Positive Behaviour Management & Support Policy

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1. Introduction

Oliver House School (OHS) is a specialist educational provision for children and young people with autism and other associated complex difficulties. The school has affiliated children's homes, which provide residential care to our learners.

At OHS, specialist, individualised education and care are delivered in a safe, positive and structured environment in which every pupil is encouraged to achieve the best possible academic, social and vocational outcomes.

We recognise that within OHS and residential services some individuals sometimes behave in ways that others can find challenging and which, on some occasions, might be dangerous and potentially result in harm to the person displaying the behaviour, others or the environment. Some of our young people might be exposed to restrictive interventions as a response to some forms of behaviours that they display.

We believe that Positive Behavioural Support represents an ethically compatible approach to address behaviours that challenge within the context of our services. The following policy provides clear guidance on the methods by which our services can promote positive behaviour in our students. It also outlines the legal requirements and the practical procedures that our services undertake to ensure the safety of the individuals in our care.

2. Aims

The purpose of this policy is:

- To ensure that Oliver House School and affiliated residential homes comply with all the relevant legislation and National Standards which govern this area of work.
- To ensure that individuals in our care and education receive ethical, effective, timely and skilled support.
- To maintain the safety of the individuals, the staff supporting them, others and the environment.
- To promote the use of effective non-restrictive intervention strategies.
- To provide guidance to staff on the circumstances in which physical and restrictive intervention might be used.

- To ensure that all staff who are likely to encounter situations in which physical or restrictive intervention may be necessary are trained in and understand the procedures of physical or restrictive intervention.
- To ensure that where physical or restrictive intervention is required, the techniques used are safe and appropriate to the situation.
- To ensure that all staff working with the individuals in our services are clear about the rights of the individuals in their care as well as their own rights and responsibilities.
- To authorise staff to use a physical intervention that is 'reasonable and proportionate' when managing distressed behaviours.
- To promote best practice

3. Positive Behavioural Support

3.1. Positive Behavioural Support approach

Positive Behavioural Support (PBS) provides a framework that seeks to understand the meaning and context of behaviour to inform the development of supportive strategies, skills and environments that can enhance a person's quality of life. PBS recognises that people may display problem behaviours because:

- They have complex, unique needs that are not being met e.g., mental or physical health conditions, sensory impairments
- They are exposed to challenging environments and situations in which behaviours of concern are likely to develop e.g., lack of stimulation or access to preferred activities, insufficient availability to positive social interaction
- Their quality of life is impoverished

Positive behavioural support focuses on preventative strategies. It also includes strategies to ensure that early signs of anxiety and agitation are recognised and responded to and strategies for when a child or young person's agitation escalates to a point where they place themselves and/or others at serious risk of harm.

Evidence has shown that by addressing individual needs and enhancing the quality of life we can reduce behaviours that challenge which results in a reduction in the use of restrictive interventions.

PBS approach involves:

- Assessment of possible functions of problem behaviours (Functional Assessment)
- The development and implementation of Behaviour Support Plans, which have been informed by the assessment, to ensure that the person's unmet needs and all aspects of their environment that they may find challenging are identified and addressed
- Using a person-centred approach which involves focusing care on the needs of individual

3.2. Functional Behavioural Assessment (FBA)

The aim of Functional Behavioural Assessment is to identify the possible functions (the reasons) behind the problem behaviour and any factors that influence the occurrence of that behaviour. Conducting an FBA assessment involves:

- Identifying and defining the problem behaviour
- Collecting the information to determine the function of the behaviour of concern. The assessment methods include:
    - indirect assessment – the information is gathered based on the personal observations of those who are around the young person frequently (interviews, questionnaires, rating scales)
    - direct assessment – it involves direct observation of the young person in their natural environment; collecting and analysing behavioural data (incident reports, ABC charts, scatterplots)
- Forming a hypothesis about reasons for the occurrence of the behaviour
- Planning interventions – developing a Behaviour Support Plan which identifies the strategies needed to modify or eliminate the problem behaviour
- Evaluating the effectiveness of the plan - this involves data collection and analysis to determine if the interventions used was successful

At Oliver House School, the FBA is carried out by the PBS team and involves the use of direct and indirect assessments undertaken across different settings (school, residential home) to gather all necessary information.

3.3. Behaviour Support Plans

Some young people at OHS and associated residential homes exhibit problem behaviours and require a clear and comprehensive Behaviour Support Plan.

