KARE
Promoting Inclusion for People with Intellectual Disabilities

Supporting people who present with behaviours that challenge.

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KARE POLICY DOCUMENT				
Policy Owner: Principal Psychologist				
Rev. No.	***Approved by Heads of Units / OMT***	***Approved by KARE Board***	***Launched Heads of Units***	***Operational Period***
Rev. 1	June 2004	Feb 2005		Feb. 05 – Oct. 09
Rev. 2	July 2009	Oct. 2009	Nov. 2009	Nov 09 – Feb 15
Rev. 3	March 2015	March 2015	April 2015	April 2015
Rev. 3.1	Not Applicable (amended to update reference re Safeguarding Policy)		April 2015	April 15 – Sept 16
Policy name changed from Supporting people with Challenging Behaviour				
Rev. 4	September 2016	Sept 2016	Oct 2016	Oct16 - Sept 2019
	Sept 2019	Oct 2019		Oct 2019 -
	Note Rev 4 was approved for continuation by KARE Board in Oct 2019 for an interim period while a major review and update is completed.			
Rev 4.1	Amendment to make accommodations for Covid Crisis – as per on page 2 Approved by SPG April 8th 2020			
Rev 4.2	Amendment to remove accommodations made for Covid Crisis Approved by OMT June 23rd 2020			
Rev 5	2020	n/a	Dec 2021	Dec 2021 -

Section 1: Policy.

1.0 Background to this Policy.

Sometimes people who use KARE services present with behaviours that challenge.

KARE believes that all people using our services, including people who present with behaviours that challenge, always have the right to be supported in a respectful manner.

This policy has been developed to ensure that we use positive strategies in response to behaviours that challenge.

This is an update to the previous policy (Ref: Revision 4 October 2016)

1.1 Aim of this Policy

The aim of this policy is to ensure that the interventions used in supporting people who present with behaviours that challenge respect the rights and dignity of the individual and are in accordance with best practice.

The policy also aims to ensure that measures are in place to address the safety and welfare of all those affected by the behaviours that challenge, including the individual presenting with behaviours that challenge, other service users, staff and families.

1.2 Scope of this Policy.

This policy is applicable to all staff, volunteers and students working with individuals who use KARE's Adult services and supports.

In the absence of a policy for children's respite, as a temporary measure this policy will also apply to, staff, volunteers and students and individuals who use KARE's children's respite service and supports.

For the purposes of this policy document, we are adopting the following definition of behaviours that challenge:

"Behaviour can be described as challenging when it is of such an intensity, frequency, or duration to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion"

(Challenging Behaviour – a unified approach; RCPsych, BPS, RCSLT, 2007)

Some behaviours may be difficult to manage and yet may not fulfil all the requirements of the above definition. These behaviours may still be challenging to manage and are therefore also covered by this policy. For the purpose of this policy, these behaviours are referred to as "**behaviours of concern".**

Behaviours of concern can be a response to something that is causing a person distress. It is our responsibility to try to understand what may be triggering this e.g. a communication barrier, pain, not understanding what is happening or an environmental event. We must also respond in a way that supports the individual's needs and provides dignity and respect.

Responding to behaviours of concern in KARE is managed in a way that is reflective of the entirety of the individual's experiences, and takes account of how they perceive their environment, the context of their behaviour and how to maximise their level of function and self-efficacy.

This policy outlines organisational strategies in response to behaviours that challenge and behaviours of concern including:

Everyday responses by frontline staff and managers at local level to sporadic behaviours of concern These might include environmental adaptations, staff responding style.

Behavioural Guidelines developed by teams at local level in response to ongoing behaviours of concern

Behavioural Management reviews supported by psychologists in response to behaviours that challenge.

Behavioural Support Plans developed by the Behavioural Support Team in response to ongoing behaviours that challenge of high intensity and high frequency.

1.3 Other related policies

This policy should be read in conjunction with the Restrictive Practices policy.

This policy is also linked with the following policies,

- Safeguarding of Vulnerable People at Risk of Abuse
- Trust in Care
- Individualised Planning Policy
- KARE Safety Statement
- Risk Management Policy
- Serious Physical Assault Policy
- Intake Policy

2.0 Policy Statements

2.1 Kare promotes a culture of Positive behaviour support in our services.

2.2 All KARE responses to behaviour that challenges, and behaviour of concern are based on an understanding of the reasons for the behaviour and what the behaviour is communicating. We recognise that often behaviours that challenge may be communicative of a stressful situation for both the individual and staff.

2.3 KARE does not advocate the use of psychotropic medication in order to solely reduce behaviours that challenge. KARE does accept that medication may be used to alleviate distress associated with recognised mental health conditions. Any medication should be prescribed by a psychiatrist and be in line with the NICE guidance on *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG11).*

2.4 All responses to behaviour that challenges in the context of a stressful situation, and behaviours of concern will follow the principals of Positive Behaviour Support (PBS) and be non-punitive.

2.5 PBS is based on the principle that by teaching an individual to use a more effective and acceptable behaviour than the behaviour that challenges, the behaviours that challenge will reduce. PBS also addresses the person's quality of life by changing the environment and teaching skills to suit the person's preferences

2.6 All staff supporting service users are provided with training in positive behaviour support.

2.7 All interventions seek to enhance the individual's quality of life and to provide them with a safe environment.

2.8 Kare will respond to behaviours that challenge in a way that is respectful of the person, that utilises the knowledge and skill of the core staff working with the individual, and when needed will provide additional supports and skills through psychology, behavioural support and other members of the clinical support team. All these responses will be provided in line with individualised planning and supports

2.9 Kare promotes restraint-free environments for all service users. In some instances, a risk assessment might indicate the need for procedures involving the use of restraint. Restraint will only be used as a last resort, when other less intrusive strategies have failed to reduce or stop the behaviour. Any strategy involving restraint must be in line with Kare's Restrictive Practices Policy. When restraint is used, this must be risk assessed, and documented in the restrictive practice register of the frontline service.

