities), the Regulations (2013) of the same act, and the Health Information and Quality Authority's (HIQA, 2013b) National Quality Standards for Residential Settings for Adults and Children with Disabilities and the Assisted Decision-making (Capacity) Bill, (2013).

It is also informed by the following Saint John of God policies:

- Policy on Rights Protection & Promotion of Rights in Intellectual Disability Services (2012)
- Risk Assessment Policy and Procedure (2014)?
- Policy and Procedures for Managing Allegations of Abuse (2010)
- Policy and Procedures for Safeguarding Vulnerable People (Intellectual Disability Services) (2013).
- Incident Management Policy & Procedure (Negligible/Minor/Moderate Impact) (2013)
- Trust in Care (2005)
- Health and Safety at work (Dignity at Work) (2004)
- Compliment and Complaints policies (2013)
- Adverse Incidents (2013)
- Values in Practice (2009)
- Volunteer Policy (2013)
- Policy on Using a Total Communication Approach (2014)
- Supports Policy: Agreement, Application, Transitions and Cessation (2014)
- Guidelines on the Establishment of Quality and Safety Governance Structures (2013)

4. Foundations of this Policy

Five key organisation-wide processes represent the foundations which underpin this and other organisational policies:

- 4.1 Being person centred within a Human Rights Based Approach.
- 4.2 Non-restrictive and non-aversive practices.
- 4.3 Incident management, risk assessment and safeguarding practice.
- 4.4 APIE – assessing, planning, implementing and evaluating.
- 4.5 Education and support for staff skill and knowledge.

4.1 Being person centred within a Human Rights Based Approach

We advocate and use a person centred approach which is guided by a Human Rights Based Approach in all areas of our support of people with behaviours of concern. We listen to the individual and identify their strengths/assets and skills and find possibilities and solutions to improve skills and life outcomes to support each individual as they contribute to their own lives, their family and their community. Both policy and the evidence base are clear that effective services start by listening to the individual, their needs, wishes and aspirations, and planning, advocating and designing services around that. Effective person centred planning (as per *SJOGCS Supports Policy*, 2014) is considered to be the best way of achieving success – and thus is at the heart of staff practice and service provision.

> *It is the policy of the organisation to respect affirm promote and protect the rights of each individual to whom support is provided … [through a] rights review process.*
>
> *(SJOGCS Policy on Rights Protection and Promotion of Rights in Intellectual Disability Services, 2012)*

The organisation advocates and uses a Human Rights Based Approach (HRBA) which is an established framework and set of guiding principles for ensuring that human rights are upheld in organisations or services that adopt these principles *(SJOGCS Policy on Rights Protection and Promotion of Rights in Intellectual Disability Services, 2012)*. It is in the interest of those with behaviours of concern and those supporting them that the link between personal plans (using person centred planning) and a HRBA is firmly established. In order to do this it is proposed that personal plans and services are provided in accordance with the five HRBA principles. These principles, defined in the context of their relevance to a person centred approach, are listed below:

- **Express link to Rights:** Identifies and names the rights that the person may not be supported to exercise or that may be restricted.
- **Participation:** Identifies barriers that exist which limit the person in terms of exercising rights.
- **Empowerment:** Explores how the person can be empowered through the selection of appropriate interventions and supports, thus building skills and capacity.
- **Non-discrimination:** Ensures that persons with disabilities and behaviours of concern are not discriminated against on the grounds of their disabilities or behaviour.
- **Accountability:** Measures that the person is receiving the *service he/she requires for optimal functioning.*

Evidenced by: Each individual has a personal plan that is linked to their daily lives and is based on individual assessment, which should include a Rights Review, and person centred planning, and is informed and guided by a Human Rights Based Approach as outlined in the Convention on the Rights of Persons with Disabilities (United Nations, 2006).

4.2 Non-Restrictive & non-aversive Practices

It is the policy of SJOGHM that a behaviour of concern should be supported using non-aversive, non-punishment based and non-restrictive strategies. A non-restrictive strategy, also referred to as a non-rights restrictive strategy, is a strategy which does not restrict a human right as interpreted through the *Universal Declaration of Human Rights* (UN, 1948). Some examples of restrictive strategies are; physical restraint, mechanical restraint, pharmacological restraint, seclusion, environmental restrictions (e.g. locked doors) no access to money, punishment based strategies for example; a personal item being taken away etc. This is of particular relevance to staff as they respond to a behaviour of concern. A non-aversive strategy is usually understood as a strategy that is liked or not aversive to the person.

Non-restrictive strategies place priority on understanding the function of the behaviour of concern and reducing the episodic severity of the incident in order to maintain safety for all. As such, if the severity of the incident can be reduced and the individual's behaviour of concern calmed by using a non-aversive and non-restrictive strategy then these are to be used. This may mean for example, using capitulation or giving in to a request; and/or offering a preferred item. In the short-term this is the correct intervention and should be recorded and should the person need additional supports, a referral could be made for more specific supports signalling for example,

a transition from Step 1, to Step 2, or Step 2 to Step 3 of Positive Behaviour Supports.

Should the use of a restrictive strategy be indicated, the policy and procedures for their use is outlined below under the headings of

- **Emergency Restrictive Reactive Strategies:** These are restrictive strategies (i.e. any strategy that restricts the rights of an individual e.g. removal of personal items, physical restraint, mechanical restraint, chemical restraint, environmental restraint) which are used in an emergency without a plan for authorisation, approval, consent, monitoring and review.
- **Authorised Restrictive Reactive Strategies:** (These restrictive strategies, which include physical or mechanical restraint, chemical restraint, and seclusion, (and environmental restraint) are governed by addendums to this policy, 8a, 8b and 8c (8d to be completed) respectively (*see* Appendix 8).
- **Prohibited Restrictive and Aversive Strategies:** These strategies include positive punishment (an intervention the person finds unpleasant) and negative punishment (something the person finds rewarding is taken away). These strategies are only permitted with appropriate authority in certain limited and strictly monitored cases such as treatment strategies (teaching strategies). Appropriate clinical personnel together with the team directly responsible for the care of the individual authorise the restrictive strategy in writing (*see* Policy 8a, section 6.2.1).
- Authorisation for use of restrictive strategies requires a comprehensive assessment, evidence of previous interventions, a rationale, risk assessment, informed consent, formal notification to the Human Rights committee (and if used, to HIQA) and a plan for reinstatement of the restricted right (see Appendix 5)

Evidenced by: Each individual who presents with a behaviour of concern is supported using non-aversive and non-restrictive practices as evidenced in their personal plan. Should the use of restrictive strategy be indicated, it is implemented in accordance with this policy.

4.3 Incident management, risk assessment and safeguarding practice

A behaviour of concern can cause harm, both to the individual presenting with the behaviour of concern and to those around them. Incident management is governed by

'*a commitment to the protection and wellbeing of individuals who use our services; to our employees and others; to be just in our approach and demonstrate compliance with legislative and regulatory requirements*.'
(SJOGHM, Incident Management Policy and Procedure, 2013)

Evidenced by: Each individual's file, records any and all behaviour incident(s), adverse incident(s), risk assessment(s) and all risk and safeguarding concerns. Personal plans also record the assessment (analysis of the data), a documented plan, implementation protocol and evaluation arising from the incident or concern (see APIE section 4.4).

4.4 APIE – Assessing, planning, implementing and evaluating

Every level of Positive Behaviour Support is underpinned by the *APIE* framework – Assessment, Plan, Implementation and Evaluation (Yura & Walsh, 1967) - to understand the function of a behaviour of concern which limits optimal functioning of an individual and to support optimal functioning.

- **Assess:** The first step in APIE involves assessment and formulation on individual, environmental and behavioural factors. Formulation is best understood as a hypothesis about the nature of the presenting problem and its development e.g. looking at individual factors: underlying medical and organic factors, psychological/psychiatric, communication, social and/or environmental etc. factors. These, together with any additional assessments (e.g. a functional assessment) lead to a clear formulation and identification of the function or message of the behaviour of concern. This step should be clearly documented with the contributors named.

- **Plan:** The formulation arising from an assessment guides the specific interventions in the written plan. The plan can be based on addressing optimal functioning and integrated into a personal plan, a Positive Behaviour Support Plan or a Multi-Element Behaviour Support Plan. All plans will be multi-component, with proactive and reactive strategies and be clinically valid. Plans are developed in line with best practice on consent and assisted decision making as outlined in Saint John of God Policy (Values in Practice) and may include a multi-theoretical approach. All plans are documented with the contributors named.

- **Implement:** The plan has a guide for implementation attached. This can be in the form of a checklist or actions of what to do, by whom and when it is to be completed by. The plan is integrated into the person's personal plan by the keyworker and is implemented as required.

- **Evaluate:** The effectiveness of a plan for a behaviour of concern can be measured by reviewing the desired increase in the person's life outcomes and quality of life; the removal/reduction of any aversive/restrictive strategies; a reduction in the frequency and episodic severity of the behaviour of concern;

the maintenance of the behavioural change over time and the generalisation of the behavioural change to different places, community facilities and people. Social validity is also measured, in that the strategies can be used in ordinary community settings and are liked and believed to be useful and effective by the individual and their circle of support. The evaluation also identifies if the current support(s) should be maintained, discontinued or reviewed and by whom, and as appropriate if the individual has been discharged by a clinician.

Evidenced by: Each individual who presents with a behaviour of concern has evidence in their personal plan that an APIE approach has been used and the plan integrated into their personal plan.

4.5 Education and support for staff skill and knowledge

Staff training is provided in a range of topics as identified from the needs of their daily work with behaviours of concern, or to enable practices for a preventative approach. Training is provided to staff, carers and family members, as appropriate, in a variety of areas e.g.:

- Person centred planning and the development of a personal plan;
- Alternative and Augmentative Communication;
- Positive Behaviour Support;
- Identifying a behaviour of concern;
- Data recording;
- Risk assessment;
- Functional Assessment;
- Writing interventions as part of a Positive Behaviour Support Plan;
- Skills teaching;
- Multi-Element Behaviour Support Model;
- Implementation processes;
- Active listening;
- De-escalation and emergency management;
- Emotional wellbeing;
- Recognition of abuse and neglect;
- Disrupted attachment;
- Verbal and non-verbal communication;

Evidenced by: There are a range of documents available to indicate that a staff training and support plan is in place e.g., an individual staff training plan and record; a training plan and record for the unit; staff meeting minutes; staff supervision notes etc. with evidence that it is being followed for staff members supporting any one individual with a behaviour of concern.

5. The 3-Step Model of Positive Behaviour Support for Preventing and Responding to a Behaviour of Concern

This 3-Step model includes:

Step 1: Service Level: Positive Behaviour Support Culture using the Wheel of Optimal Functioning.

Step 2: Unit Level: Collaborative Professional Assessment and Supports for a Positive Behaviour Support Plan.

Step 3: Specialist Level: Positive Behaviour support using specialist interventions including the Multi-Element Behaviour Support Model.

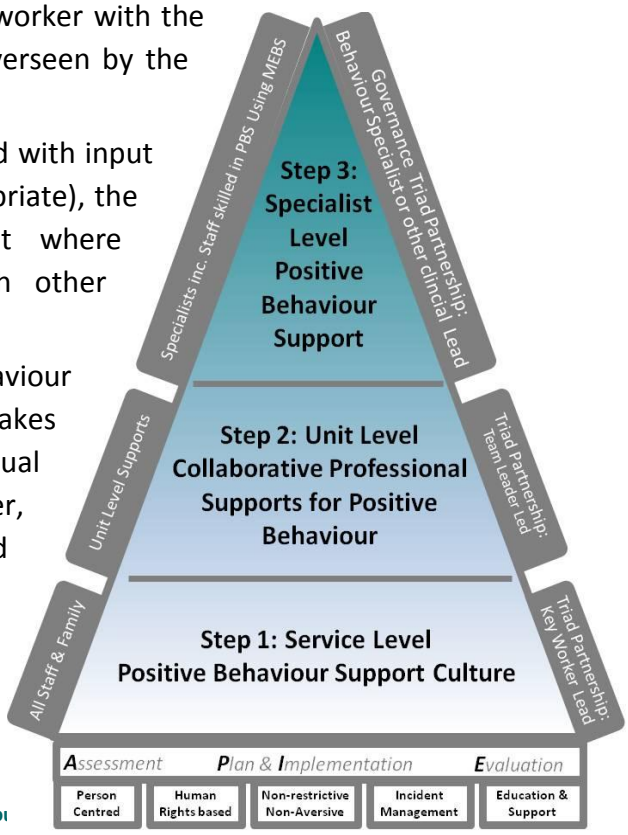
Foundations: These Steps are underpinned by the five foundations outlined above (see Section 4).

Governance: At each step a triad partnership with alternating roles is responsible for governance e.g.:

At Step 1, governance is led by the key worker with the individual (family where appropriate) overseen by the Team Leader.

At Step 2 the Team Leader takes the lead with input from the individual (family where appropriate), the key worker, the behaviour specialist where available and appropriate, along with other interdisciplinary input as required.

At Step 3 a specialist, e.g. a behaviour specialist or other clinical professional, takes the lead with input from the individual (family where appropriate) key worker, team leader, circle of support and collaborative interdisciplinary input as appropriate.



Personnel: Support is provided at service level by all staff and family at Step 1; by Unit Level staff at Step 2; and by specialist staff at Step 3.

Cumulative Model: This model requires staff to review and take-on-board the APIE developed at the forgoing steps, before taking action. As such, documentation forms an important part in establishing a record of supports which can inform subsequent assessments and plans for Positive Behaviour Supports. Documentation of assessments, plans, implementation and evaluation at each step is required.

5.1 Step 1: Service Level: Positive Behaviour Support Culture

Step 1 is built around a Positive Behaviour Support (PBS) culture which embodies universal promotion of PBS as depicted in the *Wheel of Optimal Living* (*see* Section 6). The Wheel can be used when a behaviour of concern arises, or to prevent behaviours of concerns arising.

Personnel: All staff & family members can be equipped to provide the supports to ensure optimal living through a Positive Behaviour Support culture.

Governance: At Step 1 governance is led by the key worker, overseen by the team leader.

Assessment & Formulation: A Wheel of Optimal Living prompt tool building on the key dimensions of optimal living is used with the individual, staff and family members to consider the areas where supports can be provided (*see* Appendix 1).

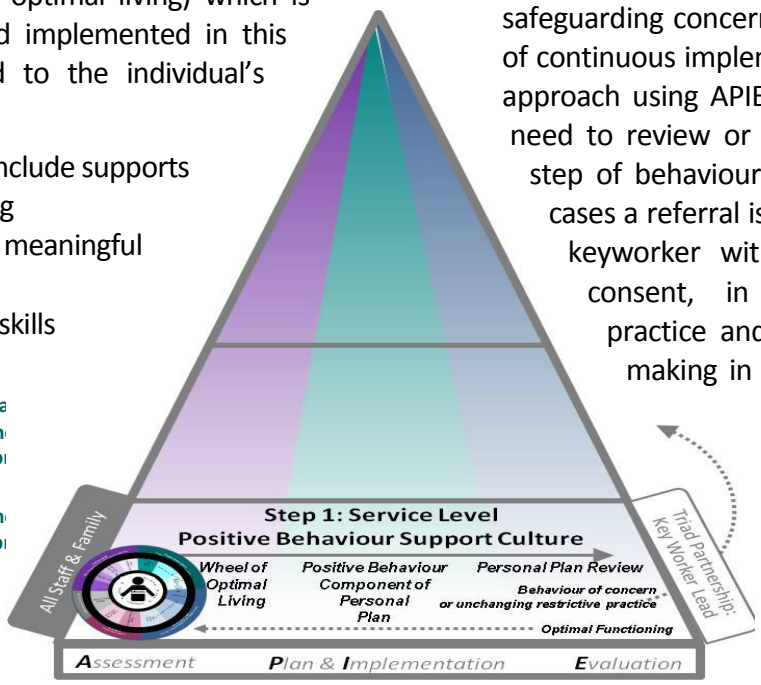
Plan & Implementation: The plan (using the Wheel of optimal living) which is drawn up and implemented in this step is linked to the individual's personal plan.