The BSPs include the following:

- information about the individual's educational, health and social needs identified in the assessment
- the individual's likes and preferences
- behaviours of concern
- information about the triggers/setting events
- possible functions of the behaviours
- support strategies:
    - proactive strategies which focus on improvement of quality of life and ensuring that the individual needs of the person are met e.g. adaptations to the young person's environment or routine
    - active strategies which are to be used by staff when the person starts to become anxious, aroused or distress; these strategies may involve de-escalation techniques, distraction, diversion, disengagement and aim to promote relaxation and avert any further escalation to a crisis
    - reactive strategies which guide staff on how to react when a person's agitation further escalates to a crisis and they place either themselves or others at significant risk of harm. This may involve the use of restrictive interventions.

Positive Behaviour Support Plans are dynamic documents and are reviewed regularly, to reflect any changes in behavioural presentation, situational changes or modification of support strategies used. All plans are agreed upon with parents/carers and shared with all staff.

4. Promoting positive behaviours

4.1. Rewards

A crucial part of PBS is developing skills and behaviours with positive reinforcement. At our services we promote positive behaviours by rewarding our children and young people for their efforts, good behaviour and achievements in a variety of ways:

- Praise and positive feedback – including verbal and non- verbal responses
- Use of personalised reinforcers (e.g. tangibles, favoured activities)
- Tokens and certificates
- Personalised reward systems

We believe that reward systems can be extremely effective motivators in the development of positive behaviours and can also develop confidence and self-esteem. Some learners respond positively to praise and encouragement and look forward to these rewarding experiences offered following an appropriate behaviour. For some learners, the intrinsic value of praise is insufficient and further rewards might be necessary such as access to a favoured item or activity. Where this is the case, these motivators can be offered to the learner alongside praise.

4.2. Sanctions and consequences

A sanction can be defined as any negative consequence applied to an individual in response to undesirable or challenging behaviour. At Oliver House School and our residential homes, we believe that an approach based on the use of sanctions or aversive consequences in the management of behaviour would be both unethical and ineffective. Our emphasis is, therefore, on the development of person-centred, proactive, and positive support, based upon a comprehensive understanding of the individual's emotional, behavioural, and educational needs. A distinction must be made between sanctions and natural consequences. Natural consequences represent the outcomes, positive or negative, resulting from a person's actions. We recognise the importance of allowing children and young people in our care to experience the natural consequences of their behaviour. Natural

consequences provide a valuable learning experience, enabling the person to establish links between their actions and outcomes.

5. The use of restrictive interventions

5.1. Restrictive interventions

Restrictive interventions are defined as *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:*

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken*
- *end or reduce significantly the danger to the person or others*
- *contain or limit the person's freedom for no longer than is necessary'.*

Physical restraint

'*Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.*

Staff must not cause deliberate pain to a person when using any form of physical intervention. These techniques should only be used by trained staff and the safety and dignity of the individual should be paramount.

The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness.

5.2. The safe and ethical use of restrictive interventions

The legal and ethical principles that allow staff to use restrictive interventions as a last resort:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than necessary
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions should only ever be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.

Positive and Proactive Care: reducing the need for restrictive interventions;

The Department of Health

5.3. Duty of care

Staff at OHS and residential services are responsible for young people's health, safety and well-being. They have a legal and moral obligation to always act within their Duty of Care by taking "reasonable care to avoid acts or omissions which are reasonably likely to cause harm".

5.4. Planned and unplanned interventions

- Planned interventions

Where there is a known likelihood that restrictive interventions might need to be used, they should, so far as possible, be planned and recorded in a Behaviour Support Plan. These interventions should be coordinated and guided by the principles and practices of TEAM TEACH.

- Unplanned interventions

In response to unforeseen hazardous events in which there is no other alternative, members of staff retain their duty of care to the person in their care and have the legal power to use reasonable and proportionate force to ensure the safety of the person and others involved in the situation. The emergency intervention should remain within the framework of the law and acceptable levels of intervention.

5.5. Reducing Restrictive Practice

Where any restrictive interventions are included in the Behaviour Support Plan or Individual Risk Assessment they should be closely monitored and reviewed with the aim of reducing the use of restrictive practice by:

- frequency
- level of restriction
- duration

The Multidisciplinary Team at OHS provides ongoing support in developing alternative and less restrictive strategies for the young people in our care.

The PBS team completes the Restrictive Intervention Minimization Programme as a part of the implementation of the TEAM TEACH framework.

5.6. Health and safety

At OHS and residential services, we recognise that all restrictive interventions can pose risks to all involved. The risks vary from intervention to intervention and those who use restrictive interventions must understand the associated risks.