2.10 Kare acknowledges that transitions can be particularly stressful for the people that we support. The stress of transitions can lead to increased episodes of behaviours that challenge. Support around more natural regular transitions such as changes of activities should be incorporated into the person's individualised support plan. Other more significant events such as moving school to adult services, moving to a new house, changing service etc may require more detailed transition plans. All plans may involve partner agencies, families and the individual working collaboratively with Kare staff to support this.

2.11 Unacceptable interventions or actions by staff in response to behaviours that challenge such as:

2.12 Withdrawal of a person's basic rights (nourishment, shelter and warmth)

2.13 Withdrawal of a person's right to normal access to places and activities as a form of punishment

2.14 Or any other form of abuse

2.15 may lead to disciplinary action up to and including dismissal.

2.16 All interventions put in place to support an individual with behaviours that challenge seek to minimise the negative impact of the behaviour on other service users, staff or others who share the same environment as well as the person themselves.

2.17 In situations where an individual's behaviour impacts on others, the individual's support plan includes interventions which seek to minimise or remove this impact on others.

2.18 If there are still concerns about how the individual's behaviours that challenge impacts on peers sharing the same environment, and the team around the individual cannot reach agreement on appropriate strategies for dealing with this, the matter should be reported to the Line Managers of those involved in the team in order to look for their input towards a resolution.

2.19 When a person's behaviour leads to a safeguarding concern, staff will report the concern using the 'Safeguarding of Vulnerable People at Risk of Abuse' policy.

2.20 When any incident of behaviours that challenge results in an injury, this will be reported by staff using the KARE CID adverse events reporting system

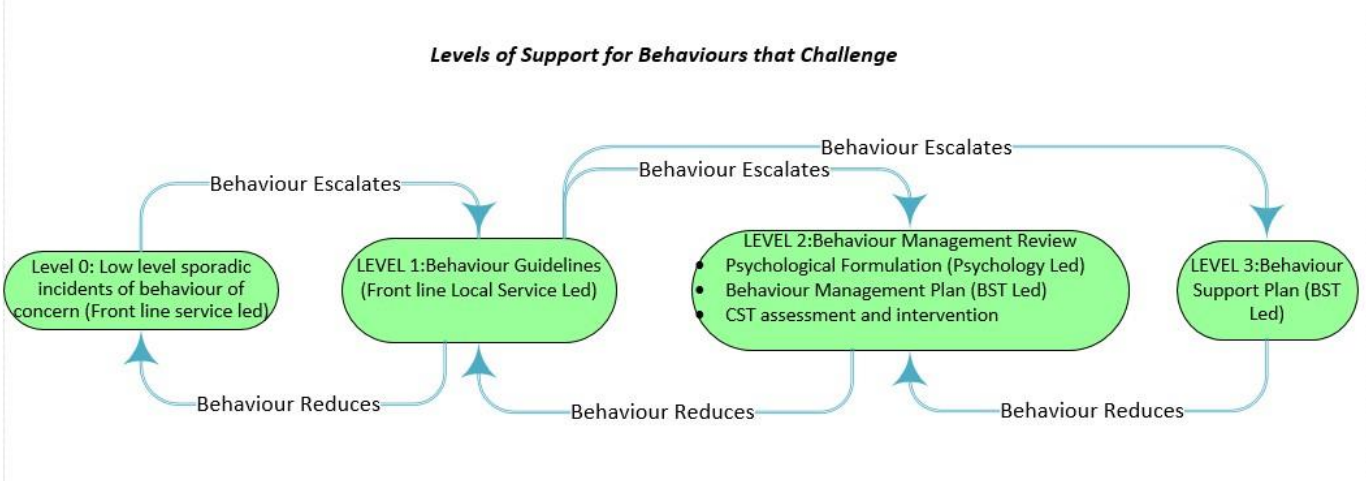
2.21 The Line Manager will ensure that any staff member working with an individual with behaviours that challenge is adequately trained and has the necessary skills to implement support plans for an individual.

2.22 Staff will use nonviolent crises intervention as taught through Kare's MAPA (Management of Actual and Potential Aggression) training programme to

respond to isolated episodes of behaviours that challenge in order to ensure the situation is managed in a way that best respects the dignity of the person involved.

2.23 2.18 Kare will train all relevant staff in the use of MAPA training programmes

2.24 The Line Manager will discuss the management and outcome of an unexpected incident of behaviours that challenge with those involved in the incident to decide on the need for specific follow up interventions/referral.