A plan might include supports in the following Interpersonal; meaningful time; physical environment; skills teaching- communication health and other; All resulting in optimal living for the individual.

Evaluation: Progress is evaluated and the plan reviewed for optimal living; the reduction/elimination of restrictive practices and the reduction in the behaviour of concern (e.g. frequency and/or episodic severity of behaviour of concern; the risk assessment ratings).

Transition 1a: A reduction in the behaviour of concern and increase in optimal functioning signal effective intervention and indicate that the level of support can be maintained.

Transition 1b: Identification of an on-going behaviour of concern, use of an unchanging or emergency restrictive practice, a risk assessment or safeguarding concern despite evidence of continuous implementation of a PBS approach using APIE may indicate the need to review or move to the next step of behaviour supports. In such cases a referral is completed by the keyworker with the individual's consent, in line with best practice and assisted decision making in Saint John of God



Services, and sent to appropriate professional/ team e.g. Speech and Language Therapist, GP, Psychologist, Behaviour Specialist, Psychiatry. The key worker also completes any additional forms required e.g. Rights Restrictions, Safe-guarding, Adverse incident, Risk assessments. Copies of all referrals and forms are kept in the individual's file.

5.2 Step 2: Unit Level: Collaborative Professional Support

Step 2 supports are implemented to address specific behaviours of concern requiring collaborative professional supports and/or ones which were not prevented or reduced by Step 1. A review of the APIE for Step 1 and the personal plan is completed. This is followed by an assessment (e.g. functional assessment or other clinically valid assessment) to develop a formulation which informs the plan and implementation of Step 2.

Governance: At step 2 the Team Leader comes to the fore in terms of governance, coordinating the APIE of collaborative supports from a range of specialties, including staff skilled in PBS if available. Input from the individual, the family (where appropriate) and the key worker of the person are an important and necessary contribution.

Personnel: Support at this step is provided by staff available to the individual (house, day programme, school, job etc). This may include e.g. family, friends, social care staff, nursing staff, psychology, OT, SLT or psychiatry supports. It may also include staff skilled in PBS e.g. staff with post-graduate training in PBS whose services are available to the individual.

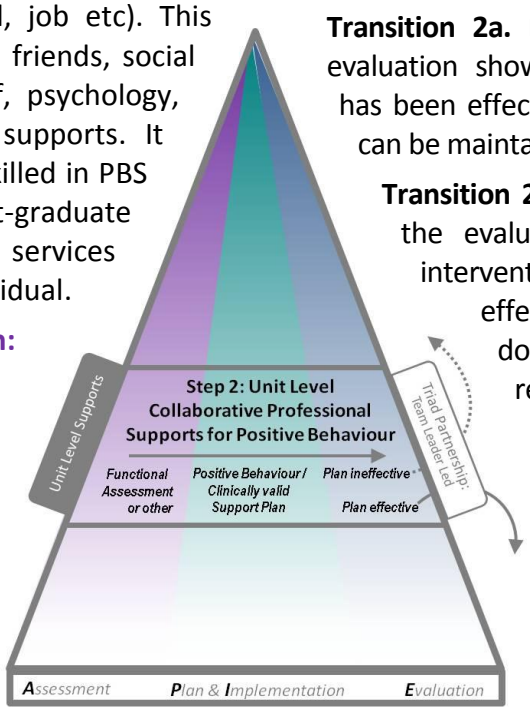
Assessment & Formulation: An assessment (e.g. functional assessment or other clinically valid assessment) is undertaken to gain a better understanding or formulation of the factors that are related to the behaviour of concern. This is undertaken and documented by the collaborating professionals to inform the plan.

Plan & Implementation: A clinically valid support plan drawing on collaborative supports is developed, documented and implemented by the collaborating professionals. A PBS plan within this context includes proactive and reactive strategies which can include some or all of the following; environmental strategies, communication skills teaching and alternative skills, trigger control strategies and reactive strategies that are evidence-based.

Evaluation: The intervention is reviewed and documented by collaborating professionals to establish if it has been effective or ineffective. This will determine which of the two following support transitions are undertaken.

Transition 2a. Maintain Step 2: If the evaluation shows that the intervention has been effective, the level of support can be maintained.

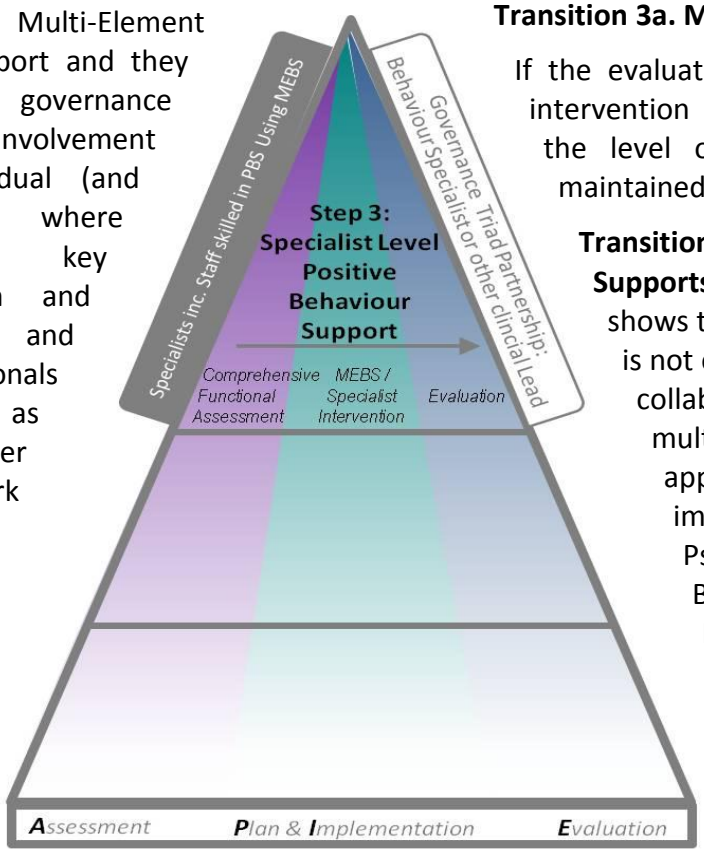
Transition 2b. Upward Transition: If the evaluation shows that the intervention has not been effective e.g. the behaviour does not reduce, or a restrictive practice is used, or a risk assessment or safeguarding concern is identified) this can signal the need to review the current supports or cycle upward to Step 3 supports.



5.3 Step 3: Specialist Level: Positive Behaviour Support

Step 3 supports are initiated if the behaviour of concern persists without reduction after cycling through the two lower steps of the support model. Step 3 begins with review of the APIE for Step 1 and Step 2. This is followed by specialist interventions such as Multi-Element Behaviour Support (MEBS) or other evidence-based specialist interventions led by a Psychologist, Behaviour Practitioner, Psychiatry, Speech and Language Therapist, Occupational Therapist, and informed by the principles and practices of Positive Behaviour Support.

Personnel & Governance: Supports at this level are provided by specialist staff, for example staff skilled in Positive Behaviour Supports using Multi-Element Behaviour Support and they hold governance responsibility. Involvement of the individual (and their family where appropriate), key worker, team and team leader and other professionals is invited as required in order to work constructively, collaboratively, creatively & responsively together.



Assessment & Formulation: A comprehensive behaviour assessment is undertaken with formulation informing intervention, namely a Multi-Element Behaviour Support plan.

Plan & Implementation: Multi-Element Behaviour Support has proactive strategies addressing environmental factors, skills teaching, direct intervention and reactive strategies.

Evaluation: The intervention is evaluated against six outcomes as identified in the MEBS Model in order to establish if it is effective or ineffective. This will determine which of the two following supports may be required.

Transition 3a. Maintain Step 3.

If the evaluation shows that the intervention has been effective, the level of support can be maintained.

Transition 3b. Additional Supports: If the review shows that the intervention is not effectivea collaborative multidisciplinary approach is implemented led by a Psychologist, Behaviour Practitioner, Psychiatry, Speech and Language Therapist, Occupational Therapist, and informed by the principles and practices of Positive Behaviour Support.

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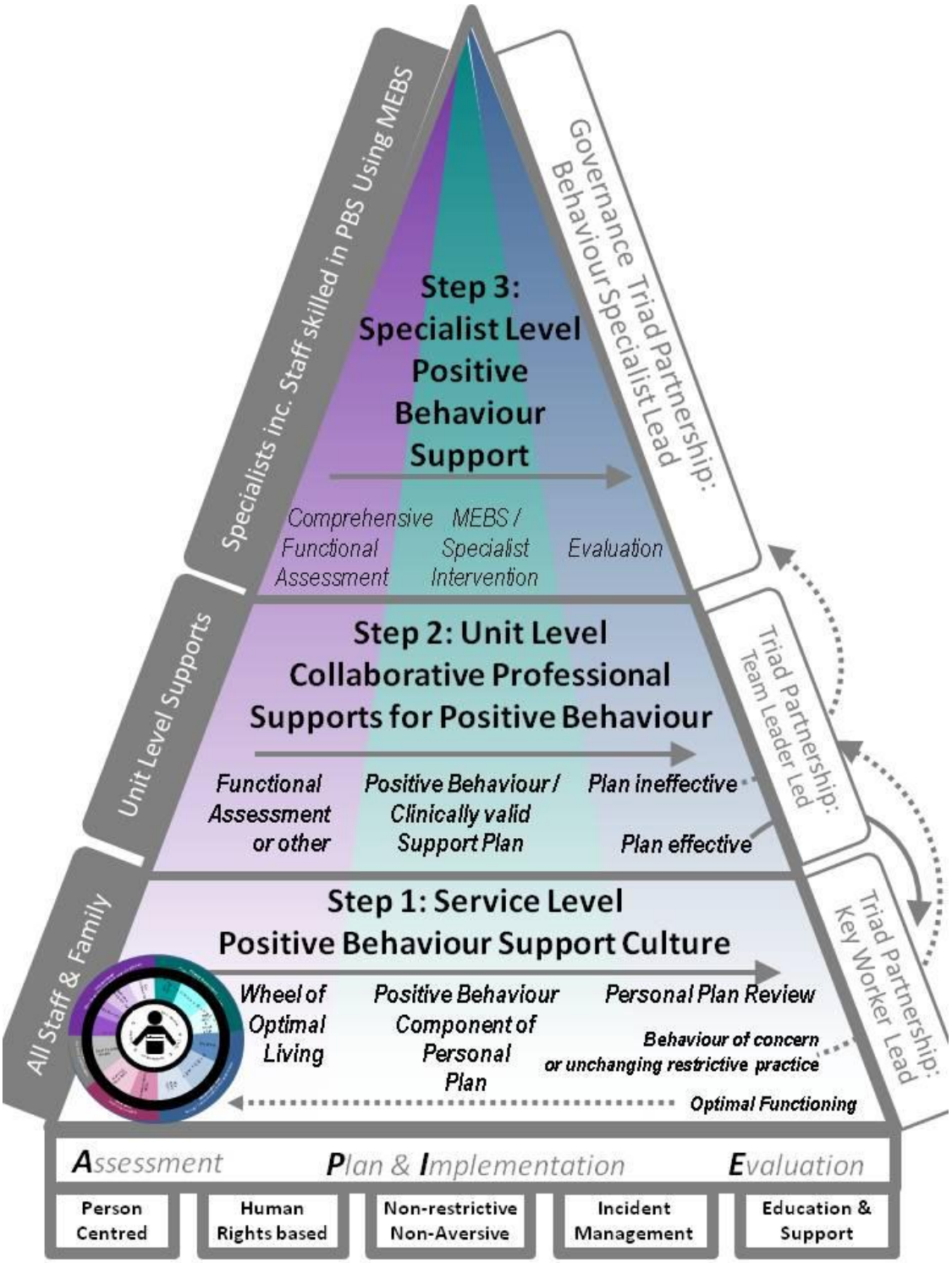
3-Step Model of Positive Behaviour Support



6 Positive Behaviour Support Culture: Wheel of Optimal Living

A Positive Behaviour Support culture strives for *optimal living* for all. The wheel of optimal living illustrates the elements which contribute to optimal living – making life good – and also illustrates the elements which may need to be addressed to make life good.

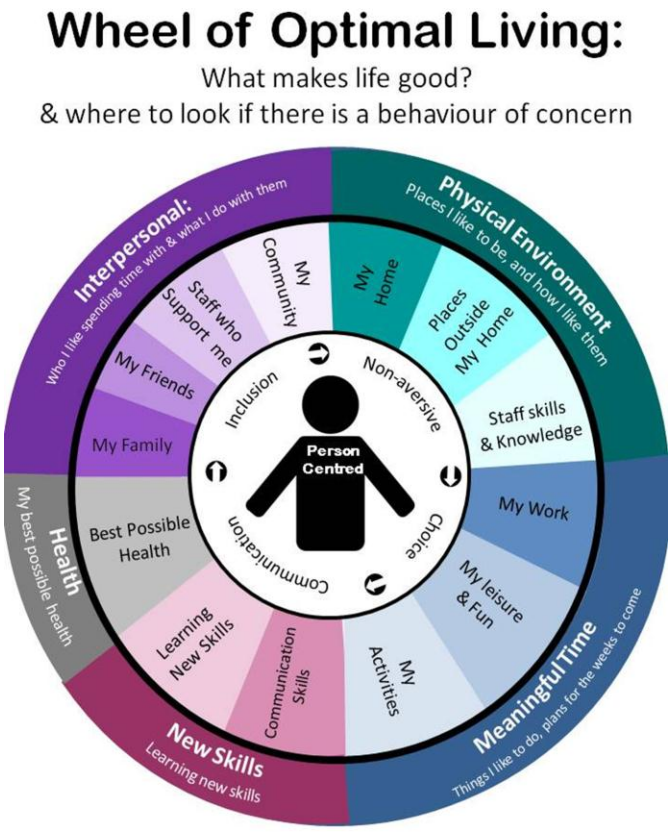
A good life is represented by five dimensions of optimal living. These include:

Health: My best possible health.

Interpersonal: Who I like to spend time with on a daily and weekly basis, and what I do with them. This may include my family, friends, staff who support me and my community.

Physical Environment: Places I like to be in and how I like them to be. This may including my home and outside my home, and staff (family members and others) with skills and knowledge to facilitate these environments.

Meaningful time: Things I like to do during the day and plans I make for the weeks and months to come.



New Skills: Learning communication skills and other skills which I can use, and new skills I want to learn.

Reflecting the key principles of Positive Behaviour Support, the wheel has at its core, four guiding principles of, communication, choice, non-aversive/non-restrictive and inclusion. These principles apply to all aspects of life e.g. non-aversive, interpersonal life, a non-aversive health programme, a non-aversive physical environment, choice in my day, choice in the skills I learn etc.

6.1 Using the Wheel to Assess Optimal Living in a PBS Culture

The core principles (*see* 6.1.1 below) and dimensions of the Wheel of Optimal Living (*see* 6.1.2 below) can be used with the individual, staff and family members to consider the areas where support can be provided. Once completed, support can be provided by

- Adapting the environment, to include the physical, interpersonal, programmatic;
- Skills teaching to include a general skill(s), communication skills and coping and tolerance skills;
- Focused supports to include removing or reducing triggers causing a behaviour of concern and increasing situations and events where the behaviour of concern is less likely;
- and also having a reactive strategy which is non-aversive and non-restrictive and whenever possible or known based on the function of the behaviour of concern.

