**BEHAVIOUR MANAGEMENT POLICY**

This Policy defines the procedures to be followed when a child / young person is unduly aggressive, or offers unacceptable harassment and / or abuse, to staff or other children in the care of 1st Healthcare. This includes threat of violence and actual assault.

1. This Policy will address abuse, harassment, aggression and violence which can manifest itself in the following ways:
	1. Verbal abuse or threats.
	2. Physical aggression, which may or may not lead to actual violence, assault or attack.
	3. Sectarian abuse.
	4. Racial abuse or harassment.
	5. Sexual harassment, which in itself can take the forms of:

 ● Verbal harassment

 ● Actual assault

 ● Exposure to offensive material

1. Staff will be trained in the techniques for identifying the causes of abuse and violence and handling potential instances of abuse and violence from a child / young person. Such training will be recorded in the Staff Training Records. Primarily, this training will focus on the measures to be taken by staff to recognise possible “flashpoint” situations as potential causes of violence and to take the appropriate action before the situation deteriorates. The basis of this is to ensure that the original Baseline Assessment of the child’s needs clearly identifies potential risk areas. This must include knowledge of a child’s clinical and psychiatric history where, for example, a history of alcohol or drug abuse is identified.
2. The following are the principal causes of violence:

3.1 Inappropriate behaviour and attitudes by staff members.

3.2 Reactions and mood swings following a change in medication

3.3 Alcohol / drug abuse.

3.4 Incompatibility between staff and child, particularly with the keyworker; an inability to appreciate differences in personalities, interests, and also ethnicity and culture.

3.5 Being drawn into conversations that may have sectarian, political or sexual overtones.

3.6 An inability to communicate or articulate properly, leading to extreme frustration.

3.7 Impact of residential living - particularly just after admission to 1st Healthcare houses

3.8 Lack of information, or just plain boredom.

3.9 Perceived lack of privacy.

3.10 Infectious reception of other people’s aggression.

1. Where there is deemed to be a high risk of abuse, aggression or assault, an additional staff member may have to be drafted in for appropriate support duties for the child. If it becomes apparent that this may become the norm, the house management will initiate a complete review of the child’s case, if necessary, referring the matter to the Responsible Authority for action.
2. Each instance of abuse, aggression or assault will be recorded in the child’s Case Notes and reported to the Operations Manager who will decide upon appropriate action. In extreme cases, the operations manager will contact the Responsible Authority with a view to exercising the right to terminate the Contract for Residency altogether, in accordance with Policy No 18.
3. In the event of actual assault, where a staff member is obliged to physically restrain a child / young person, the Restraint Policy will apply. Staff will have received full training in the requirements of this Policy.
4. Each instance of violence or assault will be reviewed positively by the 1st Healthcare Management team and involve staff members to see whether or not the situation was exacerbated by an inappropriate staff action, and what could have been done to avoid it. This is intended to be a positive approach to remedial and corrective action requirements.
5. 1st Healthcare has recourse to Counselling Services for staff members who have been subjected to abuse, aggression, harassment or actual assault.

HANDLING CHALLENGING BEHAVIOUR - GENERAL POLICY

This Policy defines 1st Healthcare’s approach to handling and managing children / young persons (referred to as “service users” for the purposes of this Policy) who exhibit challenging behaviour. This Policy is divided into 3 sections as follows:

Section A: General information regarding challenging behaviour;

Section B: Managing challenging behaviour;

Section C: Prevention of challenging behaviour.

**Section A: GENERAL INFORMATION REGARDING CHALLENGING BEHAVIOUR:**

Definitions:

Challenging behaviour is most often exhibited by persons with developmental disabilities, dementia, psychosis and by children, although such behaviour can be displayed by any person. There are 2 types of challenging behaviour for which the following definitions apply:

* “Challenging behaviour” - culturally abnormal behaviour by individuals or groups, which causes others problems, and which significantly interferes with the quality of life of all concerned. In the Care Home scenario this will relate to challenging behaviour displayed by the service user towards care staff and / or family members, visitors etc.
* “Severely challenging behaviour” - challenging behaviour of such frequency, intensity or duration, that the physical safety of the person or others is likely to be placed in serious jeopardy, and which is likely to seriously limit or delay access to and use ordinary commhousey facilities.

Types of challenging behaviour:

Challenging behaviour can manifest itself in many forms and can depend upon many parameters. The more common types that the care worker may encounter are as follows:

* Aggressive behaviour towards others; i.e. spitting, screaming, hitting, kicking, biting.
* Self-harm; i.e. hitting self, head-banging, biting, skin picking.
* Destructive behaviour; i.e. ripping clothes, breaking windows, throwing objects; stealing.
* Inappropriate sexualised behaviour; i.e. groping, public masturbation.
* Other stereotyped behaviours; i.e. repetitive rocking, elective incontinence, running away; eating inedible objects.