3.0 Organisational strategies in response to behaviours that challenge and behaviours of concern.

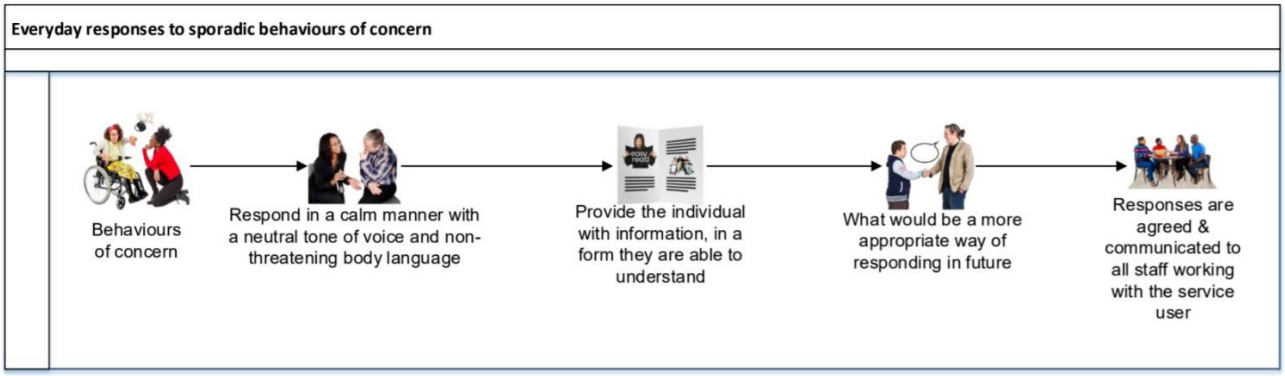
3.1 KARE has identified that different levels of support and responses are needed in respect of differing challenges. All responses are underpinned by positive behaviour support strategies (PBS) and low arousal approaches.

3.2 These approaches will be delivered in an individualised person-centred way, will develop a support plan which balances the staff response towards an individual's presenting behaviour of concern with the level of risk to the individual and others. It will focus on the least intrusive and least restrictive way to achieve this.

3.3 At all times, the Kare response will be flexible enough to increase support at times of need and reduce the intensity of support at the first opportunity in order to maximise the individual's autonomy, independence, respect and dignity.

3.4 The level of support will be designed to meet the presenting need for support as follows:

3.5 <u>Everyday responses by frontline staff and managers at frontline to sporadic behaviours of concern</u>



3.6 Any individual may at times present with behaviours of concern. These behaviours do not typically cause physical harm to the person or others but may still need to be responded to by front line staff and managers. The principles governing the response to these sporadic behaviours of concern are:

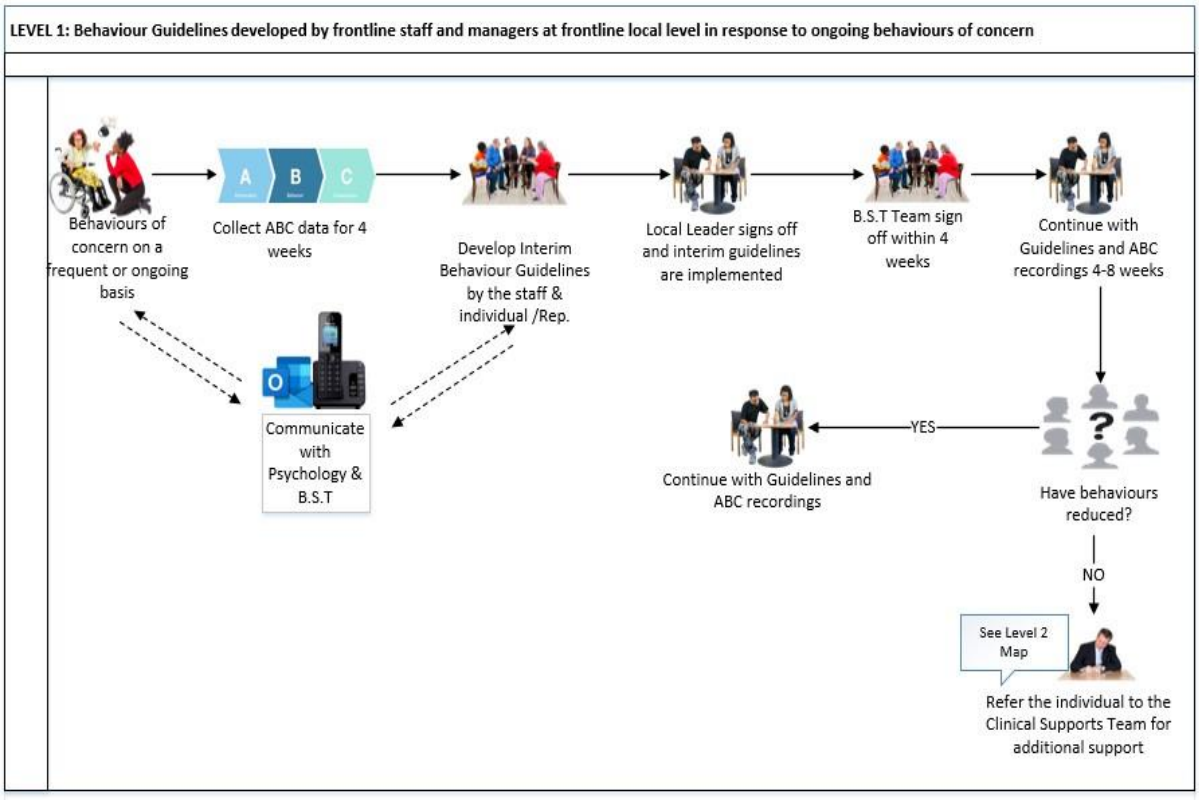
3.7 The person responding should do so in a calm manner with a neutral tone of voice and non-threatening body language

3.8 The response will be non-punitive and not involve the use of either threats or punishment

3.9 The response will provide the individual with information, in a form they are able to understand, about what was inappropriate with the behaviour of concern and what would be a more appropriate way of responding in future

3.10 These responses will be agreed, recorded in the minutes of the team meeting and communicated to all staff working with the service user in order to have a consistent response

. **LEVEL 1: <u>Behaviour Guidelines developed by frontline staff and managers at frontline level in response to ongoing behaviours of concern</u> (See diagram below)**



4.0 When an individual presents with behaviours of concern on a frequent or ongoing basis then there needs to be a consistent response to the behaviour. In order to ensure consistency, the staff team develop Behaviour Guidelines (Appendix No.1 - Template for developing behaviour guidelines)

These behavioural guidelines are developed in a way that includes the individual as part of the collaboration.