When using any physical intervention the health and safety of both staff and the young person is of the utmost importance. The following principles should be considered:

- avoid – physical contact entirely where possible
- deflect – contact and move away
- protect – vulnerable areas of the body
- stabilise – the situation and move away

The lead staff member must monitor the health and safety of the young person during and following a restrictive physical intervention. Staff should monitor:

- body alignment
- breathing
- ability to move

- noise/sound
- circulation.

Following the use of specific restrictive interventions, monitoring of the young person might be required for up to 48 hours after the incident.

5.7. Involvement of outside agencies

There may be occasions where the situation presents such a high level of risk that no direct intervention from staff is considered safe or appropriate. In such circumstances, it will be necessary to call outside agencies such as the police or an ambulance to safely resolve the situation.

6. Restrictive Physical Intervention

6.1. TEAM TEACH model

Oliver House School and associated children's homes follow TEAM TEACH positive behaviour handling model. TEAM TEACH is a whole setting, holistic, positive behaviour management approach, which emphasises that 95% of behaviour management is the employment of de-escalation techniques. It promotes strategies that emphasise team building, personal safety, communication, and verbal and non-verbal de-escalation techniques for dealing with challenging behaviour which reduce the need for physical intervention.

TEAM TEACH physical intervention techniques offer gradual and graded response to behaviours that challenge, to ensure that the minimum amount of reasonable and proportionate force is applied in a high risk situation for the minimum amount of time possible.

All Team Teach positive handling techniques have undergone a medical review carried out by independent medical experts, as required by the Institute of Conflict Management. They are also certified by the BILD ACT Association of Certified Training, complying with the Restraint Reduction Network Training Standards.

None of the physical intervention techniques rely on any type of pain or forcing of the joints in a direction or way that they would not normally move.

6.1. The use of Restrictive Physical Intervention (RPI)

Physical Intervention is principally used in situations where there is a clear, immediate threat by a young person to:

- harm themselves
- harm others
- cause serious damage to their environment
- place themselves in a situation of danger
- or when all other less restrictive interventions have been exhausted.

In some circumstances, because of the immediacy of danger or level of risk, it may be the only option available.

6.2. Authorisation of the use of RPI

All staff at OHS and associated children's homes have statutory power to use physical intervention if it is reasonable, proportionate, necessary and recorded. Those staff who may be required to use physical intervention require training on safe methods of positive handling.

7. Staffing Training

7.1. TEAM TEACH Training

Education and training are central to promoting and supporting good practice in our services. At OHS and associated residential homes, staff are trained in the TEAM TEACH approach.

Staff complete their training after appointment during their initial induction. All staff receive regular refreshers under the recommendations of TEAM TEACH. The organisation maintains an up-to-date record of the training that staff have received.

7.2. Training Needs Analysis

The content of TEAM TEACH training courses for staff at Oliver House School and residential services is informed and shaped by a regular audit of need. Training Needs Analysis considers a range of information arising from various sources such as incident recording, observations of learners, incident debriefs, staff meetings, lesson observations and learning walks. These audits inform training sessions that are rolled out across all staff teams or specific staff teams working with identified young people, ensuring that staff are able to respond with appropriate support strategies and interventions.

8. Recording & Reporting

All our services must record occasions where restrictive physical intervention is used, whether planned or unplanned. Information should be open and transparent and enable consideration to be given to the appropriateness of the use of restraint. Record keeping should be consistent with the expectations set out in the relevant regulations, guidance or standards. In children's homes, record keeping should be consistent with regulation 35 of the Children's Homes (England) Regulations 2015.

9. Post Incident Support

9.1. Debrief process

As soon as possible after the use of restrictive physical intervention, a young person and a member of staff involved should be given separate opportunities to reflect and talk about any issues raised by the incident. This should be undertaken by the line manager or other authorised person and recorded on a *'Debrief record'* form.

9.2. Debrief of a young person

- Debrief of an individual in our care must take place within 5 days from the incident.
- Any young person involved in the incident will need time to calm and self-regulate before they can continue with their usual routine.
- Due to the nature of their difficulties, some young people may struggle to engage in the debrief process; therefore, debrief process should be personalised to their level of need and ability, which should be specified within their Behaviour Support Plan. Young people with cognitive and/or communication impairments may need to be supported to access a debrief by the use of visual supports (symbols/cues), use of simplified language.
- For some young people due to the nature of their condition it may not be possible to successfully access a debrief; in which case staff must use observation to assess the indicators of young person's wellbeing and record their observations.
- On occasions, a young person may refuse to engage in a debrief. Staff should record their attempts and use observations to assess the young person's wellbeing.