Proactive Strategies			Reactive Strategies
Environmental Adaptations	Skills Teaching	Focused or Direct Supports	Reactive Strategies.

e.g. Four parts of a Positive Behaviour Support Plan

6.1.1 Core Principles Underpinning the Wheel

The principles of communication, choice, inclusion and non-aversive/non-restrictive are relevant to each of the five dimensions of optimal living.

- **Communication Skills**

'How I like to communicate, as in how I express myself and how I understand other people's communication.'

The most effective starting point for understanding a behaviour of concern is to acknowledge that it is purposeful and functional – as in, it is an individual's way of communicating something (whether they are able to speak or not) about themselves and their current situation. SJOGSC is committed to a Total Communications Approach which *"encompasses use of all means of communication, acknowledgement of all attempts at communication and identification of opportunities for communication"* (SJOGCS Policy on using a Total Communications Approach, 2014). Moreover, individuals are encouraged to appropriately express their feelings and are helped to deal with issues that impact on their emotional well-being.

Evidenced by: Each individual has a completed communication profile with a communication plan (skills teaching and environmental supports) for expressive and receptive communication support and staff members can use Alternative and Augmentative Communication (AAC) devices and methods e.g. LAMH, Picture Exchange, TEACCH, Objects of reference, Visual schedules/cards/social stories and assistive technology as appropriate to their daily work.

'Having enough information to help me understand what is happening, for myself, what I want, what I like, with help if necessary and having information to assist with decisions I might need to make.'

- **Choice**

Self-determination is a core concept of the Convention of the Rights of Persons with Disabilities (UN, 2006) and in keeping with a person centred approach, each individual is supported to make choices, based on their preferences (likes and dislikes) and receive information and support to assist in decision making so that each individual can direct their daily routine(s) e.g. choices in clothing, meals, snacks and diet, occupation, leisure pursuits, health, friend and family contact, their daily and weekly diary /schedule, in their own home and personal possessions etc.

Evidenced by: Each individual has included in their personal plan, choices they make regarding their preferences and choices in their daily routines. This can be based on a preference checklist or list of 'things I like and things I do not like' derived from interview/observation for each part of the Wheel of Optimal Living.

- **Inclusion**

'Being an equal partner in all aspects of my life.'

Inclusion and participation are core concepts of the Convention of the Rights of Persons with Disabilities (UN, 2006) and are reflective of PBS values and a person-centered approach. In keeping with this principle each individual is supported to play an active role and feel that they belong and are socially valued in all aspects of their life: at home, at work, at leisure, in the community and at an interpersonal level with their friends, family members in the community and with staff members.

Evidenced by: Each individual has evidence in their personal plan of how their 'belonging to and feeling socially valued' has been included in the assessment in the Wheel of Optimal Living and documented in their personal plan

- **Non-Aversive**

It is the policy of SJOGCS that a behaviour of concern should be responded to using non-aversive and non-restrictive strategies with the priority placed on reducing the episodic severity of the incident in order to maintain safety for all.

'Staff respond to me in ways which I like and are not aversive or restrict my rights.'

Evidenced by: Each individual has included in their personal plan a commitment to, and evidence of, reactive strategies for a behaviour of concern which are non-aversive and non-restrictive.

6.1.2 The Five Dimensions of The Wheel of Optimal Living:

The five dimensions of the Optimal Living Wheel include the following:

- Health
- Interpersonal
- Meaningful Time
- Physical Environment
- New Skills (to include communication skills)

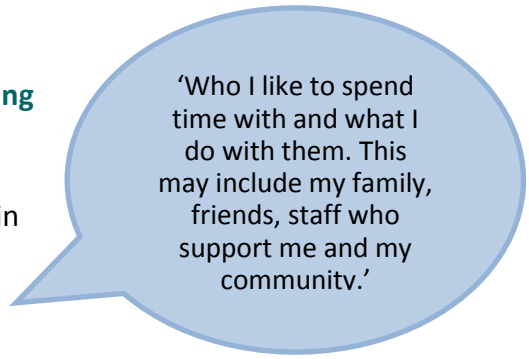
6.1.2.1 Best Possible Health as a Dimension of Optimal Living

'When I physically and emotionally feel as good as I can, life feels better.'

Health is a state of complete physical, mental, spiritual and emotional and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Accordingly, best possible health is supported for each individual as required in keeping with our policy on 'best possible health' (*see* Values in Practice Policy) .

Evidenced by: Each individual has health screening (*see e.g.* Appendix 1a) completed as part of their personal plan and there is evidence that this is reviewed in the context of a behaviour of concern to assess if a 'health' need is contributing to a behaviour of concern.

6.1.2.2 The Interpersonal Dimension of Optimal Living



This dimension of optimal living considers

a) **Family:** Each individual is supported to maintain their contact and role within their family. Families are also supported as they support their family member.

b. Friends: Each individual is supported to make, keep and enjoy their friends and develop relationships. A friend is a person whom one knows and with whom one has a bond of mutual affection, typically exclusive of a professional relationship, intimate/sexual relationship or family relations.

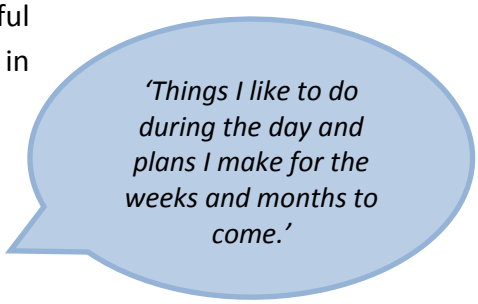
c) Relationship with staff: Each Individual is supported by staff members who they like e.g. who are kind, listen, speak nicely and respectfully, provide assistance and support as required, have a person centred approach and are an advocate for the person and act professionally and responsibly at all times.

d) Living and participating in the community: Evidence shows that individuals with a behaviour of concern are best supported in ordinary community settings, in a place to call home, having socially valued roles, using individualised and personalised approaches.

Evidenced by: Each individual has an Interpersonal profile (*see* Appendix 1b) completed and there is evidence that this is reviewed in the context of a behaviour of concern to assess if an 'Interpersonal' need is contributing to the behaviour of concern. A community participation plan is also included as part of their personal plan.

6.1.2.3 Meaningful Time as a Dimension of Optimal Living

Each individual is supported to have meaningful activities, hobbies, tasks, fun and work to participate in each day and meaningful activities to look forward to each week or month. For example in environments (physical, interpersonal and programmes) that have a goodness of fit for their own individual needs and allow for some consistency and predictability as required by the individual.



Evidence by: Each individual has a completed Meaningful Time profile (*see* Appendix 1d) e.g. a 'meaningful day (weekly) schedule' as agreed with them which includes a review of any environmental factors that need to be adapted for the individual. There is evidence that this is reviewed in the context of a behaviour of concern to assess if a 'meaningful time' need is contributing to a behaviour of concern.

6.1.2.4 The Physical Environmental as a Dimension of Optimal Living

'Places I like to be in and how I like them to be, including my home, outside my home, and staff with skills and knowledge to facilitate these environments'

a) My home: Each individual is supported to express where, and with whom they like to live. They are supported to make choices to facilitate their comfort, support, pleasure and privacy within their home.

b) Outside my home: Each individual is supported to have full access to a range of environments of their choice outside their home, to afford them a variety of opportunities and activities. Any specialised training, exposure, support, adaptations or personal assistance required to facilitate enjoyment of these environments is established and provided by those supporting the individual.

c) Staff Skills and Knowledge to facilitate these environments: Each individual is supported by staff (family or others) that have the knowledge and skill to support them as they participate in their physical environments; for example, mobility, communication skills (expressive and receptive), skill development (coping and tolerance); self-care; access etc.

Evidenced by: Each individual has a physical environment profile (*see* Appendix 1c) completed and there is evidence that this is reviewed in the context of a behaviour of concern to assess if a 'physical environment' need is contributing to a behaviour of concern e.g.

(a) An opportunity to express their preferred living arrangements which is recorded in their personal plan;

(b) An activities support plan which outlines environments and activities the person would like to access and the supports required to do so;

(c) Identified the Skills and knowledge that their support personnel (staff, family, other) require to support them and this is identified in their personal plan.

6.1.2.5 The New Skills Dimension of Optimal Living

Learning new skills plays an important role in feeling good about one-self. Skill development can occur in communication, both in expressing oneself and in understanding others; self-care e.g. grooming, dressing, washing etc.; activities of daily living e.g. cooking, cleaning, gardening, shopping; leisure e.g. painting, cycling, music; and in work or education etc. Each individual has the opportunity to identify skills they would like to learn, and they are supported to learn these using evidence-based strategies for skills teaching.

Evidenced by: Each individual has a communication profile and a skills profile (*see* Appendix 1e) completed and there is evidence that this is reviewed in the context of a behaviour of concern to assess if a 'skills' need is contributing to a behaviour of concern e.g. new skills in communication and other areas and skills teaching procedures as part of their personal plan.

7 Roles & Responsibilities

The roles and responsibilities of the following staff groups and committees under this policy are outlined below:

7.1 All Staff

7.2 Frontline Staff members

7.3 Assigned Staff Members

7.4 Service (Line manager)

7.5 Practitioners with PBS expertise

7.6 Director of Services

7.7 Organisational Supports

7.8 Local Human Rights Committee

7.9 Restrictive Practice Review; Structures and processes in each local service.

7.10 Positive Behaviour Support Committee

7.1 All Staff

All staff are responsible for the following:

7.1.1 Non-aversive, non-restrictive practices

- All staff members are responsible for using non-aversive and non-restrictive strategies.
- If, under very limited circumstances, an aversive/restrictive strategy is authorised (*see* criteria for authorisation section 4.2 above), all staff members adhere to the practice guidelines for their use.
- If an emergency restrictive practice (*see* glossary) is used on more than one occasion this prompts a review of the person centred plan, review of Step 1 of the 3-Step Model of PBS and a referral to Step 2. Please note: Restrictive strategies used need to be recorded on your local behaviour incident form and the data sent to the line manager and/or person in charge (*see* HIQA form NF15D).

7.1.2 Incident Management and Safeguarding

- All staff are responsible to ensure that each individual is free from abuse, neglect, intimidation and that each individual is treated with respect, privacy and dignity in a safe and enabling environment within a human rights based approach.

- Ensure that the well-being of all parties who experience, observe or are involved in an incident and/or are at risk, are promptly responded to and incidents recorded.

- Ensuring all incidents are recorded as required by the policies below and participate in assessment and/or review, and/or investigation relating to an incident with a service user, employee and/or other as outlined in the following

    a. This policy on Positive Behaviour Support

    b. Policy on Incident Management Policy and Procedure

    c. Risk management

    d. Policies & Procedures for Managing Allegations of Abuse and Policy and Procedures for Safeguarding Vulnerable People.

7.1.3 Education and Support for Staff Skills and Knowledge

- All staff are responsible for identifying their education and support needs as appropriate for the individuals they support, (and to support a family/carer identify support and education as required) for example:

- Person centred planning
- Development of a personal plan
- Positive Behaviour Support (PBS)
- Wheel of Optimal Living
- Alternative and Augmentative Communication
- Identifying a behaviour of concern
- Data recording
- Risk assessment
- Functional Assessment
- Writing interventions as part of a PBS Plan,
- Skills teaching
- Multi-Element Behaviour Support Model
- Implementation processes
- Active listening
- De-escalation and emergency management
- Emotional wellbeing
- Recognition of abuse and neglect
- Disrupted attachment
- Verbal and non-verbal communication

- Attend and complete education and support training as evidenced in their personnel file and for each individual they support.

7.2 Frontline Staff members

Frontline staff members are responsible for the following

7.2.1 A Positive Behaviour Support Culture and Optimal Living

- Implement a Positive Behaviour Support Culture for each individual as part of the individualised assessment and personal planning process (*see* Appendix 2 & 3).
- Record each occurrence of a behaviour of concern on your local *Behaviour Incident and Planning form* and / or other forms as required e.g. the Adverse Incident Form / Critical Incident / Safeguarding Vulnerable Persons / Rights Restriction Data / Risk Assessment.
- Identify and make a referral (in line with best practice and assisted decision making, *see* SJOG Policy, Values in Practice) if an individual requires additional Positive Behaviour Support (or any other supports) due to optimal functioning level decreasing or being impaired or the use of a restrictive practice.
- Work collaboratively with the team, the line manager, the individual and the family (as appropriate) to support each individual with a behaviour of concern.

7.2.2. Assessment

- Record the APIE process in the individual's personal file. Participate in data analysis and assessment to determine an understanding or formulation and /or function of the behaviour of concern.
- Ensure that the individual/family and any other relevant party have contributed to the assessment

7.2.3 Planning

- Contribute to the development of the PBS plan.
- Ensure that the individual/family and any other relevant party have contributed to development of the intervention, PBS plan.
- Present the PBS plan in accessible format for the individual and others, to include family and staff members.

7.2.4. Implementation

- Develop and implement strategies as part of a Positive Behaviour Support Plan (with appropriate support and supervision).
- Ensure that the individual/family and any other relevant party contribute to implementation of the PBS plan.

7.2.5 Evaluation

- Monitor the implementation of the PBS plan using a checklist or the Periodic Service Review on a regular basis as agreed by the team.
- Evaluate and review the Positive Behaviour Support plan against a range of outcomes on a formal basis every three months.

7.3 Assigned Staff Members

In addition to the responsibilities of frontline staff, assigned staff members and/or keyworkers are responsible for:

7.3.1 A Positive Behaviour Support (PBS) Culture / The Wheel of Optimal Living

- Promote a PBS Culture for each individual assigned to them, by monitoring the individuals PBS plan as it relates to The Wheel of Optimal Living for that individual.
- Recognising that behaviours of concern are communicative, that the individual has an unmet need and that their physical and emotional well-being requires additional support.

7.3.2 Assessment

- Ensuring that the consent process (in line with best practice and assisted decision making, *see* SJOG Policy, Values in Practice) is adhered to and a signed consent form (individual or representative) is available.
- Assessing or participating in an assessment of a behaviour of concern for 'reason', 'function' or 'meaning' in order to provide an individualised PBS plan.

7.3.3 Planning

- Listen, participate, be creative and plan with an individual as they develop their plan for the behaviour of concern.
- Plan in partnership with an individual, their family and their circle of support.
- Include proactive and reactive strategies, with the appropriate support and supervision.
- Ensure the PBS Plan is available to the person in an accessible format.
- The PBS Plan notes the contributors to the plan.

7.3.4 Implementation

- To implement and ensure the daily implementation of interventions.

7.3.5 Evaluation

- Evaluate the effectiveness of PBS (optimal living) for an individual.
- Monitor the checklist of interventions or Periodic Service Review on a regular basis i.e. at least monthly.
- Discuss an individual's PBS plan at the team meeting.
- Complete a quarterly report on the PBS plan.
- Collect, analyse and summarise data.
- Incident form completion, summary and review.

- Referral for any additional PBS supports and services.

7.3.6 Skills Building

- All staff members are responsible for identifying and completing education and information workshops as required. Workshops are also available to family members, if required.

7.4 Service (Line Manager)

7.4.1 Person Centred Planning

- Provide training and support to staff members in person centred planning.
- Ensure that each individual has an active personal plan that is designed to achieve optimal functioning.