There should be an effort to understand what led to the incidents at this time with a view to trying to determine what could be altered for the person and thus avoid a recurrence

The guidelines should be based on a review of the individuals ABC records (See Appendix A) to identify possible environmental, communication, health or other events that may have caused the service to respond in a way that presented as challenging. This will ensure that that any behaviour guidelines will be evidence based.

Behaviour Guidelines should also explore whether skills training could be provided in supporting the individual.

Once developed, these Behaviour Guidelines will form the interim plan to be used. These interim guidelines can be signed off by the team leader.

The Clinical Support Team will be available to offer brief advice and consultation on strategies for inclusion in the guidelines. This can be sought through an informal drop in/phone in.

4.1 ABC incident records are collected for a period of 4 weeks initially by staff team involved. The purpose of collecting this information incident data is to assist in reviewing how to best support the person and analysing the events. The interim guidelines are then developed based on evidence gathered from these ABC forms. The Clinical Support Team are also available for informal consultation on how to review and condense the ABC information Please use the Behaviour Guidelines Template (Appendix1) to create the interim guidelines.

4.2 The line manager will sign off the interim guidelines, and these will be implemented for a period of at least 4 weeks. No changes should be made to the interim guidelines during this time. Staff should continue to collect ABC information to inform whether guidelines are working, or whether they need further refinement.

4.3 The line manager will also send the interim guidelines and all the ABC information to the behaviour support team for sign off and to be finalised. Please note that a clinical referral does not need to be made for behaviour guidelines to be signed off. They can be forwarded directly to the Clinical Support Team Behaviour Support Team/Psychology for review.

4.4 The focus of this sign off review by Clinical Support Team the behaviour support team and psychology is to ensure that the guidelines include the essential elements outlined below:

A clear and concrete description of the behaviour/s of concern that the guidelines are written for.

A baseline recording of the frequency of the behaviours prior to implementation of the behaviour guidelines.

A clear description of the consistent response from staff when episodes of the behaviour/s of concern occur.

These guidelines should be Non-punitive and not involve the use of either threats or punishment. Informative re what is inappropriate about the behaviour/s of concern and alternatives that are more appropriate.

Should include skill teaching.

Include MAPA de-escalation strategies where appropriate.

A time plan for implementation and reviews of the behavioural guidelines

4.5 After the guidelines have been finalised, the frontline service will continue to apply the guidelines and collect ABC information. This will be used as evidence for either the reduction in behaviours that challenge (and the success of the behaviour guidelines), or to evidence the requirement for a more intensive intervention and review from the Clinical Support Team.

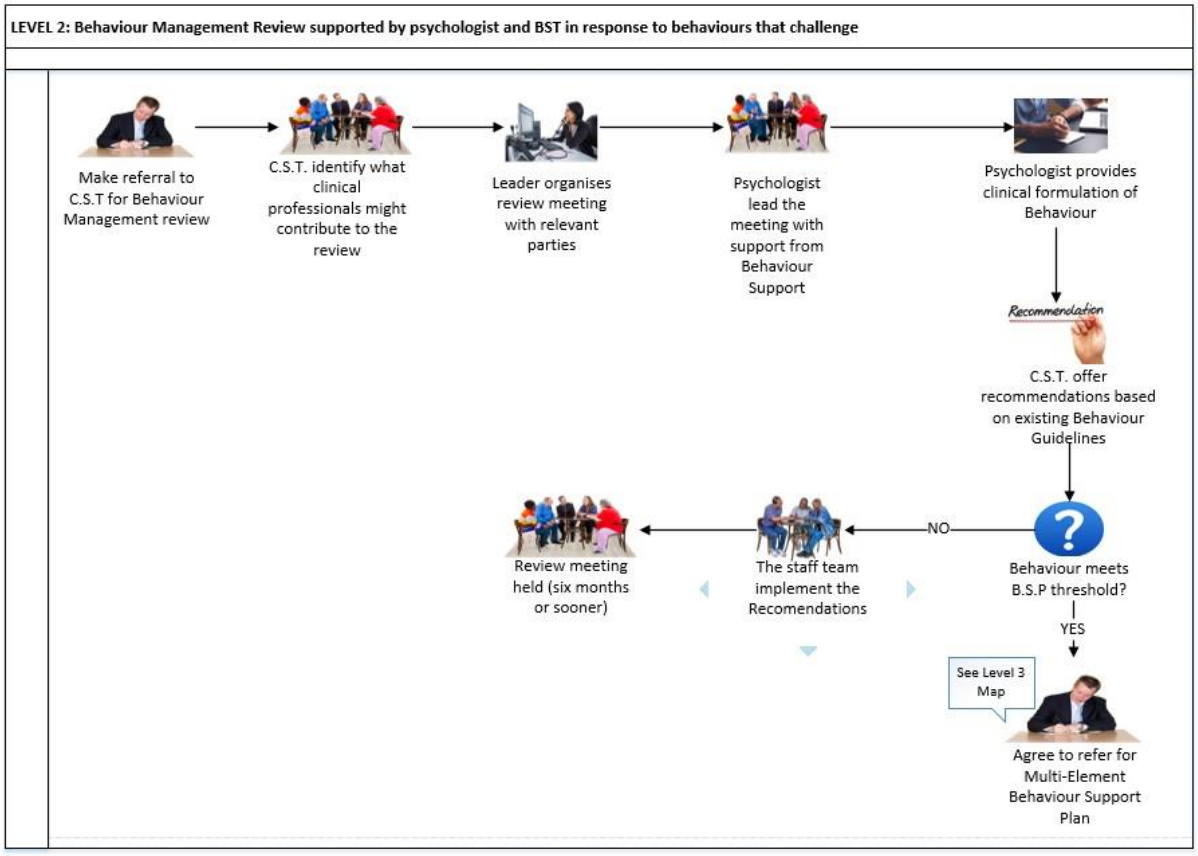
4.6 The behaviour support team (and in time appropriately and approved trained staff) will sign the behaviour guidelines to acknowledge that they fulfil the above criteria.