Causes of challenging behaviour

Challenging behaviour can be caused by a number of factors. It is expected that the original Baseline Assessment of Needs conducted on the service user at the initial stages of service provision will highlight concerns in this respect and provide a basis for addressing these issues through the care services to be delivered. The following can contribute to challenging behaviour:

* Social factors - i.e. social isolation, reaction to change, boredom, seeking social interaction.
* Inadequate management of 1st Healthcare Care Service - i.e. insensitivity of the staff and / or services to the service user’s wishes and needs, incompatibility with the allocated Keyworker, both of which could trigger a latent reaction.
* Clinical factors - i.e. pain, medication, constipation, PMT.
* Environmental factors - i.e. physical aspects such as
noise and lighting, or prevention of access to preferred objects or activities.
* Psychological factors - i.e. stress, anxiety frustration, or feeling lonely, excluded, devalued, disempowered, or living up to people’s negative expectations.
* Mental illness - i.e. personality disorder, psychosis, imagines seeing things.
* Past environment or circumstances - i.e. home environment, sexual abuse,

institutionalisation,

* Learning disability or specific syndrome - i.e. autism, Asperger syndrome,

ADHD

* Communication skills - i.e. frustration at lack of ability to communicate.

Section B: MANAGING CHALLENGING BEHAVIOUR:

Since challenging behaviour can manifest itself for a number of reasons, the actual management of such behaviour can often be a complex process. For management purposes, challenging behaviour can be viewed as occurring in a cycle:

* Trigger
* Escalation
* Crisis
* Recovery

It follows that great emphasis should be placed on training staff to recognise possible “flashpoint” (trigger) situations and minimise any potential confrontations. In this way, handling challenging behaviour situations will be pro-active rather than reactive.

1. Staff Training

Staff will undergo specialist training to ensure awareness of the types, causes and effects of challenging behaviour, and to ensure that they are able to work pro-actively in a person-centred way to respond effectively to triggers, signs and symptoms of challenging behaviour. Staff training will be built into Induction programmes, and will be structured as a 3-stage strategy:

Stage 1: All staff should receive training appropriate to their needs in how to develop the skills and knowledge necessary to support service users with mental health disorders. Training should meet Learning Disability Advisory Framework requirements at Induction and Foundation levels.

Stage 2: More intensive training will be provided to care staff working with service users where the expected level of challenging behaviour is high. It will be tailored to meet the specific needs of the individual whose behaviour has been identified as challenging. The basis for the provision of this training will be the original Baseline Assessment of Needs leading to the service user’s Care Plan.

Stage 3: Training will address the management of complex situations, including the use of physical intervention in line with the British Institute of Learning Disabilities’ Code of Practice.

1. Duty of Care to Staff:

1st Healthcare acknowledges its responsibilities under the Health & Safety at Work Act, 1974 and the Management of Health & Safety at Work Regulations, 1999. This legislation places a duty upon 1st Healthcare as an employer to conduct appropriate and adequate assessments of risk to the health and safety of employees (care staff) while they are at work.

Detailed assessments of a service user’s needs and wants prior to starting service delivery.

In this way adverse clinical conditions such as challenging behaviour can be identified and the service user’s Care Plan developed accordingly to address these issues as far as possible.

1. Baseline Assessment of Needs before Admission

A detailed needs assessment of a service user is undertaken prior to admission to 1st Healthcare houses. This will form the basis of the service user’s Care Plan and it is at this point that careful consideration will need to be given to any aspect of the managing of challenging behaviour. It is the responsibility of 1st Healthcare Management to determine whether the designated houses is able to meet the specific needs of the prospective service user. In this respect, the following will be considered:

3.1. Whether the stated Aims and Objectives of 1st Healthcare are applicable to this service user.

3.2. Whether 1st Healthcare can meet the service user’s developmental, care and support requirements.

3.3. Whether there are adequate levels of staff support to meet the service user’s needs; for example, “doubling up” in high risk situations.

3.4. Whether staff have the skills and experience necessary to deliver the required service.

3.5. Where the Assessment of Needs have identified that physical intervention may be required, a service user risk assessment must be conducted to identify the benefits and risks associated with different intervention strategies and ways of supporting the service user.