9.3. Debrief of staff

De-brief of staff members must take place within 48 hours. There are different forms of debriefing that could be offered to staff after the use of restrictive physical intervention i.e.:

- time out in another area
- an opportunity to talk through the incident with a colleague staff team discussion
- an opportunity to talk through the incident with the line manager (e.g. phase leader, teacher)
- an opportunity to discuss the incident during the next supervision (residential staff)
- an opportunity to discuss the incident with a TEAM TEACH instructor

It is the staff responsibility to make sure that debriefing has taken place and to seek additional support after an incident.

9.4. Injuries

After an incident, the young person and the staff involved should be given emotional support and if required receive basic first aid for any injuries. If necessary, further medical advice and assistance should be sought. All injuries should be recorded in the 'Accident book' and reported as appropriate to the Health and Safety Executive.

9.5. Body maps

Body Maps should be used to document and illustrate visible signs of physical injury. Any concerns should be reported and recorded without delay and appropriate safeguarding procedures should be followed when necessary.

Staff should not attempt a thorough medical examination or diagnosis of the injury it is a record of what can be seen. Completing the Body Map should not replace getting a medical opinion and treatment whenever felt to be necessary.

10. Assessing & Managing Risks

Our services are guided by The Health and Safety at Work Act (1974) which '*places duties on employers and employees to work together to anticipate foreseeable risks and take reasonably practicable steps to reduce them'.*

At OHS and residential services, 'risk' refers to any circumstances, which could lead to adverse outcomes for the young person or others. Risks may arise in relation to a number of factors including the direct impact of behaviours presented by the young person. The impact of the risk to the individual, staff, others and the environment is assessed using the risk matrix.

The risk assessment actively looks for hazards and takes reasonably practicable steps to reduce the likelihood of people being hurt whilst also ensuring the progressive development of the individual in the least restrictive environment as possible.

Risk assessment is not risk avoidance, which would be deemed, as likely to restrict an individual's lifestyle and lead to an increase in behaviours.

Types of risk assessments at OHS and children's homes:

- Formal risk assessments – these assessments are prepared in advance, recorded and monitored on a regular basis.
- Dynamic risk assessments - these are carried out "in real time" in response to an unforeseen risk. The dynamic management of risk is about decision making and taking action to eliminate or reduce risk in the rapidly changing circumstances of an incident. The need for carrying out a dynamic risk should result in a review of the formal risk assessment.

11. Monitoring and Review

Each establishment maintains ongoing monitoring of all restrictive interventions. All incidents are recorded on the web-based system 'Engage'. Staff record a detailed description of the events, the behaviour displayed and strategies implemented including restrictive interventions if used, as well as action taken following the incident. A member of the PBS team or management team reviews the incident and provides written feedback including identifying further staff support or training that may be required. Staff are responsible for implementing actions included in the written feedback.

Gathered behavioural data allows monitoring and analysis of incidents, identifying triggers and behaviour patterns. This informs functional behavioural assessment and the development of an individualised support plan. It also allows monitoring of any changes in the behaviour pattern.

12. Working with families and other agencies

It is imperative that we work closely with parents or carers to evolve effective support strategies for our young people. Regular liaison and collaboration help to develop consistent approaches that enable the young person to generalise his/her skills and behaviours across a range of contexts. The school and residential services actively engage with other agencies and professionals where it is considered by the service and the parents or carers that this action is in the best interests of the learner.

Parents must be informed of any major incidents, of all agreed physical interventions that require monitoring and of any unplanned restrictive interventions. Parents should also be

immediately informed of any injuries. Agreement with families is needed in the frequency of informing parents of minor incidents.

13. Complaints

Parents, individuals and others who have been involved or witnessed any restrictive interventions being used have a right to complain about the actions taken by staff during the situation. If an allegation of abuse is made against a member of staff the service needs to follow the guidance set out in the Safeguarding Policy. Any other complaint should be dealt with under the Complaints Policy.

14. Links to other local policies and protocols

- Safeguarding Children Policy
- Safeguarding Adults
- Rewards and sanctions
- Sanction Guidance
- Health & Safety Policy
- MCA Deprivation of Liberty Safeguards
- Mental Capacity
- Complaints
- Complaints Procedure
- Communication with Parents

15. National guidance and regulations

- Positive and Proactive Care: Reducing the Need for Restrictive Interventions DoH 2014
- Positive and Proactive Workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in health and social care (Skills for Care & Skills for Health April 2014)
- Transforming Care: A national response to the Winterbourne View Hospital DoH 2012
- Mental Capacity Act 2005: Deprivation of Liberty Safeguards
- Health and Safety at Work Act: (1974)

- The Human Rights Act: (1998)
- The BILD Code of Practice (2014)
- The Health and Social Care Act: (2012)