4.7 If the behaviour guidelines have not been effective in reducing the behaviour despite reviews and revisions, or the team implementing the guidelines are of the opinion that there has been no positive reduction in the frequency of the behaviours of concern following a 4 week implementation and evaluation phase, the line manager may decide to refer the individual to the Clinical Supports Team for additional support.

4.8 If there are any changes to the behaviour guidelines, the line manager needs to inform the behaviour support team of this and document the changes. The amended behaviour guidelines will need to be signed off again.

4.9 If behaviour guidelines are successful, it is anticipated that the individual will have an improved quality of life, and staff may look supporting them at Level 0: Everyday responses to sporadic behaviour.

5.0 LEVEL 2: Behaviour Management Review supported by psychologist and BST in response to behaviours that challenge



5.1 The service leader will submit all the completed ABCs and Behaviour Guidelines. Behaviour Support and Psychology will review this information and agree whether the individual meets the threshold for a behaviour management review.

5.2 In coordination with the psychologist, and behaviour support team the service leader will set up a behaviour management review meeting with the relevant people involved in the individuals care. This may include the individual themselves (when possible), key workers, family, local service

staff, and members of the CST as appropriate. The aim is to have a whole team approach. This is similar to the team around the individual referred to in the level 3 response also (see below).

5.3 The behaviour management review meeting response will be structured in the same way as a case review meeting. It will be chaired by the service leader, but the case discussion will be led by the psychologist, but if appropriate will be co-facilitated by a member of the behaviour support team. It is recognised that there may be important points of learning to be shared at this stage from behaviour support, but there may not necessarily a requirement for a specific piece of work to be taken on by the behaviour support team.

5.4 The focus of this review meeting will be to identify a shared response to the behaviours that challenge or the stressful situation. This will include

5.5 A psychological formulation of the presenting problem/situation that challenges

5.6 A Behaviour Management plan based on the existing behaviour guidelines and constructed as part of the initial review meeting.

5.7 The psychological formulation of the presenting problem will take account of all the issues that might be relevant to supporting positive behaviour support at a service level. It will draw on the existing ABC charts and any evidence collected by the service and also take account of multiple people's perspectives of the behaviours, i.e. the antecedents, triggers and setting events, as well as the responses of the individual and the team around them. It will draw upon psychology principles of managing deteriorating mental health, the impact physical pain on behaviour, as well as the relevance of current or historic trauma.

5.8 An outcome of the behaviour management review will be an agreed behaviour management plan. This will be developed in collaboration with all attendees at the review meeting. This plan:

5.9 Will be based on the conclusions of the current behaviour guidelines and from a thorough sample of ABC charts and describe both the proactive and reactive strategies in place in response to the behaviour.

5.10 Will follow the principles of positive behaviour support and will not involve the use of punishment.

5.11 Will offer strategies and skills to promote a low arousal approach to stressful environments.

5.12 Will identify criteria for when to reduce clinical support involvement and when to increase clinical support involvement.

5.13 Will identify what training and resources may be required to support this plan and the individual, and who will provide this training.

5.14 Will when appropriate, identify the psychologist who will work directly with the individual to develop skills and strategies for managing their emotional distress.

5.15 After the behaviour review meeting, the psychologist will share the psychological formulation and summarise the agreed behaviour management plan. This will be shared with all the staff involved in the individuals care, their family, and where possible the individual.

5.16 The Leader will ensure that staff working with the individual are made aware of and understand the elements of the Behaviour Management Plan and psychological formulation.

5.17 The Leader will have responsibility for implementing the management plan and will ensure that ABC data collection continues. This data should be used as evidence of a successful plan or the need for a review. If clinically indicated, and resources are available, intensive support workers will support the local team for a short time to embed the behaviour management plan.

5.18 An alternative outcome of the behaviour review meeting might be that a referral is made for a multi element positive behaviour support plan. This will be decided on the basis of need and on the severity and impact of the behaviours that challenge. Due to the intensity of this level of support, all alternative interventions should be explored before a referral is made. Psychology will remain involved and when possible will co-work with behaviour support.

5.19 Supporting individuals with a behaviour management plan should be reviewed formally after six months. The Leader can request a review of the plan sooner if clinically indicated, and this will be facilitated at the earliest convenience, but may require some advance planning based on availability of the relevant people.