7.4.2 A Positive Behaviour Support Culture for Optimal Living

- Ensure the implementation of a Positive Behaviour Support Culture for each individual as appropriate and as guided by the Wheel of Optimal Living.

7.4.3 Assessment

- Ensure assessments are completed by a suitably qualified professional with the appropriate support and supervision.
- Ensure incident forms are correctly completed.
- Review incidents or assign this review and identify any further supports required.
- Support referrals for PBS or access to additional supports.

7.4.4 Plan and Implementation

- Oversee and support PBS plan implementation with regular monitoring in place.

7.4.5 Evaluation

- Ensure that, at a minimum, written quarterly evaluations of a PBS plan are completed.
- Coordinate monthly team meetings with PBS plans as part of the agenda, with minutes available.
- Ensure particular attention is paid to the reduction and elimination of any restrictive practices and an increase in the person's optimal functioning level.

7.4.6 Skills Building

- Ensure training and skill workshops are available to staff and family members in Positive Behaviour Support and other areas as identified and required in accordance with each individual's assessment, plan, implementation and evaluation.
- Identify and support access to any additional training or support needs required

7.4.7 Optimal Living

- Each team leader collates and audits data on the dimensions of optimal living – interpersonal, environmental, meaningful time, skills building and best possible health - for the individuals they support in order to prevent behaviours of concern.

7.4.8 Non-aversive, Non-Restrictive Practices

- Ensure that all practices are non-aversive and non-restrictive through supporting staff training in areas such as Positive Behaviour Support.
- If an aversive or restrictive strategy is used or identified as required, review incident reports and make a referral to the appropriate professional for assessment and ensure a Restrictive Practice Review and/or to the local Human Rights Committee.
- Send the data on the restrictive strategy used to the person-in-charge or designated person.

7.4.9 Incident Management and Safeguarding

- Ensure all incidents are recorded, safety concerns are managed and adhere to the polices listed below, especially after a serious incident or the use of an emergency restrictive practice.
  - Incident Management Policy and Procedure
  - Policy & Procedures for Safeguarding Vulnerable People (Intellectual Disability Services) 2013
  - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons - Children and Adults - with Disabilities) Regulations (2013)
  - HIQA National Quality Standards for Residential Settings for Adults and Children with Disabilities (2013b)
  - SJOG Employee Assistance Programme
  - SJOG Policies on Restrictive Practices, 8a, 8b and 8c (see attached)"Restrictive Practices….

- Ensure that access and support is provided to any individual (e.g. service user or staff) who is involved in or witnessed a behavioural incident of a serious nature. This can be done informally, by facilitating a break and talking with the individual, or formally in counselling or therapy for an individual should they require or request this.
- Collate data on Notification of Adverse Incidents (from review of adverse incident form/behaviour incident and planning form/ critical incident/safeguarding/rights restriction data/risk assessment). As outlined in part 8 of the Health Act and submit this data to their person in charge (*see* Appendix 5).

- Ensuring support for the individual and team member(s)
- Reviewing the plan or the APIE,
- Ensure the incident is communicated to the person in charge or line manager and notified to the relevant authorities as appropriate.

7.5 Practitioners with PBS expertise

Practitioners with PBS expertise, such as Behaviour Specialists/Clinical Nurse Specialists in Behaviour/Psychologists, are responsible for the following:

7.5.1 Active Caseload:

- Maintain an active caseload in assessment, intervention design, implementation, monitoring and evaluation of PBS needs in their service.

7.5.2 A Positive Behaviour Support Culture for Optimal Living

- Contribute to and promote a PBS culture / preventative approach as evidenced by a 24-month plan as part of the PBS Committee in the local service.

7.5.3 Skills Building

- Provide training on a range of topics as identified by the training plan of the PBS Committee e.g. an Introduction to PBS, skills teaching, AAC, etc.
- Provide supervision in PBS assessment, intervention design, implementation, monitoring and evaluation to individual cases with the staff team, family and individual.
- Provide mentoring in PBS to other practitioners (front-line staff) as they complete Assessments, Plans, Implementation and Evaluation(APIE model) at Step 1 and Step 2.

7.6 Director of Services

7.6.1 Positive Behaviour Support Committee

- Establish a Positive Behaviour Support Committee (PBSC) with clear terms of reference. The **PBSC** develops a strategy to promote and support access to PBS and reduce use of restrictive practices for behaviours of concern as appropriate. The Committee's strategy also includes implementation, monitoring and review of this policy document (*see* 7.10 below).
- The PBSC will also ensure that there is a monthly **PBS Mentoring Group** is available in each service. This group supports PBS through assessment/formulation, planning, implementation and evaluation as it may relate to new referrals, on-going work and individual cases which may require additional support.

7.6.2 Restrictive Practice Review

- Establish a Restrictive Practices Review process in each local service.
- SJOGCS promotes the use of positive approaches. As such if any restrictive or aversive strategies are authorised for a behaviour of concern these are documented and reported to either the PBSC or a restrictive practices review group who oversees all restrictive practices in the service and Positive Behaviour Support is also advocated for by the review and implemented with the individual.

7.6.3 A Clinical Governance /**Quality and Safety Committee** is in place within each local service.

7.6.4 A Management of Consumer Feedback to include comments, compliments & complaints procedure is in place within each service.

7.6.5 An independent advocate is available to individuals, should they require it.

7.6.6 Legal representation is available to any individual, should they require it.

7.6.7 Callan Institute provides training in PBS, Functional Assessment and MEBS to local services on request. Bespoke training is also available.

7.6.8 Review & Sharing

- Receive a quarterly report from each of the above committees and groups on Positive Behaviour Support Services and Restrictive Practices in the service which is shared with the local Clinical Governance/Quality and Safety Committee.
- Receive an audit of this policy annually from internal /external audit reports and share this audit with the Chair of the PBSC, person in charge and the Clinical Governance/Quality and Safety Committee.

7.7 Person in Charge

To support the implementation of this policy the Person in Charge will ensure that following are in place:

7.7.1 Staff members have access to this policy and the information, literature, training, materials, resources and supervision required to implement it.

7.7.2 Each individual and family have access to this policy and information on Positive Behaviour Support in accessible formats.

7.7.3 Frontline staff, supervisors and managers attend education and training events related to the implementation of this policy and are confident and competent in implementing this policy document.

7.7.4 Each service aims to collaborate with families through the provision of information, education, advice and support in PBS for family members receiving support from SJOGCS.

7.7.5. **A Local Human Rights Review Committee**, supported by the Provincial Human Rights Committee, is available to each service to review any rights issues as they might relate to behaviours of concern on behalf of individuals with intellectual disabilities. The committee is responsible for reviewing data from line managers about aversive or restrictive strategies employed for a behaviour of concern with a view to recommending Positive Behaviour Support.

7.7.6 **A Restrictive Practices Review structure and process is in place in each local service which** oversees all restrictive practices in the service and is linked to the Human Rights Review Committee and the PBS Committee for behaviours of concern. The Restrictive Practices Review process uses data from the incident reports which is reviewed by the line managers about aversive or restrictive strategies employed for a behaviour of concern with a view to recommending Positive Behaviour Support.

7.8 Positive Behaviour Support Committee

The Positive Behaviour Support Committee (PBSC), as established by the Director, has responsibility for promoting, implementing and compliance with this policy. The committee is made up of people with expertise in PBS and the MEBS model; and includes a certified instructor in the approved crisis management physical intervention training programme. The committee develops its terms of reference in the following five areas below:

7.8.1 Prevention

- Develop a plan for promoting a PBS culture as identified in this policy (*see* 6.1 above: Wheel of Optimal Living).
- Develop and advise on a staff-training plan (and family training as required) required to implement this policy and liaise with the Human Resource Department and Line managers with regard to training as appropriate.
- Review any internal and external audit reports and use these to inform an implementation plan for the subsequent 12 months.
- Request and participate a thematic audit in PBS if required, from the internal Programme, Quality and Safety team.

- Develop quarterly reports against a 1-3 year strategic implementation plan based on this policy and submit these to the Director or designate, for example, Chair of the Clinical Governance Committee. .

7.8.2 Assessment

- Collate and summarise data on individuals who require PBS using data from Referral forms; incident reports; adverse incidents; allegations of abuse/safeguarding Incidents; use of rights restrictive practices (as they relate to behaviours of concern);
- Develop a plan to support access to PBS services in partnership with the appropriate personnel (e.g. Individual, Keyworker, line manager, behaviour specialist).
- Coordinates the allocation of referrals to the appropriate person/team as required.

7.8.3 Planning

- Monitor assignment of clinical input for each PBS plan to ensure it is clinically valid.
- Oversee the PBS mentoring group.

7.8.4 Implementation

- Audit data on the implementation of each PBS plan e.g. the periodic service review score, the use of restrictive practices; and any additional services/support requests required to implement a PBS plan.

7.8.5 Evaluation

- Ensure PBS effectiveness is audited through the following:
  - Review incident forms for frequency, episodic severity and restrictive practices.
  - Data on the use of restrictive practices for behavioural reasons is collated and analysed. This data is also used to inform waiting lists for PBS supports, current status of PBS for individuals and to identify if any additional PBS services are required.
  - Data on person centred planning using Personal Outcomes Measures is reviewed to assess increases in optimal functioning level.
  - Implement an audit of PBS services which is informed by Heath Act 2007 and HIQA Standards 2013 in partnership with the Quality Team of SJOGHM.

8 Consent and Assisted Decision Making

This policy adheres to Saint John of God Policy and Practice on Consent as outlined in our Values in Practice Policy 2009.

The Assisted Decision Making (Capacity) Bill (2013), will be adhered to when it is enacted. The bill is founded on the principals of presumption of capacity and the legal right of all adults to make decisions for themselves.

9 Consultation

This policy was developed by a policy working group in consultation with service representatives and focus groups.

Members of the policy working group:

Caroline Dench, Niamh Flanagan, Sean Shanahan, Dr Noel Hannan, Liz McGuinness, Helen Thompson, Christina Doody, Yvette Ebbs, Zafar Iqbal, Elaine Fitzsimons, Aislinn Hutchinson, Joe Whyte, Gillian Martin and Gary Lucky.

10 Revision and Audit of the Policy

This policy is audited for implementation internally by Programme Quality and Safety team, and externally by HIQA . Data from these audits informs the revision of this policy.

10.1 All audit data is made available to the local Chair of the Positive Behaviour Support (PBS) Committee on an annual basis. This audit data forms the basis of the subsequent quarterly reports to the Director of Service who shares them with the Clinical Governance/Quality and Safety Committee.

10.2 The Director of Service presents the audit report to the Director of Programme, Quality and Safety. Saint John of God Hospitaller Ministries.

10.3 This Policy will be reviewed in January 2017.

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12. Appendices

Additional information is included in this section that will support and provide a rationale for the policy, procedures, protocols and guidelines. This could include:

Appendix 1: Sample Prompt Tool for the Wheel of Optimal Living (inc. worked example)

The following sample tools offer suggestions for prompts and are intended to augment the tools currently in use when considering a behaviour of concern.

a) Health Prompts

Health is a state of complete physical, mental, spiritual and emotional and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Accordingly, best possible health is supported for each individual as required in keeping with our policy on 'Best Possible Health'. A best possible health profile may need to be completed.

Physical Health	***Mental Health***	***Social Well being***
These are my physical health needs, which include my sensory processing needs, my dental health and my sexual health: *This is how they are supported:* *This is what I now need to support my physical health needs:* ***Consider:*** *assessing for pain; headache, earache, toothache; gastrointestinal upset; constipation; foot problems; age appropriate screenings (menopause, cancer, dementia); along with acute and chronic conditions the individual is diagnosed with.*	*These are my mental health needs:* *This is how they are supported:* *This is what I now need to support my mental health needs:* ***Consider:*** *assessing for worry and stress as it may relate to the individual's life at the moment; along with acute and chronic conditions the individual is diagnosed with (e.g. consider; relaxation, mindfulness, therapy).*	*These are my emotional and social well-being needs:* *This is how they are supported:* *This is what I now need to support my social well-being needs.* ***Consider:*** *assessing for meaningful friendships, caring staff, family support, meaningful roles and meaningful activities, valued in their daily occupations and relationships; spiritual needs, along with acute and chronic conditions the individual is diagnosed with.*
This is how I like to get information about my health needs: *This is how I like to be included in my health needs, assessment, plan and treatment:* *This is how I communicate and talk about my health needs:* *These are the supports and adaptations I need as I make choices and communicate about health needs and as I plan for my health needs:* *These are my health needs, which if addressed could reduce my behaviour of concern:* *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behaviour of concern and the following supports, interventions and resources will now be provided:		

b) Interpersonal Prompts

My Family	*My Friend*	*Staff who support me*	*My Community*
Each individual is supported to maintain their contact and role within their family. Families are also supported as they support their family member.	*Each individual is supported to make, keep and enjoy their friends.*	*Each Individual is supported by staff members who they like, have a person centred approach and are an advocate for the person.*	*The evidence shows that individuals with a behaviour of concern are best supported in ordinary community settings, in a place to call home, having socially valued roles.*
This is my family (family tree): *This is how I am or what I do as a son/daughter,; sister/brother, aunt/uncle:* *This is who I like to spend time with in my family:* *This is what I like to do with my family (member(s):* *This is how often I like to see my family (member):* *This is how I would like to have more contact with my family (member(s):* *This is what I do not like about (or where I have problems coping) my contact time/opportunities with my family and where I might need some help:*	*These are my friends:* *This is how I am or what I do as friend:* *This is who I like to spend time with:* *This is what I like to do with my friend(s):* *This is how often I like to see my friend(s):* *This is how I would like to have more time with my friends:* *This is how I would like to meet new friends:* *This is what I do not like (or have problems coping with) about my contact with my friends where I might need some help:*	*These are my staff who support me:* *This is how they support me:* *This is how I like to spend time with my staff:* *This is what I like to do with my staff:* *This is how often I like to spend time with my staff:* *This is the information I need from my staff:* *This is how my staff could improve their support:*	*These are the places in my community:* *These are the people in my community:* *This is what I do in the community:* *This is who I like to spend time with in the community:* *This is how often I like to go to the places in my community:* *This is what I do not like about (or have problems coping with)my time and places in my community, and I might need help:* *In my community, these are some of the opportunities I would like to explore, try and have more of:*
This is how I like to get information about my family/friends/staff/community: *This is how I include the important people in my life in my home(house) on a daily/weekly basis:* *This is how I like to be included in my family/friends/staff/community issues discussions on a daily basis:* *This is how I communicate and talk about my family/friends/staff/community on a daily basis.* *There are the supports and skills my family/friends/staff/community need to support me everyday:* *This is how my time with my family, friends, staff and people in the community could be improved upon to reduce my behaviour of concern on a daily basis* *(Note: Rights Restrictions check is complete)*			
The following was identified as contributing to a behaviour of concern and the following supports, interventions and resources will now be provided:			

c) Environmental Prompts

My Home	*Places outside my home*	*Staff Skills & Knowledge*
Each individual is supported to express where, and with whom they like to live. They are supported to make choices to facilitate their comfort, support, pleasure and privacy within their home.	*Each individual is supported to have full access to a range of environments of their choice outside their home, to afford them a variety of opportunities and activities.* ***a)***	*Each individual is supported by staff (family or others) who have the knowledge and skills to support them as they participate in their physical environments e.g. mobility, communication skills (expressive and receptive), skill development (coping and tolerance), self-care, access etc.*
This is how I like my home to be: *This is how I like my bedroom to be:* *This is how I like my kitchen to be:* *This is how I like my sitting room to be:* ***Consider:*** *all senses e.g. noise, lighting, space for resting, hobbies, friends etc; smell, movement, crowds, textures, privacy, personal belongings, access to food/drinks, seating/furniture, adaptive equipment, assistive technology.* *This is who I like to live with:* *This is what I do not like about my home (or where I have problems coping) and I might need help;*	*These are the places outside my home that are important to me:* *That relate to work; leisure, friendships, volunteering; family, spirituality, health:* *This is what I do there (consider all places):* *This is who I like to spend time with when I am there (consider all places):* *These are the supports, adaptive equipment, assistive technology, people (skills and knowledge) I now need when outside my home:* *This is what I do not like or find hard when outside my home and I might need some help with:*	*These are my staff who support me:* *This is how they support me when I am out and about:* ***Consider:*** *mobility, communication skills (expressive and receptive), skill development (community skills, coping and tolerance), self-care, access, reactive strategies, adaptive equipment, health supports.* *These are other things that could be tried and /or that I need:*
This is how I like to get information about my home and my life outside my home: *This is how I like to be included in issues & discussions about my home and my life outside my home:* *This is how I communicate and talk about my home, life outside my home and what I need:* *There are the supports and adaptations I need in my home and as I use places outside my home:* *These are the / There are no restrictive practices used with me in my home:* *This is how my environments could be improved upon to reduce my behaviour of concern:* *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behaviour of concern and the following supports, interventions and resources will now be provided:		

d) Meaningful Time Prompts

Each individual is supported to have meaningful activities, hobbies, tasks, fun and work to participate in each day and meaningful activities to look forward to each week and month e.g. in environments (physical, interpersonal and programmes) that have a goodness of fit for their own individual needs and allow for some consistency and predictability as required by the individual.