1. Specific Recommendations

The action that can be taken to manage the escalation, crisis and recovery stages of challenging behaviour can vary widely, depending upon the type and intensity of the behaviour; i.e. challenging or severely challenging behaviour. The service user’s Care Plan will often involve specialised professionals or outside agencies who may contribute to the Care Plan. 1st Healthcare Management should consider the following recommendations for reducing incidences of challenging behaviour to a manageable level for individual service users, as appropriate to circumstances. This can involve input from outside agencies or health professionals, as relevant:

4.1. Increased emphasis on all areas of health promotion for service users with mental health disorders.

4.2. Recognising that health and medical conditions can be a contributory cause to challenging behaviour and organising regular health screening for service user’s with mental health disorders.

4.3. Equal access to treatment for diagnosed medical and psychiatric conditions.

4.4. Cautious prescribing of psychotropic medication

4.5. Speech and language therapy interventions should include communication skills to help individuals identify pain and illness and communicate this to others.

4.6. Active involvement from 1st Healthcare’ senior staff that ensures the care staff are valued, supported and adequately monitored to provide best practice at all times. For specific job positions this should start at the interview stage to ensure candidates are clear about the job requirements and expectations, and promote the selection of staff who are truly committed to providing the highest standards of care.

Section C: PREVENTION OF CHALLENGING BEHAVIOUR

When managing challenging behaviour, a care staff member’s first priority is to prevent a challenging situation from either occurring or worsening. There are 3 basic principles involved in preventing challenging behaviour:

* Reviewing a service user’s general life situation and environment;
* Acting to de-fuse a challenging situation at its earliest stage;
* Managing one’s own behaviour appropriately.
1. Service user’s life situation and environment:
	1. Care staff must be sensitive to the environment in which a service user with challenging behaviour lives, and how best to provide an environment that offers the greatest possible control for the service user.
	2. Care staff must be sensitive to the need for a service user with challenging behaviour to communicate their needs and feelings in all aspects of their life.
	3. Care staff must be sensitive to the need to maintain a balance when considering a service user’s general lifestyle, particularly in the areas of social contact and task requirements. Too much stimulation can prove as counterproductive as too little.

1. De-fusing a challenging situation

Prevention of challenging behaviour should begin at the initial stages, i.e. ensuring effective needs assessment, care planning for the service user, and thorough risk assessments. However, in the event of a challenging situation occurring care staff should employ the following techniques or approaches as appropriate to the situation. These techniques must be identified and agreed at the care planning stage:

* 1. Talk calmly to the service user - try and find out what the service user is thinking or feeling, or whether he / she is upset, hurt, annoyed or in pain. Try and find out what triggered the behaviour.
	2. Comfort the service user - if upset, try and comfort the service user verbally and, if appropriate, by gentle physical contact. It is vital that touching is not interpreted as an invasion of space; some people hate being touched and may react adversely.
	3. Ignore the behaviour, but not the person - treat the service user as if the behaviour is not occurring, though there is a risk that this may trigger an escalation of challenging behaviour if the service user feels that he / she is being ignored.
	4. Interrupting and deflecting - try and get the service user to focus upon another person or situation.
	5. Rewarding positive behaviour - reward any positive behaviour that the service user may be showing with praise or attention.
	6. Allow the service user time - access to a quiet place and giving the service user some time to recover themselves can be helpful.
	7. Use the physical environment - ensure that type and layout of furniture and space enhances positive behaviours; i.e. not too cluttered or too sparse. If the service user is being aggressive, and if it is safe to do so, place a table or chair to act as a natural barrier.
	8. Monitor other’s behaviour - challenging situations often happen in the presence of others. It must be ensured that they do not inadvertently make a challenging situation worse, and they must be managed accordingly.

3. Managing your own behaviour

How the care worker appears and behaves are key factors in preventing the onset and escalation of challenging behaviour. The care worker should be aware of himself / herself and be in control at all times. When faced with a challenging situation the care worker should try to:

* acknowledge personal prejudices, emotions and feelings;
* appear calm and confident;
* be aware of not being arrogant, aggressive or challenging;
* consider the causes of previous episodes of challenging behaviour;
* move slowly and purposely;
* keep proper space and distance;
* identify a safe exit;
* speak clearly and calmly;
* remain relaxed and maintain normal breathing;
* maintain eye contact but do not stare or show anger.

HANDLING CHALLENGING BEHAVIOUR - THE USE OF PHYSICAL INTERVENTION

This Policy defines 1st Healthcare’ philosophy towards the use physical intervention by care staff in situations of challenging behaviour. For the purposes of this Policy children / young persons are referred to as “service users”.