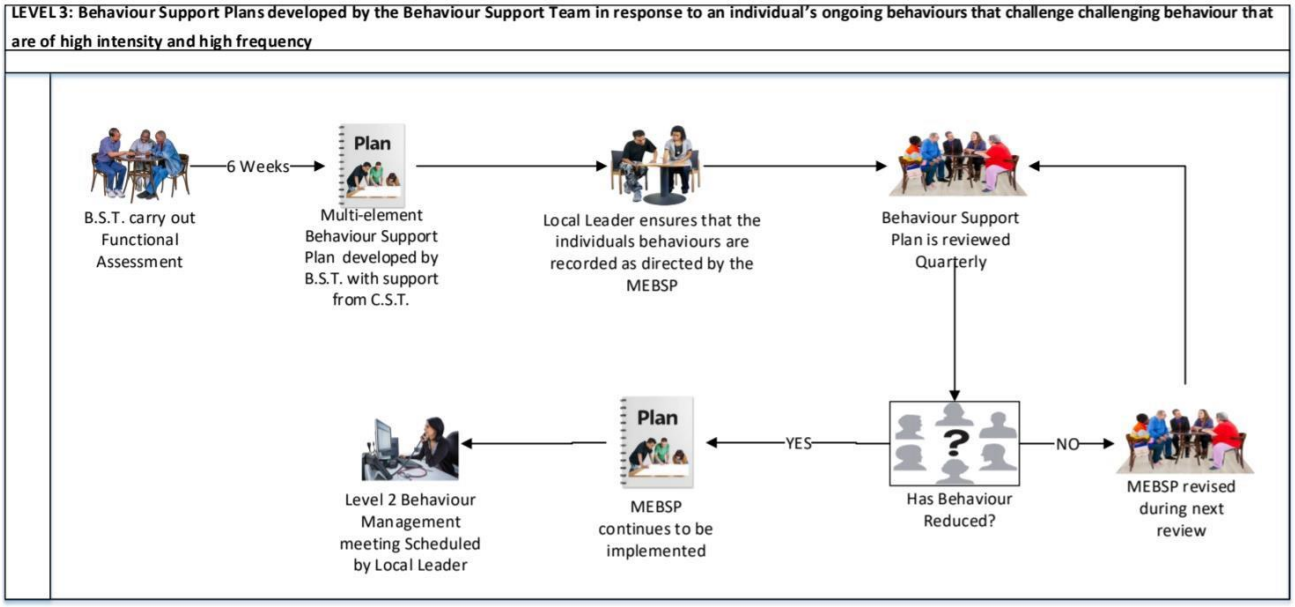
5.20 If a behaviour management plan is shown to be effective after the initial 6-month review or subsequent reviews, the frontline team will continue to implement it but can adjust as needed. Any changes should be identified to the psychologist and behaviour support team. However, at this stage, the psychologist and/or other members of the clinical support team will step back from direct involvement.

5.21 If a behaviour management plan is shown to be ineffective, then a referral to the Behaviour support team will be considered at the next review meeting or sooner if indicated. At this stage it will be identified whether a more intensive behavioural response will be effective in reducing behaviours that challenge.

5.22 Criteria that indicate an effective behaviour management plan would include improved quality of life and general wellbeing for the individual, and a satisfactory reduction in behaviour that challenge. Any decision to change the level of response will be made when the individuals plan is reviewed and when there is agreement to do so between the individual, their family, frontline staff, and representatives of clinical support such as psychology and behaviour support.

5.23 Where families request support to manage behaviours that challenge at home, this will be provided through information and guidance on PBS principles and will be based on the elements of the individuals support plans shown to be effective. We will seek consent from the individual before sharing their plan. Direct behaviour support is not provided into the home setting.

6.0 LEVEL 3: Behaviour Support Plans developed by the Behaviour Support Team in response to an individual's ongoing behaviours that challenge that are of high intensity and high frequency.



6.1 An Individual who presents with severe levels of ongoing behaviours that challenge requiring intensive support should be referred to the Clinical Supports Team (CST). The Behaviour Support team on the CST will determine whether the case should be accepted for intensive support. The timing of involvement of the BST will be based on agreed prioritisation which focusses on existing or potential harm or risk of harm to self, others or staff. This response will also be prioritised based on level of distress experienced by the individual. The higher the risk or distress, will merit a higher priority for intervention.

6.2 The Behaviour Support Team will carry out a Functional Assessment with the individual, their service, and key staff around the individual. This comprehensive assessment will inform the individuals multi-element Behaviour Support Plan. Please note this assessment will take place over a period of time and will involve a number of sessions observing and analysing an individual's environment and behaviours

6.3 A multi-element Behaviour Support Plan will consist of a number of positive strategies for facilitating a reduction in behaviours that challenge and improvement in quality of life for the individual. These strategies will include plans for:

6.4 Promoting environments that are positive for the individual

6.5 Development of new skills

6.6 Development of coping strategies

6.7 Systematic behavioural techniques

6.8 The plan may include reactive strategies as ways of responding to the behaviours that challenge when it occurs. Any strategy involving restraint must be in line with Kare's Restrictive Practices Policy. When restraint is used, this must be risk assessed, and documented in the restrictive practice register of the frontline service.

6.9 Changes to the Behaviour Support Plan can only be made by a behaviour therapist or Behaviour Specialist.

6.10 Intensive Support Workers will directly support the local team to implement the agreed Behaviour Support Plan.

6.11 The Line Manager will ensure that the individual's behaviour is recorded in accordance with their multi-element Behaviour Support Plan, and that this data is sent to the BST each week for review.

6.12 The Line Manager, key staff and the BST will communicate/meet at regular intervals as agreed to evaluate progress and discuss and agree minor revisions to the plan.

6.13 The team around the individual will evaluate and formally review the plan on a monthly basis or as often as agreed by the team

6.14 Any intervention that is not demonstrated to be effective within a reasonable period of time from the point of implementation will be revised in agreement with the behaviour support team.

6.15 Once there is evidence and agreement that the Behaviour Support Plan is effective in increasing the individuals quality of life, reducing the level of behaviours that challenge and managing the behaviour, the BST will reduce their level of input and the individual will be moved to level 2 (behaviour management review). Behaviour Support Team will request a behaviour management review to facilitate this step down.

6.16 Criteria for reduction of BST support to a level 2 (behaviour management review) are as follows:

6.17 There is an increase in the individual's quality of life, and a decrease in incidents of behaviours that challenge and when there is agreement between Behaviour support, the frontline service, the individual and their family.