My Work	My Leisure time and fun	My Activities
This is my job: *These are my jobs in my home:* *These are my jobs outside my home:* *These are my jobs in the community:* *These are jobs I would like to try:* ***Consider:*** *what I do, what I like about each job, what I do not like about each job, how often I do each job, the payment I receive: the people I meet: adaptive equipment, assistive technology, etc.* *This is what I do not like about my job(s) (or where I have problems coping):*	*These are my hobbies and interests:* *This is how I enjoy them at home alone:* *This is how I enjoy them with my family, my friends and in the community:* *This is what I do for fun and enjoyment:* *These are some other hobbies and interests I would like to try:* ***Consider:*** *what I do, what I like about each hobby/leisure activity, what I do not like: how often I do each hobby/leisure: the people I do the hobby with: adaptive equipment, assistive technology, etc.* *This is what I do not like about my leisure time and fun (or where I have problems coping):*	*These are other activities I do e.g. cooking, shopping, cleaning, etc.* *This is how I do them at home alone:* *This is how I do them with my family, my friends and in the community:* *These are some other activities I would like to try:* ***Consider:*** *what I do, what I like about each activity, what I do not like: how often I do each activity: the people I do the activity with: adaptive equipment, assistive technology, etc.* *This is what I do not like about my activities (or where I have problems coping):*
This is my daily /weekly schedule: *This is how I like to get information about my daily and weekly schedule:* *This is what I like and don't like about it and how I like to be included in my weekly schedule:* *This is how I communicate and talk about my weekly schedule:* *These are the supports and adaptations I need to help me understand my daily and weekly schedule:* *These are the supports and adaptations I need as I make choices and communicate about my weekly schedule and as I plan for upcoming activities and things to look forward to:* *This is how my daily /weekly schedule could be improved upon to reduce my behaviour of concern:* *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behaviour of concern and the following supports, interventions and resources will now be provided:		

e) Skills Building Prompts

Learning new skills plays an important role in feeling good about one-self. Skill development can occur in communication, both in expressing oneself and in understanding others: *self-care*; e.g. grooming, dressing, washing etc; *activities of daily living*; e.g. cooking, cleaning, gardening, shopping; *leisure:* e.g. painting, cycling, music; *work*: education etc. Each individual has the opportunity to identify skills they would like to learn, and they are supported to learn these using evidence-based strategies for skills teaching.

<table>
<tr><th colspan="2">Communication Skills</th><th>Learning New Skills</th></tr>
<tr><td>Expressing my-self:

This is how I express myself:

This is how I communicate the following critical messages - without using a behaviour of concern - (e.g. LAMH, PECS, Objects, picture cards, word cards, textures, scent etc).

'No: I want…..:
• break
• help
• finished
• sad
• angry
• Happy

This is how I recall a memory to you - with adaptive equipment if needed- example e.g. memory boards, slide shows etc.

(complete a communication profile for expressive language/communication)

I am having difficulty communicating the following:</td><td>Understanding others:

This is how I need information to be provided to me so I can understand it (e.g. Pictures, objects, words, technology):

This is how I need information to be provided to me about new events or situations (social stories, picture stories, audio/video):

This is how I need information to be provided to me so I can remember:

(complete a communication profile for receptive language / communication)

I am having difficulty understanding the following:</td><td>These are the skills I am learning:

These are the skills I would like to learn:

(complete a skills profile via interview, POM, observation, skills assessment and consider, skills needed for work, fun, leisure, self care, relaxation and body awareness, identity, friendships, relationships, sexuality, independent living, friendships, community etc.)

If I could do [a named skill] my day would be a little easier:</td></tr>
<tr><td colspan="3">This is how I like to get information about learning new skills:

This is how I like to be included in Identifying and learning new skills:

This is how I communicate and talk about my skills:

These are the supports and adaptations I need as I make choices and communicate about my skills learning and as I plan for new skills to learn:

This is how others could improve their communication style with me:

These are skills/ communication skills I could learn to reduce my behaviour of concern:

(Note: Rights Restrictions check is complete)</td></tr>
<tr><td colspan="3">The following was identified as contributing to a behaviour of concern and the following supports, interventions and resources will now be provided:</td></tr>
</table>

A worked sample of interventions that may be identified for an individualised plan as a result of using the *Wheel of Optimal Living* as part of a personal plan at step 1 of PBS;

Vignette: Emily was presenting with a behaviour of concern in her home. She was observed to hit herself on the side of her head or hit another person as they walked by. Her person centred plan was reviewed along with a number of incident forms and a risk assessment and it was agreed that the Wheel of Optimal Living would be completed. In the **interpersonal section**, it was identified that Emily did not have any friends to spend time with. She was also unsure of what staff member was working with her each evening. The **environmental section** identified that she did not have a chair to sit on in her bedroom and the **Meaningful Time section** discovered that the evening time was a little boring for Emily and she had little to do. The **skills section** indicated that Emily could not ask for a specific activity and no augmentative communication system was in place. Emily was also not learning any skills in the area of hobbies or things to do at home in the evening time. The **health section**, as part of social well-being indicated that Emily was possible lonely in her home. The keyworker and the team, together with Emily and her circle of support agreed that Emily's behaviour of concern was possible communicating that she was feeling bored in the evening and that she was trying to communicate 'I would like something to do please'. They put the following plan in place:

Environmental Adaptations	Skills to Learn	Focused and Direct Supports	Reactive Strategies (Function known: 'I would like something to do please'
1. A Chair in my bedroom 2. A staff picture schedule 3. Things to do with a friend 4. My evening schedule 5. Hobby sampling	1. General Skill(s): Jewellery making 2. Communication Skills: a). 'I would like to do X' b). 'I need some help please' 3). Coping & tolerance skills Relaxation & body awareness; Social story on 'Let's do something, can you help'	1. Trigger control: reduce time sitting unoccupied in the evening. 2. Include Emily in the evening plan using a picture schedule.	Active Listening: Redirection to preferred x Offer reassurance Facilitate communication using the picture card.

Appendix 2: Individual Checklist for Positive Behaviour Support

Name: **Date:**

	Indicator	In Place + / Not in Place -	Action
1.	**Personal Plan:** Score a + if the person has a personal plan which has been developed with the person, their circle of support and is based on the person's needs and goals' in each of these areas; home, work, leisure, learning, health, family, friendships.		Person centred plan for person centred living.
2.	**Wheel of Optimal Living:** Score a + if the Wheel of Optimal Living has been completed with the APIE documented for a behaviour of concern or to prevent a behaviour of concern.		Interview with Individual, family, extended family
3.	**A Written Plan:** Assessment, Plan, Implementation and Evaluation (APIE) has been used: Score a + if the person has an individualised plan based on APIE at step 1 using the Wheel of Optimal Living or Step 2 a clinically valid assessment and a PBS plan or Step 3 A comprehensive assessment and a MEBS plan; with multi-component interventions which are currently being implemented and evaluated.		APIE completed and a written plan Is present
4.	**Non-aversive and Non-restrictive Practices:** Score a + if there are no aversive or restrictive practices in place.		Restrictive Practices Check
5.	**Collaborative, Integrated and Interdisciplinary Approach:** Score a + if the person has access to, (as required) other professionals e.g. an SLT, OT, GP, Score N/A if not required.		Evidence of Referral to x, with consultation note and recommendations available.
6.	**Measuring Outcomes:** Score a + if The effectiveness of Positive Behaviour Support is measured by reviewing the desired increase in the person's life optimal functioning and quality of life; the removal (reduction) of any aversive or restrictive strategies; as well as the other outcomes on a quarterly basis.		Evaluation evident as part of the personal plan review minutes.
7.	**Incident Management and Safeguarding Support:** Score a + if Incident Management and/or Safeguarding policies have been adhered to for this person and all necessary supports are in place or N/A if not applicable.		Incident review, Risk Assessment Review and Safeguarding supports review inform practice.
8.	**PBS Checklist:** Score a + if the PBS checklist for this individual has been completed at least once every 12 months.		PBS check completed and verified by…
	Total:	**/8**	

Actions	
1.	4.
2.	5.
3.	6.

Completed by: _____

Appendix 3: Service Checklist for Positive Behaviour Support

	Standard	Yes	No	Comment
1	On interview staff can describe behaviours of concern?			
2	On interview staff can describe Positive Behaviour Support and what restrictive practices are?			
3	On interview staff can describe the 3-step approach used for PBS services?			
4	There is an accessible leaflet/DVD for individuals and families describing the use of Positive Behaviour Support.			
5	There is a written policy 'Positive Behaviour Support' which staff can locate and talk about.			
6	There is a plan in place to implement the Positive Behaviour Support policy in the area in question, unit, group home. This is written with evidence of progression from minutes etc.			
7	Individual records show evidence of assessment and a Positive Behaviour Support Plan for an individual (if required) which has been developed and reviewed as part of the personal planning process.			
8	Individual records show evidence of interdisciplinary, individual and family involvement in decision making and consent practices.			
9	Individual records show evidence of use of APIE for a Positive Behaviour Support plan for each individual, as required.			
10	Individual records and personal plans have been updated within the last month and are in line with this policy, HIQA standards and best practice in the use and non-use of restrictive practices.			
11	Behavioural Incident reports / Adverse Incidents / Risk Assessments are analysed and inform the strategy plan as outlined by the PBSC as they implement this policy.			
12	Person Centred Planning is in line with best practice and evident in the individual's personal plan.			
13	Staff have attended induction on the PBS policy and training in PBS for at least 1-day as evidenced by the training record.			
14	Staff have attended training in the safe management of behaviour of concern including de-escalation and intervention techniques as evidenced by the training records.			
15	Restrictive practices data are collated, reviewed, and reported on to HIQA and/or the Quality and Safety Committee.			
16	Positive Behaviour Support Committee is active with meeting minutes and reports evident to the Director and Quality and Safety Committee.			

Appendix 4: Positive Behaviour Support Practitioners in Saint John of God Community Services Ltd

Region	Contact
Region: Saint John of God Carmona Services Saint John of God STEP/Citygate Services Saint John of God Kerry Services	Elaine Fitzsimons, Principal Clinical/Educational Psychologist. Chair of the PBSC. Elaine.Fitzsimons@sjog.ie Des North, Programme Manager, Chair of the PBSC. Desmond.north@sjog.ie Aislinn Hutchinson, Behaviour and Risk Aislinn.Hutchinson@sjog.ie
Region: Saint John of God Menni Services Saint John of God Kildare Services	Mr Kevin Coyle, Principal Clinical Psychologist. kevin.coyle@sjog.ie Dr Sean Shanahan, Principal Clinical Psychologist, Chair of the PBSC. Sean.shanahan@sjog.ie
Region Saint John of God North East Services	
Region Saint John of God Hospitaller Ministries Callan Institute Programme Quality and Safety	Caroline Dench, Prinicpal Clinical Psychologist; caroline.dench@sjog.ie (01 2814139) Gillian Martin, Behaviour Specialist; gillian.martin@sjog.ie(01 2814139) Padraig Walsh, Behaviour Specialist; padraig.walsh@sjog.ie(01 2814139) Christina Doody, Behaviour Specialist/ Quality Advisor; Christina.doody@sjog.ie (087 - 9124198)

Appendix 5: HIQA Notification and Reporting Requirements

HIQA Notifiable Events and Notification Form Numbers for behaviours of concern in bold.

Form	Nature of Notification	Timeframe	Person Responsible
NF01	The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre	Within three working days of the incident	Person in charge
NF02	Outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre	Within three working days of the incident	Person in charge
NF03	Any serious injury to a resident which requires immediate medical or hospital treatment	Within three working days of the incident	Person in charge
NF05	Any unexplained absence of a resident from the designated centre	Within three working days of the incident	Person in charge
NF06	Any allegation, suspected or confirmed abuse of any resident	Within three working days of the incident	Person in charge
NF07	Any allegation of misconduct by the registered provider or by staff	Within three working days of the incident	Person in charge
NF08	Any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body	Within three working days of the incident	Person in charge
NF09	Any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place	Within three working days of the incident	Person in charge
NF20	When the person in charge proposes to be absent from a designated centre for a continuous period of 28 days or more	20 working days in advance of the change or within 3 working days if absence arises as a result of an emergency	Registered provider
NF21	Return of the person in charge after being absent for a continuous period of 28 days or more	Within three working days of return of the person in charge	Registered provider
NF30	Change of the person in charge. Please contact the Registration Office on 021 240 9340 or email registration@hiqa.ie	Within 10 working days of the change	Registered provider

Form	Nature of Notification	Timeframe	Person Responsible
	and ask for an NF30 pack		
NF31	Change in key senior management personnel. Please contact the Registration Office on 021 240 9340 or email registration@hiqa.ie and ask for an NF31 pack	20 working days in advance of the change	Registered provider
NF32	Change in ownership of the body corporate	8 weeks in advance of change	Registered provider
NF33	Change to the Director, Manager, Secretary or any Similar Officer of the Corporate Body	8 weeks in advance of change	Registered provider
NF34	Change in the name or address of a Corporate Body	8 weeks in advance of change	Registered provider
NF35	To cease to carry on the business of the designated centre and close the centre	Not less than six months	Registered provider
NF37	Change to the committee of management or other controlling authority of an unincorporated body	8 weeks in advance of change	Registered provider
NF38	Change to the person responsible for the application on behalf of a partnership, company, unincorporated body or statutory body, a body established under the Health Acts 1947 to 2008 or a body established under the Health (Corporate Bodies) Act 1961	8 weeks in advance of change	Registered provider
Quarterly Notifications Excel Spreadsheet (older people	**Any occasion when restraint was used (any restrictive procedure to include physical, chemical, environmental)**	At the end of each quarter	Registered provider
	Any occasion on which the fire alarm equipment is operated other than for the purpose of fire practice, drill or test of equipment		
	A recurring pattern of theft or burglary		
	Any injury to a residents other than those previously noted (NF03)		
	Any death, including cause of death, other than those specified above		

Form	Nature of Notification	Timeframe	Person Responsible
Follow-up Report	If additional information has been requested or is required in relation to notifications forms NF01, NF03, NF06 & NF07	As requested or required	Registered provider
Six-monthly nil-return notification	Where no incidents which require to be notified under Regulation 31 have taken place within the preceding six months	Six monthly	Registered provider