A: BACKGROUND:

1. Here we address the concept of challenging behaviour and how it may be managed, depending upon the circumstances. In exceptional circumstances a service user may display an episode of challenging behaviour which requires physical intervention in order to prevent harm or injury to the service user, or to others. The need for possible physical intervention will have been identified at the Baseline Assessment of Needs stage for the service user and integrated into the service user’s unique Personal Care Plan as an agreed strategy should circumstances require it. This will justify, and support the need for, physical intervention.
2. Physical intervention is defined as the use of force to restrict or restrain movement or mobility, or the use of force to disengage from harmful or dangerous physical contact initiated by a service user. Physical intervention involves the application of the minimum degree of force necessary to prevent injury or serious damage to property.

B: THE USE OF PHYSICAL INTERVENTION:

1. Guidelines:
	1. Physical intervention should always be used as a last resort, except where the service user, staff or others are in immediate and serious physical danger
	2. At all times, the least restrictive procedure must be used, with the minimum of force for the shortest period of time.
	3. Physical intervention must be used in such a way that maintains the dignity of the service user, staff and others as far as possible.
	4. The application of physical intervention must take into account the service user’s physical characteristics, behaviour and location.
2. Planned Physical Intervention:

This is where care staff employ pre-arranged and agreed strategies and methods, and will differ from the measures taken to address emergency or unplanned physical intervention. Planned interventions must be developed as follows:

* 1. They must be agreed in advance by a multi-disciplinary team working
	in consultation with the service user, family members or advocate (as appropriate), their carers and, in the case of a child, those with parental responsibility.
	2. They must be recorded in writing so that the method of physical intervention, and the circumstances under which it is sanctioned for use, are clearly understood by all persons. The strategies for planned physical intervention will be fully documented in the form of authorised instructions and written records that includes the following:
* The names and responsibilities of those persons present at the planning meeting
* Description of the behaviour sequences and settings that may require physical intervention;
* The results of an assessment that determines any alternative actions to the use of physical intervention;
* Details of previous techniques that have been tried without success.
* A Risk Assessment that balances the use of physical intervention against the risks involved in not using physical intervention.
* A description of the specific physical intervention techniques that may be used.
* A record of which care staff are authorised and who are deemed competent to use these techniques with the service user.
* Procedures for reviewing this approach, the frequency with which reviews are carried out, and members of the review team. An up-to-date authorised copy of these instructions will be included as part of the service user’s Care Plan.
	1. They must be implemented under the supervision of an identified member of staff who has appropriate qualifications and experience.
1. Emergency or Unplanned Physical Intervention:

This is where physical intervention is used without there being an explicitly agreed plan permitting its use. It should be very rare for care staff to have to physically intervene in unplanned situations, since care managers will normally be aware of the possible need for intervention and have contingency plans in place accordingly.

1. Correct use of Physical Intervention

When care staff are obliged to physically intervene with a service user they will be required to work within the following guidelines:

* Wherever possible, hold the service user’s clothing and not the service user.
* Use deflection and re-direction over continuous contact with the service user.
* Do not inflict pain on the service user to gain control or to inflict punishment.
* Always ensure that the service user’s airways are kept clear.
* Consider the size, height and weight relevant to the individual.
* Consider the behaviour of the individual and others.
* Consider the environment - the location and context of the situation.
* Consider professional ethics and be mindful of the law.
* A written record of the incident must be recorded in a dedicated bound and numbered book within 24 hours of the incident. This record must include the following:
	+ name of the service user;
	+ date, time and location;
* details of the behaviour requiring use of restraint;
* details of the type of physical intervention used;
* duration of the restraint;
* names of the staff member(s) using restraint;
* names of other persons present;
* effectiveness and consequences of restraint;
* signature of the authorised person (authorised by the registered person).
1. Unacceptable forms of Physical Restraint on Mobility and Movement

The following are UNACCEPTABLE techniques for applying physical intervention or restraint to a service user, and must NOT be used under any circumstances:

5.1. The tying of a service user’s arms / legs to furniture such as chairs or a bed.

5.2. Positioning furniture so that it becomes impossible for the service user to move or rise.

5.3 Tilting a chair back, or using a low sitting position, so that the service user is immobilised.

5.4. Using sleeping bags or bean-bags to restrict movement.

5.5. Tucking bedclothes in tightly such that movement is restricted.

5.6. Inappropriate use of cot sides / bed rails on beds to restrict movements.

5.7 Unjustifiably locking doors or locking the service user in a room to restrict movement.

5.8. Failing to provide reasonable assistance to a service user that results in them unjustifiably being left in bed or placed in bed early.

5.9. Removing mobility aids or placing them out of reach of the service user.

5.10. Inappropriate use / administration of drugs outside the service user’s prescribed medication regime.

5.11. Inappropriate use of listening devices and video cameras.

5.12. Using threats or threatening language that undermines the service user with the intention of restricting his / her movement.

5.13. Coercive use of emotional or social punishment.