6.18 The individual has had the same Behaviour Support Plan for six months and behaviours have continued to decrease or are maintained at an agreed acceptable level.

6.19 All staff involved in supporting the individual have received the relevant training and have the required skills for implementation of the plan.

6.20 After someone has been stepped down to level 2.

6.21 There should be no changes made to the BSP without consultation with BST or Psychology.

6.22 Staff should continue to keep data and graph behaviours that challenge for monitoring purposes locally. This data does not need to be sent to the BST or psychology.

6.23 A behaviour management review meeting will be held within 6 months where a member of the BST will attend. BST will step back after this meeting, and psychology will oversee the CST response to behaviours that challenge.

6.24 6.7 Procedure for step down from level 2 to level 1 (after a BSP has been utilised):

6.25 If after 1 year of sustained or continued improvements in an individual's quality of life, the level 2 behaviour management review meeting focus will be to determine if the individual can be supported by the frontline service, and the CST support can withdraw.

6.26 Frontline staff will continue to implement the BSP, keep data and graph behaviours that challenge. This data does not need to be sent to the BST.

6.27 If there are parts of the plan that the team feel should change due to the individual's progress/changes in needs etc the team should write new behaviour guidelines with the individual. The guidelines should be sent to the BST to confirm they are positive practices and are in keeping with Kare's policy.

6.28 If there is an unexplained ongoing increase in an individual's levels of distress or behaviours that challenge the team should re-refer to the CST.

6.29 Should any new members join the team it is the responsibility of the key worker to meet with them and go through the plan and data sheets prior to them supporting the individual. The keyworker should also work alongside the new team member for one day as part of the initial training.

6.30 Any recurrence of behavioural issues will require a new referral through the Clinical Supports Team process.

6.31 Supporting people following a traumatic incident of behaviours that challenge:

6.32 All people using KARE's services and staff involved in an incident of behaviours that challenge which is distressing to them will be given an opportunity to debrief with their unit/line manager as soon as possible after the event.

6.33 Psychology support can be requested to provide a de-brief to the staff team or the service users following a significant event. The psychologist will offer a debrief session to the staff team as a group or the service users as a group. The psychologist can also accept a CST referral for support for individual services users following a traumatic incident of behaviours that challenge.

6.34 The MAPA (post-vention) COPING technique will be used by the line manager to support people using KARE's services and members of staff involved in a traumatic incident to review their experience of the situation and decide on any further actions required.

6.35 The unit/line manager should ensure that the staff involved are made aware/reminded of the supports available through the KARE Employee Assistance Programme.

6.36 Where a staff member is working alone when they experience a traumatic incident of behaviours that challenge, they should seek support and personal debriefing using the protocols agreed for that location.

6.37 The Line Manager should be informed of the Incident and the outcome of the personal debriefing as soon as possible. If the line manager is

unavailable the relevant manager should be informed. If the incident occurs out of hours, On Call should be contacted.

6.38 Where the debriefing process highlights the need for a response to the incident this should be acted on by the Line Manager as soon as possible.

6.39 Where it involves injury/ absence from work, the reporting process should be followed as per serious physical assault policy.

Appendix 1

Name: **File Number** **D.o.B.:** **Address:**		**Date:** **Review date:**	

A brief history of [NAME]'s life
Quality of Life Questions
What activities does [NAME] enjoy? How do we know they enjoy it? How often do they get to do this? **Does [NAME] have the opportunity to try new activities? Have you used activity sampling with them?** **Does [NAME] have opportunities for community inclusion? How often? Where do they go? What do they do?** **Does [NAME] have a job or have desire to be employed?** **Does [NAME] have specific communication needs? Are these needs being met?**

Does [NAME] have opportunities to express their emotions? Do they have emotional support? How is this done?

Does [NAME] have friends, or the opportunity to make friends? How often do the see each other? Do they have shared interests?

Is [NAME] in good physical health?

Does [NAME] have any known sensory likes/dislikes?

What are [NAME]'s current coping strategies for stress?

Wellbeing (PERMA Model)

The **PERMA model** is an approach used to give people a heightened sense of well-being and meaning in their lives, certain tasks are important to give us all more fulfilment.

Positive Emotion (**Things that make [NAME] smile**)

Engagement (**Things that [NAME] enjoys and keep their focus**)

Relationship (**Key relationships in [NAME]'s life**)

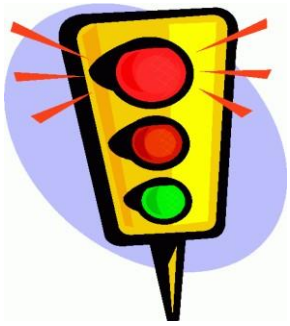
Meaning (**What gives [NAME]'s life meaning**)

Achievement (**What gives [NAME] a sense of achievement**)