Appendix 6: Sample list of interventions as part of a PBS Plan using MEBS Model (proactive and reactive)

Environmental Adaptations	*Skills Teaching*	*Focused or Direct Supports*	*Reactive Strategies*
Pictures Schedule Chat-time Access to drinks, snacks, food. An enjoyable daily routine A job Friend time Family time Decorate my… bedroom Things to do… hobbies, chores, etc. Things to look forward to	Fun skills: baking an apple tart; painting a flower pot. Communication skills; 'no', 'I want' 'break' 'finished' 'help' 'sad' 'happy' Choice making; Relaxation based strategies; Breathing and calming exercises Self regulation: Mindfulness, Cognitive based; Therapy/Counselling Social Stories	Reduce triggers (things that may cause a behaviour of concern) e.g. noise, light, inactivity; Increase things, events, access to people/activities that bring enjoyment; Reward Contracts, guidelines and rules Satiation Stimulus based strategies Cooperation training	Active Listening Capitualtion Redirection to a preferred activity, object, person Facilitative strategy(prompts to use a communication skill, a relaxation skill etc.) Use of positive touch; Stimulus change to a person, activity. Proxemics- change person space Inter-positioning Self-protective; Remove un-necessary demands/requests

Appendix 7: Guidelines for Reactive Strategies as part of a PBS Plan using the MEBS Model

Reactive strategies must always reflect:

1. The use of non-aversive, non-restrictive strategies to respond to behaviours that challenge.
2. The reduction of the episodic severity of each incident of behaviour that challenges by responding to the function of the behaviour.
3. Functionally based and non-functionally based strategies that are always non-restrictive and non-aversive.
4. Their use in the context of a functionally equivalent /communication skill.
5. On occasion an intervention which is considered non-aversive and non-restrictive may escalate a behaviour. If this occurs, the intervention should be discontinued immediately.
6. Strategic Capitulation: This intervention forms the basis of a MEBS reactive strategy and it identifies that 'if you know what the individual wants and what would calm the individual down then provide it immediately' (providing access to the reinforcer known to be maintaining the behaviour early on in behavioural escalation can reduce the episodic severity of the incident).
7. In the absence of a MEBS plan it is ethical and consistent within a Human Rights Based Approach to respond functionally and use non-aversive approaches to de-escalate the behaviour that challenges.

Appendix 8: Sample list of interventions that make up a reactive strategy in a PBS and/or a MEBS Plan

The following reactive strategies can be used when responding to behaviours of concern within a MEBS model; These interventions are non-aversive and non-restrictive.

1. **Strategic Capitulation:** If you know what the person wants and what would calm the person down, then provide it immediately (providing access to the reinforcer known to be maintaining the behaviour early on in behavioural escalation).

2. **Redirection or diversion** to a preferred activity/object.

3. **Active listening:** An empathetic response involving identification of the communicative intent of behaviour, verbal feedback allowing the person to further discuss any issues, e.g. stimulus naming (identifying and naming the trigger, e.g. 'I can see you're tired'), positive framing and affirmation/confirmation of the person.

4. **Facilitative Strategy:** Prompts to use coping skills, relaxation skills, communication skills, move to calm place (NB: Not forced to).

5. **Stimulus change:** Introduction of a completely different trigger, e.g. person, place, object, activity humour.

6. **Diversion** to compelling activity (diversion to an activity that the user is typically compelled to do or wants to do).

7. **Proxemics:** Awareness/modifications of personal space intrusions.

8. **A change** in non-verbal, body language, tone of voice, personal style and verbal behaviour protocol, in response to early indicators of behaviour escalation.

9. **Ignore**: Respond to person as if behaviour has not occurred. Note: This is not extinction and should be included if the behaviour functions in order to elicit attention. May ignore the physical (topographical) behaviour not the function of the behaviour.

10. **Remove un-necessary demands or requests**.

11. **Self-protective**, for example, blocking a strike.

12. **Inter-positioning:** Placing an object between the physical act of aggression, for example a table, a cushion.

13. Use of **Physical Prompts or Positive Touch:** At times it may be necessary to use a gentle touch on the arms, hands, shoulders or upper body (back) of an individual. This touch is used to calm an individual, to get an individual's attention and is always done gently and if at any time the individual's behaviour escalates as a result of this touch, it should be discontinued immediately. The use of physical prompts or positive touch is used with the following guidelines

    - The person gives permission to be touched on the arm, hand, shoulder or upper body (back). The individual shows no resistance and no pressure is used.

    - The touch is used to calm the person down and to address the function of the behaviours that challenge

    - The touch is used to enable access to a 'right', so serves the purpose of honouring a right, be it accessibility, participation for example.

    - If touch is used to assist a person who is resisting, this may be a form of physical restraint and as such requires authorisation by an appropriate professional and written consent from the individual or their advocate. This intervention must be consistent with the policy guidelines on physical restraint.

Each of these strategies can be used as a restrictive strategy to any behaviour of concern. They are non-restrictive, and for most people are non-aversive. Should any of these strategies escalate behaviours of concern, this would mean they are aversive for the person and should be discontinued immediately.

For these strategies to be most effective they should be used as part of a PBS approach, which could include a the result of a comprehensive behaviour assessment and a PBS plan or a Multi-Element Behaviour Support Plan. If these strategies are used on an ongoing basis the APIE is required at the appropriate step. Reactive strategies as part of PBS approach and in particular in the MEBS model can be functionally based and non-functionally based, but are always, non-restrictive and non-aversive.

- **Functionally based:** The reactive strategy is based on the function of the behaviour e.g. If an individual hits another individual and the function is 'to leave the room', then the reactive strategy is to support the person to leave the room.

- **Non-functionally based:** e.g. when an individual hits another individual to 'leave the room' and the individual is affirmed and the message is acknowledged by saying "I know you want to leave the room. However," (redirection is used, a non-functionally based intervention, while the staff member waits for a colleague to

return) “can you help me with this first until ‘staff member’ comes back and I can leave the room with you”.

Appendix 9: Restrictive Strategies Eligible for use within SJOGCS for a behaviour of concern

There may be occasions when restrictive interventions may be deemed necessary and are then authorised in accordance with the following policies to manage behaviours that challenge:

1.1 Physical and Mechanical Restraint
1.2 Seclusion
1.3 The use of Medication for behavioural purposes

The key principle underlying the use of authorised restrictive reactive interventions is that they shall only be used as a last resort. In line with best practice, the least restrictive strategy should always be used to manage behaviour.

The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount and the use of restrictive reactive strategies should only be used if an individual poses a significant threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

2. Prohibited Restrictive and Aversive Strategies

The following strategies are only permitted with the appropriate authority in certain limited and strictly monitored cases as treatment strategies (teaching strategies) in Saint John of God Community Services Limited:

1. Any type of punishment strategies:

- Positive punishment: application of an intervention the person finds unpleasant;

- Negative punishment: something the person finds rewarding is taken away;

Should any of these interventions be necessary for safety reasons, the intervention requires authorisation. This authorisation requires:

1.1 Evidence to support the intervention;

1.2 A risk assessment

1.3 Informed consent

1.4 Formal notification to the Human Rights Committee as a Human Right may be restricted as a result of the intervention.

1.5 If rights are restricted by any intervention(s), a plan will need to be developed to reinstate the restricted right within a given timeframe.

13. Restrictive Practices Policies

Sample Addendum to Policies 8a, 8b, 8c

(Name of service) subscribes to the Saint John of God Community Services Policy on the Positive Behaviour Support but adds the following statement that will apply to …… Service

(Name of Service) prohibits the use of Seclusion (the placing or leaving of a person in any place alone, at any time, with the exit locked or barred in such a way as to prevent the person leaving) and prone restraint (holding a person in a face down position).

Policy on the Use of Physical or Mechanical Restraint for Behavioural Purposes (SJOGCS 08A)

If your service does not intend to activate the use of this policy, the relevant pages should be removed & the addendum (page 64) inserted and disseminated accordingly.

Document Reference Number:	**SJOGCS 08a**
Revision Number	Second Version
Approval Date	October 2009
Due for Revision	October 2011
Document drafted by	Behaviours that Challenge Policy Group
Document Approved by	Board of SJOGCS
Responsibility for implementation	Directors of Services All employees Saint John of God Community Services Limited (Intellectual Disability Services only) Positive Behaviour Support Committees
Responsibility for evaluation and audit	Positive Behaviour Support Committees

1. Policy Statement

Saint John of God Community Services Limited is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies. It is the policy of Saint John of God Community Services Limited to use Physical Restraint or Mechanical Restraint for behavioural purposes as an intervention of last resort.

In line with best practice, the least restrictive strategy should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount. The use of restraint should only be used if an individual poses a significant threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

1.1. Physical or Mechanical Restraints are not used

There are certain circumstances in which Physical or Mechanical Restraint for behavioural purposes are never used:

1.1.1 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

1.1.2 Solely to ameliorate operational difficulties or to maintain a smooth running programme, including where there are staff shortages;

1.1.3 With an individual with a known psycho-social/medical condition, in which restraint would be contraindicated;

1.1.4 Where the functional assessment of the behaviour indicates that restraint would be contraindicated;

1.1.5 Where the risk of harm from the restraint becomes greater than the risk posed by the acute episode of physical aggression;

1.1.6 In the case of a physical restraint, where it involves the individual in the 'prone', face down position. This should be avoided. In extreme circumstances it may be conducted within the local guidelines of the accredited crisis management system;

1.1.7 With people who are tactile defensive;

1.1.8 Where it is deemed unsafe to do so.

2. Purpose

The purpose of this policy is to ensure a collaborative and consistent approach in supporting individuals with behaviours that challenge within Saint John of God Community Services Limited. In particular, it aims to provide guidance to all staff members who may require to support an individual using restrictive practices. It seeks to ensure a proper balance between an individual's needs and the needs of others responsible for supporting them.

3. Scope

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation and Other Related Policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009.

5. Definitions

5.1 Physical Restraint

Physical restraint is the use of physical intervention (by one or more persons) for the purpose of preventing the free movement of an individual's body.

5.2 Emergency use of Physical Restraint

Emergency use of Physical Restraint is the use of physical restraint which has not been approved in advance and is not part of the agreed individual restrictive reactive plan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

5.3 Mechanical Restraint

Mechanical restraint is the use of devices or garments for the purpose of preventing or limiting the free movement of an individual's body. Devices used should in general be devices manufactured for such purposes and approved by the relevant personnel. Any means of mechanical restraint used in an emergency situation must not compromise the safety of the individual being restrained.

5.4 Postural Support Appliance/Equipment as a means of mechanical restraint Any postural support appliance/equipment that is not being used for the purposes for which it was supplied or manufactured and which is used to manage behaviour comes within the remit of this Policy. There must be evidence that the use of such equipment for this purpose has been subject to due consideration and its use outlined. The circumstances where it can be used for this purpose must be delineated in the service-user's restrictive reactive strategy*.

5.5 Emergency Use of Mechanical Restraint

Emergency use of mechanical restraint is the use of mechanical restraint which has not been approved in advance and is not part of the agreed individual restrictive reactive plan. A response is not considered to be an emergency if it is required to be used on more

than 3 times in a six month period [American Association on Mental Retardation].

5.6 Multi-Disciplinary Team (MDT)

For the purpose of prescribing physical or mechanical restraint for behavioural purposes the MDT must include the discipline of Psychiatry/ Psychology.

To classify Postural Support appliances/equipment as 'mechanical restraint' is inaccurate as it suggests that this is the primary purpose of this equipment. In this context Postural Support equipment does not come within the scope of this policy. Such appliances/equipment can only be referred to as 'Mechanical Restraint', if used for a purpose other than that for which they were supplied or manufactured. Guidelines outlining best practice in terms of supply, use and maintenance of postural supports, including equipment donated to the Services, should be available locally as a means of minimising misuse.

6. Roles and Responsibilities

6.1 All staff ensure:

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 The restrictive reactive strategy is carried out as authorised.

6.1.3 Their certification in the use of physical interventions is current if they are required to participate in an authorised restraint.

6.1.4 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 Multi-Disciplinary Team or Clinical personnel ensure:

6.2.1 Appropriate clinical personnel together with the team directly responsible for the care of the individual authorise the restraint in writing.

6.2.2 There is evidence that the consent process has been adhered to.

6.2.3 That no single opinion or report alone influences decision on authorisation of the restraint.

6.2.4 That local processes include a documented record of the full team's views which is brought to the attention of the prescribing members of the MDT.

6.2.5 Authorisation is documented in the individual's agreed Restrictive Reactive strategy. This authorisation shall remain in force for a maximum of three months and must be renewed thereafter.

6.2.6 The strategy details the restriction to be implemented, the circumstances, the duration and any specific precautions.

6.2.7 Authorisation of the restraint is only agreed where a current physical/medical report or functional assessment does not contraindicate use of the restraint. The MDT determines if a medical report is required.

6.2.8 Authorised restraints must be reviewed on a 3-monthly basis or within 72 hours in the case of an emergency restraint.

6.2.9 The restraint employed is proportionate to the risk posed and in accordance with the individual's agreed restrictive reactive plan and risk assessment findings,

6.2.10 The strategy includes a description of the circumstances under which restraint may be applied, and a description of the restraint authorised. This authorisation must also detail the means by which the individual will be monitored during the episode.

6.2.11 That any device used for mechanical restraint is regularly checked to ensure it is intact, clean and is safe for the individual for whom it is intended.

6.2.12 The decision to initiate the use of physical restraint is taken in accordance with the agreed restrictive reactive plan by the designated staff member on duty. One staff member must be identified as the designated staff member, taking responsibility for implementation of the restraint.

6.2.13 A referral is made to the Rights Review Committee outlining the process undertaken in regard to the authorisation of the restraint.

6.3 Positive Behaviour Support Committee ensures:

that all restrictive practices are appropriately authorised and reviewed with a plan in place to remove or reduce the restriction in accordance with agreed timelines.

6.4 Rights Review Committee ensures:

that due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of Physical Restraint or Mechanical Restraint

7.1.1 Restraint must only be used when an individual poses a significant threat of harm to self or others and it is considered the safest intervention at that time. Where the use of restraint is foreseeable a risk assessment must be undertaken. The potential hazards associated with each physical intervention must be identified and the level of risk associated with each intervention determined for the specific service-user on which it is being applied. This must be documented.

7.1.2 All alternative interventions to manage the individual's unsafe behaviour must have been considered and the process recorded in the relevant documentation.

7.1.3 Except in the case of extreme emergency the use of restraint should be discussed with the individual and their family and/or their advocate as part of the development of their individual plan, and recorded. There is evidence that the consent process has been adhered to.

7.1.4 In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.1.5 The duration of the period of restraint must be the minimum necessary to protect the individual being restrained, or others, from immediate and serious harm, in accordance with the individual's agreed restrictive reactive strategy.

7.1.6 Special consideration should be given when restraining individuals who are known by the staff involved in applying the restraint, to have experienced physical or sexual abuse.

7.1.7 The individual must be monitored as per their individual restrictive reactive plan throughout the use of restraint to ensure his or her safety, dignity, health and wellbeing.

7.1.8 The relevant documentation/protocols, as appropriate to the use of restraint are completed.

7.1.9 Where a restraint is being used to manage behaviour consideration must be given to the possibility of the individual becoming restraint dependent. Attention should be given to minimising its use to ensure the individual does not become restraint dependent.

7.2 The implementation of physical restraint involving physically holding or moving an individual who is resisting

7.2.1 The use of physical restraint may only be initiated by the designated staff member, who takes the lead throughout the procedure.