Vision & Goals

- **0 – 6 months**
- **6 – 12 months**
- **12 – 24 months**
- **24 months plus**

Stages of Support

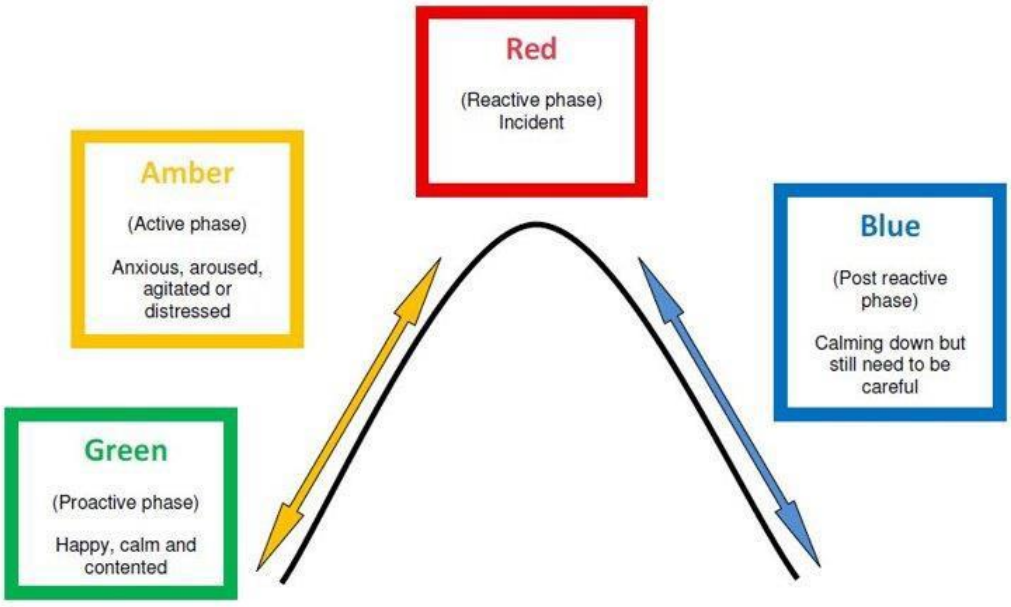


Green: Calm & Relaxed

Amber: Anxious, aroused or distressed

Red: Incident!

Blue: Calming down



"Calm & Relaxed "Green" Strategies (Proactive)	
What [NAME]X does, says and looks like that gives us clues that he is calm and relaxed.	**The things that we can do or say to help [NAME] be calm and relaxed.**
• •	• •

Early Warning "Amber" Strategies	
What [NAME]X does, says and looks like that gives us clues that they are becoming anxious or stressed.	**The things that we can do or say to support [NAME] when they are stressed so that we can help them return to being calm and relaxed.**
• •	• •

Reactive "Red" Strategies	
What [NAME]X does, says and looks like when there is an incident	**The things that we can do or say to quickly manage the situation and to prevent unnecessary distress, injury and destruction.**
• •	• •

Post-Incident Support "Blue" Strategies	
What [NAME]X does, say and looks like that gives us clues that he is becoming calmer	**The things that we can do or say to support [NAME] to become calm again and to return to the proactive phase.**

• •	• • **Formal debriefing should take place after an incident.** Discussion: • What happened? • Why did it happen? • What were the results? • What did we learn? • How can we improve for next time?

How to complete the ABC CHART		
ANTECEDENT A Location, people activity	BEHAVIOUR B Describe what you saw	C CONSEQUENCE What did the carer do/how did the person react?
Record the <u>ANTICEDENT</u> events (Things that happened <u>BEFORE</u> the behaviour) Record things such as: • Where was the person? Exactly what were they doing? • Was anyone else around or had anyone just left? • Had a request been made of the person? • Had the person asked for, or did they want something specific to eat or drink? • Had the person asked for, or did they want a specific object or activity? • Had an activity just ended or been cancelled? • Where were you? What were you doing? • How did the person's mood appear E.g. happy, sad, withdrawn, angry, or distressed? • Did the person seem to be communicating anything through their behaviour e.g. I want/don't want something?	Record a detailed description of the actual <u>BEHAVIOUR</u> (what did it look like?). This involves documenting: • Provide a step-by-step description of exactly what happened e.g. he ran out of the living room, stood in the kitchen doorway and punched his head with his right hand for approximately 1 minute.	Record the <u>CONSEQUENCES</u> of the behaviour. (What happened <u>AFTER).</u> This involves recording: • Exactly how did you respond to the behaviour? Give a step-by-step description • How did the person respond to our reaction? • Was there anyone else around who responded to or showed a reaction to the behaviour? Did the person's behaviour result in them gaining anything they did not have before the behaviour was exhibited, e.g. attention from somebody (positive/negative); an object; food or drink; or escape from an activity or situation?

• Were there any obvious triggers e.g. too noisy, sitting on own for some time? Are there any obvious setting events E.g. feeling ill, bad night's sleep, missing their mum or dad?		

Possible Reasons for Behaviour (there may be many other reasons)	Strategies for Managing Behaviour
Sensory: Henry seeks sensory stimulation through skin picking	Proactive: Provide Henry with a texture fabric to stimulate his sensory needs when he arrives in the morning Reactive: Offer Henry some sensory stimulation such as encouraging him to go to the sensory room and use his texture fabric
Escape: Henry has a fear of falling and wishes to escape or avoid activities. He does this through refusing to get on the transport or spilling his food on his clothes	Proactive: Review his daily timetable regularly and explore his thoughts and feelings about new activities. Reactive: offer Henry a relaxation exercise and sit with him until his anxiety reduces then offer him his chosen activity
Tangible: Henry wishes to get a drink of juice but expresses this by throwing his cup at staff.	Proactive: Provide a jug of juice and a cup in the morning when he arrives in the service and top it up before meal times. Reactive: bring Henry to the sensory room to listen to his music or if the weather is nice bring him to the garden and have a drink of juice with him
Attention: Henry wishes to spend time with staff but does this by banging his hand on the office door.	Proactive: Assign staff time in the morning for 30 minutes, and afternoon for 30 minutes, offer Henry choice of fun activity Reactive: Remind Henry of his timetable of staff time, and manage the immediate situation, perhaps supporting Henry into the sensory room

NAME:		ABC RECORD CHART			
DATE	**TIME**	**ANTECEDENT** **Location, people,** **activity**	**BEHAVIOUR** **Describe what you saw**	**CONSEQUENCE** **What did the carer do/how did** **the person react**	**POSSIBLE REASON/** **PURPOSE**