7.2.2 Only staff members who are certified in approved accredited crisis management systems may conduct physical restraint.

7.2.3 The individual should be informed of the reasons for and likely duration of physical restraint, unless the provision of such information might be prejudicial to the individual's mental health, well-being or emotional condition, as outlined in the individual's agreed Restrictive Reactive Plan. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.2.4 The individual must be continuously monitored throughout the use of restraint by the designated staff member, to ensure his/her dignity, safety, health and wellbeing.

7.2.5 Following each episode of physical restraint the team is allocated time for analysis of the incident. This analysis/review must include an appraisal of the effectiveness of the protective/preventative measures employed to manage the risks associated with the restraint.

7.3 Recording

7.3.1 The use of restraint is recorded in accordance with the individual's restrictive reactive plan or individualised restraint protocol.

7.3.2 Physical Restraint:

Each episode of physical restraint should be clearly documented. This record should include, but is not limited to the following:

- The reasons for its use;
- Date and duration of its use;
- Alternatives which were implemented and unsuccessful and the reasons why or considered and deemed ineffective and the reasons why;
- If the behaviour resulting in physical restraint was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;
- Members of the team involved directly in management of the physical restraint episode;
- A record is made at 15 minute intervals of the individual's level of distress, their physical status, mental status and presenting behaviour. The record is signed by two staff members including the designated staff member.

7.3.3 Communication with an individual's next of kin or advocate in relation to the use of physical restraint is dictated by the individual's agreed restrictive reactive strategy.

7.3.4 A contemporaneous account of the use of physical restraint must be placed in the individual's record on each occasion, to include a description of the type of physical restraint used, the reasons for its use and the duration of its usage.

7.3.5 **Mechanical Restraint:**

Where any mechanical restraint is implemented, a record of its usage must be made at least every 15 minutes for the initial 48 hours. This record should detail the individual's level of distress, their physical status, mental status and presenting behaviour during the preceding 15 minute period.

7.3.6 If the mechanical restraint is continued beyond 48 hours the frequency of recording may be reduced and will be dictated by the individual's needs and responses.

7.3.7 The frequency of observation may be decreased in accordance with the individual's response, needs and clinical assessment as recorded in the individual's restrictive reactive plan.

7.4 Reviewing the Use of Physical Restraint or Mechanical Restraint

7.4.1 The use of approved mechanical restraint should be reviewed by the MDT involved in the care and treatment of the individual within a week or earlier if any concerns arise. Thereafter review should occur at least every 3 months or earlier if required. Where this review does not occur within this timeframe, the reasons must be documented in the individual's record.

7.4.2 The review considers all the evidence for continuing or discontinuing the restraint and other important factors, including the reasons why interventions were deemed unsuccessful or ineffective. The review should also consider plans to reduce or eliminate the use of the mechanical restraint for the individual. The outcome of this review and a plan for future review should be recorded in the individual's record.

7.4.3 The individual should be involved in the review process unless they do not have the capacity to do so (at this time), or their involvement is prejudicial to their mental health, well-being or emotional condition. In such cases a family member/parent/advocate acting on behalf of the individual should be involved in the review process.

7.4.4 *If the approved physical or mechanical restraint is not required in a three month period it should be removed from the persons care plan or Kardex. In the event of a situation arising again in the future whereby such restrictive interventions are required, emergency procedures as per policy should be followed.*

7.4.5 If the individual or their advocate objects to application of the restraint, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view.

7.4.6 Where the individual or their advocate objects to the restrictive procedure they are advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.5 Emergency Use of Restraint

7.5.1 In the event of an emergency situation arising staff should take all reasonable and proportionate steps to maintain the safety of the individual and those in the environment.

7.5.2 Assistance is summoned as soon as practicably possible.

7.5.3 Appropriate and proportionate crisis management strategies are implemented.

7.5.4 In an emergency situation where the use of restraint has not been previously authorised, and where an individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe, restraint may be initiated by designated staff/team leader Each service must have guidelines as to the competencies required by such staff and must have a nominated person with these competencies rostered at all times**.**

7.5.5 The emergency use of restraint should be reviewed by the MDT involved in the care and treatment of the individual within 72 hours of the episode. Where this review does not occur within this timeframe, the reasons must be documented in the individual's record.

7.5.6 In the case of use of emergency restraint being used more than 3 times in a six month period (see 7.4). This review should lead to a planned restrictive reactive strategy and a full multi-element behaviour support plan put in place.

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Policy on the Use of Medication for Behavioural Purposes (SJOGCS 08B)

If your service does not intend to activate the use of this policy the relevant pages should be removed & the addendum (page 64) inserted and disseminated accordingly.

Document Reference Number:	**SJOGCS 08b**
Revision Number	Second Version
Approval Date	October 2009
Revision Date:	October 2011
Document drafted by	Behaviours that Challenge Policy Group
Document Approved by	Board of SJOGCS
Responsibility for implementation	Directors of Services All employees Saint John of God Community Services Limited (Intellectual Disability Services only) Positive Behaviour Support Committees
Responsibility for evaluation and audit	Positive Behaviour Support Committees

1. Policy Statement

Saint John of God Community Services Limited is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies.

It is the policy of Saint John of God Community Services Limited that Psychotropic Medication for Behavioural Purposes shall only be used in combination with other non-pharmacological interventions. In line with best practice, the lowest effective dose of medication should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount and medication should only be used to control behaviour if the behaviour is due to a diagnosed underlying psychiatric condition that responds to medication or in a narrow group of situations (see below) where behavioural interventions alone have not been effective.

Research shows that people with intellectual disability are more likely to be prescribed Psychotropic Medication than those without such a disability and that such comparative overuse is difficult to justify (King, B., 2007). Research has also shown that people with intellectual disability are more vulnerable to the side-effects of such medication and that such medication is of questionable use in treating behaviours that challenge in the absence of mental illness (Baumeister et al, 1998). Thus Psychotropic Medication should only be prescribed for people with intellectual disabilities in certain situations.

2. Purpose

The purpose of this policy is to ensure that Psychotropic Medication is only prescribed for people with intellectual disabilities after a full psychiatric assessment and with a targeted mental illness as the rationale for prescribing it.

Exceptions to this include:

2.1 The use of anxiolytic/sedative medication where an active Multi-element Behaviour Support Plan is in place and where it is necessary to reduce anxiety with medication in order for the person to benefit from the plan;

2.2 The extraordinary use of anxiolytic/sedative medication to facilitate an individual availing of an opportunity that anxiety would prevent them from availing of (e.g. hospital visit);

2.3 In the case of a person without mental illness who manifests regular behaviours that challenge of an aggressive nature and the medication has been demonstrated to reduce the frequency and/or intensity of the behaviour;

and

2.4 in the case of a person who displays intermittent serious behaviours that challenge where the use of P.R.N. Psychotropic Medication has been shown to help in the safe management of such behaviours that challenge;

2.2), 2.3) and 2.4) should be considered as forms of restraint.

3. Scope of Policy

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation and Other Related Policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009;

4.10 Irish Medicines Board (Miscellaneous Provision) Act 2006 (No. 3 of 2006) (Section 10 (ii);

4.11 Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007;

4.12 Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007, Statutory Instrument No 201 of 2007;

4.13 Misuse of Drugs (Amendment) Regulations 2007, Statutory Instrument No. 200 of 2007;

4.14 Nurses Rules (An Bord Altranais 2007);

4.15 To give effect to nurse prescribing for the Drugs Payment Scheme (DPS) the following was signed into law on 25th February, 2009 Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order Statutory Instrument No 67 of 2009.

5. Definitions

5.1 Psychotropic Medication

Psychotropic Medication is any medication capable of affecting the mind, emotions, and behaviour.

5.2 Psychotropic Medication for Behavioural Purposes

This is the use of Psychotropic Medication for the purpose of curtailing the behaviour of an individual. Medication used for this purpose can either be prescribed for regular use or for use in certain specific circumstances (PRN use) or prescribed in an unexpected emergency where the staff involved believe its use is the only way to

alleviate a dangerous situation. Medication treatments for medical or psychiatric conditions which underlie the disturbance are not included.

5.3 Anxiolitic Medication/Sedative

Medications that are sedative are those medications having a soothing, calming, or tranquilizing effect and can be classified as minor or major tranquilizers. Minor tranquillizers, also called anxiolytic medications, are medications, such as diazepam or lorazepam, that in approved doses are usually mildly sedative and are used for relief of anxiety or to promote sleep. Their effect depends on the dose in which they are given as all minor tranquillizers in sufficient doses will cause sleep. Major tranquillizers are those medications designed to treat major psychiatric illnesses such as schizophrenia and the agitation that accompanies them. Major tranquilisers are also used to decrease activity, diminish irritability, and reduce excitement in aggressive people to decrease risk. This group of medications includes drugs such as Chlorpromazine and Olanzapine. Minor and major tranquillisers are used in the management of challenging behaviour both in cases where it is secondary to mental illness and when no mental illness can be diagnosed.

5.4 Multi-Disciplinary Team (MDT)

For the purpose of prescribing Psychotropic Medication for behaviours that challenge the MDT must include the discipline of Psychiatry.

5.5 P.R.N. Medication

P.R.N. / :(Abbreviation meaning "when necessary", from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed). This abbreviation is used in prescriptions and/or medication cardex when the medication is used only in certain circumstances particular to the patient in question. For the purposes of this document the circumstances are in response to behaviours that challenge and/or circumstances that are known to precipitate such behaviours where medication has been shown to be effective.

5.6 Emergency use of Psychotropic Medication as Restraint

The use of Psychotropic medication as restraint prescribed on a once-off basis in an emergency situation that has not been anticipated by a restrictive reactive strategy or medication prescription on a once off basis.

6. Roles and Responsibilities

6.1 All staff ensure:

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 The prescribed medication is administered as authorised.

6.1.3 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 Multi-Disciplinary Team or Clinical personnel ensure prescribed medications are reviewed in the context of a multi-element behavioural support plan

6.3 The Rights Review Committee ensures that due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of Psychotropic Medication for Behavioural Purposes

7.1.1 **Psychotropic Medication** for behavioural purposes must only be used when an individual poses a significant threat of harm to self or others and assessment has shown that no other intervention alone is helpful.

7.1.2 **Psychotropic Medication** for behavioural purposes should only be used after completion of a psychiatric and behavioural assessment to exclude treatable causes of behaviours that challenge such as mental illness.

7.1.3 **Psychotropic Medication** for behavioural purposes should only be prescribed by a Psychiatrist. In emergencies another medical practitioner may be more readily available to prescribe but the situation should be reviewed by a Psychiatrist before any long term prescription is initiated. The prescription must specify the medication to be used, the circumstances of its use, the dosage, frequency and period covered by the prescription.

7.1.4 Any person prescribed **Psychotropic Medication** for behavioural purposes must have a Multi-element Behavioural Support Plan and a Restrictive

Reactive Strategy stating the reason for prescription of the **Psychotropic Medication** for behavioural purposes and guidance as to its use.

7.1.5 The individual and their family and/or their advocate should be informed and involved, where appropriate (with individual consent) for the use of Psychotropic Medication for behavioural purposes and the associated treatment plan, including the reasons for it, potential side effects and signs of success. Where the individual lacks capacity to consent, the individual's family member, as appropriate, should be involved in decisions regarding its use.

7.1.6 In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.1.7 There is written evidence that the consent process has been adhered to.

7.1.8 The dosage, frequency and duration of prescription for Psychotropic Medication for behavioural purposes must be the minimum necessary to protect the individual and/or others from harm in accordance with the individual's agreed Restrictive Reactive strategy.

7.1.9 The use of Psychotropic Medication for behavioural purposes should be approved by the Multi-Disciplinary Team (MDT) together with the team directly responsible for the care of the individual.

7.1.10 In all MDT deliberations on the use of Psychotropic Medication for behavioural purposes, processes (to include documentary evidence) must be in place to ensure that no single opinion or report alone influences the decision on the prescription.

7.1.11 Local processes must be in place to ensure that a documented record of the full team's views are brought to the attention of the prescribing medical practitioner.

7.1.12 Approval must only be provided where a current physical/medical report or functional assessment does not contraindicate the use of Psychotropic Medication for behavioural purposes.

7.1.13 A referral is made to the Rights Review Committee outlining the process undertaken in regard to authorisation of the use of Psychotropic Medication **(including P.R.N.)** for behavioural purposes.

7.2 Reviewing the Use of Psychotropic Medication for Behavioural Purposes

7.2.1 Frequent medical monitoring of the dosage and assessment of its continuing need should be carried out as long as the medication is prescribed.

7.2.2 The prescription must be reviewed by a Psychiatrist in consultation with the appropriate staff at least every three months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used. This review must be recorded in the individual's clinical notes.

7.2.3 Both the above reviews must consider any episode requiring use of Psychotropic Medication for behavioural purposes having regard to the individual's care and personal plan, the trend in relation to how often Psychotropic Medication for behavioural purposes has been dispensed and other influencing factors. The findings of the review should include an assessment of the effectiveness of the Psychotropic Medication for behavioural purposes and the reasons why Psychotropic Medication for behavioural purposes should or should not be continued and describe plans to decrease/cease its use for the individual. The findings of this review should be recorded in the individual's record.

7.2.4 The individual should be involved in the review unless they do not have the capacity to do so, or their involvement might be prejudicial to their mental health, well-being or emotional condition. In which case a family member/parent/other carer/advocate acting on behalf of the individual should be involved in the review process.

7.2.5 If the individual or their advocate objects to Psychotropic Medication for behavioural purposes, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view (i.e. external Psychiatrist). Where the individual or their advocate objects to the restrictive procedure they are also advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.3 The use of P.R.N. Psychotropic Medication for Behavioural Purposes

7.3.1 The decision to use P.R.N. Psychotropic Medication for behavioural purposes is taken in accordance with the agreed individual Restrictive Reactive Plan and supervised by the Psychiatrist.

7.3.2 The prescription must be reviewed by a Psychiatrist at least every three months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used.

7.3.3 Where Psychotropic Medication for behavioural purposes is being given as P.R.N. and being used daily, or more often, the person should be reviewed by a Psychiatrist and consideration given to the prescription of regular medication rather than emergency/PRN Psychotropic Medication.

7.3.4 P.R.N. Psychotropic Medication for behavioural purposes should only be given if it is written up on the appropriate form (usually known as a drug cardex) and signed by a Psychiatrist or a medical practitioner on the direction of a Psychiatrist.

7.3.5 Each time P.R.N. Psychotropic Medication is used for behavioural purposes it should be clearly documented and a copy placed in the individual's record. This documentation should include, but is not limited to the following:

- Medication and dosage;
- The reasons for its use;
- Date and time of its use;
- Alternatives which were implemented and unsuccessful or considered and deemed ineffective;
- If the behaviour resulting in the prescription of Psychotropic Medication is the same behaviour as that addressed in the Multi-element Behaviour Support Plan;
- The individual's level of distress, their physical status, mental status and presenting behaviour is recorded at the time of dispensing the PR.N.

Psychotropic Medication and at 15 minute intervals for at least an hour afterwards. It may not be possible to safely ascertain the person's physical status if they are agitated and if so this fact should be recorded and the appropriate physical examination (e.g. blood pressure & pulse monitoring) should be done as soon as it is safe to do so.

7.3.6 The use of P.R.N. Psychotropic Medication for behavioural purposes is reported in accordance with local policy.

7.3.7 Communication with an individual's next of kin or advocate in relation to the use of P.R.N. Psychotropic Medication for behavioural purposes is dictated by the individual's agreed restrictive reactive strategy.

7.3.8 If the use of P.R.N prescribed for behavioural purposes is not required for use in a three month period it should be removed from the person's kardex or care plan. In the event of a situation arising again in the future whereby P.R.N is required for behavioural reasons emergency procedures as per policy should be followed

7.4 Emergency use of Psychotropic Medication for Behavioural Purposes

7.4.1 In an emergency situation where the use of Psychotropic Medication for behavioural purposes has not been previously authorised, and where a individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe Psychotropic Medication may be given in an emergency by a designated staff/team leader on the direction of the Psychiatrist on call. The medication can be prescribed by phone but each service must have in place criteria for the acceptance of a phoned prescription. It is preferable that some form of written prescription be available to staff but this is not always possible (An Bord Altranais, 2007).

7.4.2 The use of Psychotropic Medication for behavioural purposes in an emergency should be reviewed by the MDT involved in the care and treatment of the individual a soon as practicable after the event.

7.4.3 If the emergency use of Psychotropic Medication for behavioural purposes is required more than three times in a seven-day period a planned response is required. This should include a full functional assessment, initiation of a MEBS plan and a full review by a Psychiatrist.

7.5 Medication for Restraint should not be used:

7.5.1 Where it is contraindicated by the individual's medical condition in accordance with the individual's risk assessment;

7.5.2 Where the possible benefits of the medication are outweighed by the risk of side effects;

7.5.3 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

7.5.4 Where it is deemed unsafe to do so;

7.5.5 Where the functional assessment of the behaviour indicates that this intervention would be contraindicated;

7.5.6 Medication for restraint should not be used to ameliorate operational difficulties or to maintain a smooth running programme. For example, medication for restraint should not be used as a response to staff shortages.

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Policy on the Use of Seclusion for Behavioural Purposes SJOGCS 08C

If your service does not intend to activate the use of this policy the relevant pages should be removed & the addendum (page 64) inserted and disseminated accordingly.

Document Reference Number:	**SJOGCS 08c**
Revision Number	Second Version
Approval Date	October 2009
Due for Revision	October 2011
Document drafted by	Behaviours that Challenge Policy Group
Document Approved by	Board of SJOGCS
Responsibility for implementation	Directors of Services All employees Saint John of God Community Services Limited (Intellectual Disability Services only) Positive Behaviour Support Committees
Responsibility for evaluation and audit	Positive Behaviour Support Committees

1. Policy Statement

Saint John of God Community Services is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies.

2. Purpose

The purpose of seclusion is that it shall only be used as a last resort. In line with best practice, the least restrictive strategy should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount. Seclusion should only be used if a person poses an immediate threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

3. Scope of Policy

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation/Other Related Policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009.

5. Definitions

5.1 Seclusion

Seclusion is the placing or leaving of a person in any room where the person's egress is prevented, or the person believes it to be so.

5.2 Emergency Use of Seclusion

Emergency use of seclusion is the use of seclusion which has not been approved in advance and is not part of the agreed individual Restrictive Reactive Pan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

5.3 Direct Observation

Direct observation is the observation of the individual by a staff member is within sight and sound of the person. The observation of an individual by CCTV does not constitute "direct observation".

5.4 Indirect Observation

Indirect observation is the observation of the individual which may include the use of CCTV.

5.5 Best Interest

Due regard shall be given to respect the right of the person to dignity, bodily integrity, privacy, autonomy and health and safety.

5.6 Acute Physical Aggression

Acute physical aggression is behaviour likely to result in physical injury to theindividual, other individuals [service-users and staff] who are at imminent risk of physical harm.

5.7 Multi-Disciplinary Team

For the purpose of prescribing Seclusion for behaviours that challenge the MDT must include the discipline of Psychiatry.

5.8 Rights Review Committee

The purpose of the Rights Review Committee is to consider if due process has been followed in imposing a rights restriction on an individual.

6. Roles and Responsibilities

6.1 All staff ensure:

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 The Positive Behaviour Support Committee ensures that all restrictive practices are appropriately authorised and reviewed with a plan in place to remove or reduce the restriction in accordance with agreed timelines.

6.3 The Rights Review Committee ensures that due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of seclusion

7.1.1 Seclusion must only be used when an individual poses a significant threat of harm to self or others and it is considered the safest intervention at that time. Its use must be in proportion to the risk posed. All alternative interventions to manage the individual's unsafe behaviour must be recorded the process recorded in the relevant documentation.

7.1.2 The use of seclusion must be approved by the MDT.

7.1.3 This approval must only be agreed where a current physical/medical report or functional assessment does not contraindicate the use of seclusion.

7.1.4 In all MDT deliberations on the use of restraint for behavioural purposes, processes (to include documentary evidence) must be in place to ensure that no single opinion or report alone influences decision on authorisation of the restraint.

7.1.5 Local processes must be in place to ensure that a documented record of the full team's views are brought to the attention of the prescribing medical practitioner.

7.1.6 The decision to initiate the use of seclusion is taken in accordance with the agreed individual restrictive reactive plan by the designated staff member on duty.

7.1.7 Except in extreme emergency the use of seclusion should be discussed with the person and their family and/or their advocate as part of the development of their individual plan, and recorded. There is evidence that the consent process has been adhered to.

7.1.8 In the event that this communication does not occur, a record explaining why it has not occurred must be entered into the individual's record.

7.1.9 Where seclusion is planned a risk assessment of the environment is carried out to ensure that the facility is appropriate for seclusion prior to its use as a seclusion facility.

7.1.10 The seclusion area is checked prior to and following its use to ensure that it is in tact.

7.1.11 The maximum duration of seclusion is 15 minutes. If an extension of this time is required, a formal review is undertaken by the senior team on duty.

7.1.12 The duration of an episode of seclusion must be the shortest possible in accordance with policy and the agreed individual restrictive reactive plan.

7.1.13 One staff member must be identified as the staff member taking responsibility for the implementation of the intervention.

7.2 Reporting and recording of the use of Seclusion

7.2.1 The use of seclusion is reported in accordance with the individual's restrictive, reactive plan. This record should include, but is not limited to the following:

7.2.1.1 The reasons for its use;

7.2.1.2 Date and duration of its use;

7.2.1.3 Alternatives which were implemented and unsuccessful or considered and ruled out;

7.2.1.4 If the behaviour resulting in seclusion was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;

7.2.1.5 Members of the team involved directly in management of the seclusion episode;

7.2.1.6 A written record of observation of the individual in seclusion must be made at least every 15 minutes (in emergency situations every 5 minutes) in a specific Seclusion document. The individual's level of distress, physical status, mental status and presenting behaviour during the preceding 15 minute period must be recorded and signed.

7.2.2 Where the transfer of an individual into the seclusion facilities involves the use of physical restraint techniques, staff must adhere to Saint John of God Community Services policy on the use of physical restraint.

7.2.3 A referral is made to the Rights Review Committee outlining the process undertaken in regard to the authorisation of the restraint.

7.3 Procedure for the monitoring of an individual during seclusion

7.3.1 The individual should be observed at all times during the use of seclusion.

7.3.2 If facilities for indirect observation (CCTV) are available, these can be used. However, in such circumstances direct observation is undertaken by a second staff member every 15 minutes. A record is maintained every 15 minutes.

7.3.3 Communication with the individual whilst in seclusion is dictated by the individual plan.

7.4 Ending Seclusion

7.4.1 Seclusion must be immediately terminated if a significant risk to the person is identified and its management dictates that the person needs to leave the room.

7.4.2 Seclusion must be discontinued at the earliest possible time. Discontinuation of seclusion means that the person physically leaves the room in which they were secluded.

7.4.3 When the individual's unsafe behaviour has abated, termination of seclusion must be considered.

7.4.4 When a person exits the seclusion area this is considered the end of the seclusion period.

7.4.5 The decision to discontinue seclusion will be informed by the predefined criteria as identified in the individual's written Restrictive Reactive strategy.

7.4.6 The reason for discontinuing seclusion must be recorded.

7.4.7 When seclusion is discontinued, any concerns regarding the individual's well-being are addressed. The individual is observed for a defined period in accordance with his/her agreed plan. This is recorded and signed.

7.4.8 Re-establishing relationships: The opportunity to discuss and/or reassure the individual is taken as soon as is practicable unless to do so would be prejudicial to the service-user's mental health, wellbeing or emotional condition. In the event that this communication does not occur, the reason for this must be documented in individual's record.

7.5 Reviewing the use of seclusion

7.5.1 The use of seclusion should be reviewed by the MDT involved in the care and treatment of the individual a soon as practicable after the event.

7.5.2 The review considers each episode having regard to the individual's care and personal plan, the trend in relation to how often and for how long and where seclusion has been initiated and other influencing factors. The

findings of the review should include the reasons why seclusion should or should not be continued and describe plans to decrease/cease seclusion for the individual. The findings of this review should be recorded in the individual's record.

7.5.3 The individual should be involved in the review unless they do not have the capacity (at this time), their involvement might be prejudicial to their mental health, well-being or emotional condition. In which case a family member/parent/advocate acting on behalf of the individual should be involved in the review process.

7.5.4 If the individual or their advocate objects to seclusion, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view. Where the individual or their advocate objects to the restrictive procedure they are also advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.5.5 If the use of seclusion is not required in a three month period it should be removed from the person's care plan or Kardex. In the event of a situation arising again in the future whereby seclusion is required, emergency procedures as per policy should be followed. (amended May 2011)

7.6 Emergency Seclusion

Where possible, two staff agrees that seclusion is necessary, having considered and deemed ineffective all other means of managing the behaviour.

7.6.1 In an emergency situation where the use of seclusion has not been previously authorised, and where a individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe. Seclusion may be initiated by designated staff/team leader. Each service must have guidelines as to the competencies required by such staff and must have a nominated person with these competencies rostered at all times.

7.6.2 In the event of an emergency seclusion taking place, the senior person on call is contacted immediately. If there is a medical concern during or at the end

of seclusion the G.P. is contacted. A review of the seclusion episode is conducted within 72 hours by the team with responsibility for the welfare of the individual, or earlier as required. In reviewing the use of seclusion, the environment is also reviewed.

7.6.3 In an emergency seclusion a written record is kept every 5 minutes.

7.6.4 In an emergency situation the environmental risks are immediately identified and managed.

7.6.5 The duration of an episode of seclusion must be the shortest possible in accordance with policy.

7.6.6 The maximum duration of seclusion is 15 minutes. If an extension of this time is required, a formal review is undertaken by the senior team on duty.

7.6.7 The use of emergency seclusion must only be agreed where a current physical/medical report or functional assessment does not contraindicate its use.

7.6.8 One staff member must be identified as the designated staff member taking responsibility for the implementation of the intervention.

7.6.9 All episodes of emergency seclusion should be clearly documented. This record should include, but is not limited to the following:

7.6.9.1 The reasons for its use;
7.6.9.2 Date and duration of its use;

7.6.9.3 Alternatives which were implemented and unsuccessful or considered and deemed ineffective;

7.6.9.4 If the behaviour resulting in seclusion was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;

7.6.9.5 Members of the team involved directly in management of the seclusion episode.

7.6.9.6 A written record of observation of the individual in seclusion must be made at least every 5 minutes. The individual's level of distress, mental status and presenting behaviour during the preceding 15 minute period must be recorded and signed.

7.6.10 Where the transfer of an individual into the seclusion facilities involves the use of physical restraint techniques, staff must adhere to Saint John of God Community Services Limited policy on the use of physical restraint.

7.6.11 In the case of seclusion being used in an emergency situation, the use of seclusion should be discussed with the person and family/relevant advocate/s after the event. The individual plan should be discussed and agreed with the relevant parties and recorded.

7.6.12 In the case of use of emergency seclusion being used more than 3 times in a six month period (see 3.2) this review should lead to a planned restrictive reactive strategy and a full multi-element behaviour support plan is put in place.

7.7 Seclusion is never used

There are certain circumstances in which seclusion is never used:

7.7.1 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

7.7.2 Solely to ameliorate operational difficulties or to maintain a smooth running programme, including where there are staff shortages, for example, seclusion being used during staff breaks, dinnertime or at night;

7.7.3 With an individual with a known psycho-social/medical condition, in which close confinement would be contraindicated;

7.7.4 Where the functional assessment of the behaviour indicates that this intervention would be contraindicated;

7.7.5 Where the risk of harm from the seclusion becomes greater than the risk posed by the acute episode of physical aggression;

7.7.6 Where it is deemed unsafe to do so.

7.8 The planned use of seclusion ensures that:

7.8.1 Its use is governed by organisational policy;

7.8.2 There is immediate and serious risk to the safety of individuals or staff and there is evidence that all other means of eliminating the risk have been considered and deemed ineffective;

7.8.3 It is subject to multidisciplinary approval and review;

7.8.4 The consent of the individual/advocate is obtained;

7.8.5 A comprehensive risk assessment has been conducted;

7.8.6 An agreed individual Multi-element Behaviour Support Plan is in place;

7.8.7 A written restrictive reactive plan that outlines least to most restrictive strategies is in place;

7.8.8 The development of a functional assessment is prioritised in the absence of a Multi-Element Behaviour Support Plan;

7.8.9 The individual plan has been subject to review by the Rights Review Committee;

7.8.10 There is a safe, suitable environment for seclusion;

7.8.11 There is evidence that the consent process has been adhered to.

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Appendix 10: Flow Chart for a Behaviour of Concern and PBS

START

Behaviour of Concern Occurs

Behaviour Incident and Planning Form Completed by staff on duty and/or

Adverse Incident Form and/ or

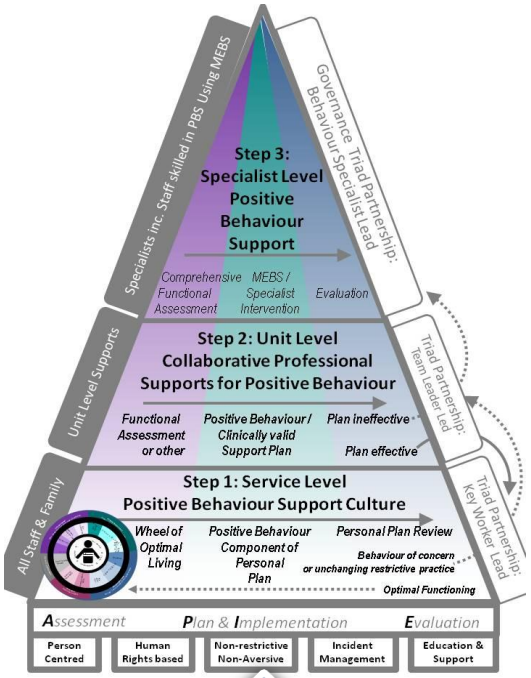
Safeguarding Incident Form

and /or Risk Assessment

Safeguarding Referral to Designated

Liaison Person

Serious Incident Management Policy



1. Incident Form sent to team leader; for assessment, review and filing.

2. Recommendations noted and communicated to the team by the team leader.

3. Copies sent to Data entry person & person in charge or delegate.

Notifications and Reporting Procedures Completed to:

Legal and Statutory Authorities e.g. Family, HIQA, Garda and

Local Service Committees; e.g. Quality and Safety Committee, PBSC, Rights Review Committee etc.

If the behaviour of concern is on-going and not reducing and /or optimal functioning is affected

And /or If Restrictive Practices are Used

Proceed to a review of the person centred plan and STEP 1: the wheel optimal living

Restrictive Practice Notification completed and sent to the Restrictive Practice Review process (and/or HRC) and a copy to the person in charge

Positive Behaviour Support Committee: Prevention- Assessment-Plans-Implementation- Evaluation

Quality and Safety Committee