Person Centred
Positive Behaviour Support

Currajong Disability Services Inc.

and

The Westhaven Association

NDIS Transition Fund Project 2014

CURRAJONG
DISABILITY SERVICES INC.

Positive behaviour support places an emphasis on responsiveness to a person's feelings and needs, and the right for their dignity and respect to be upheld as any other member of the community.

Education and training helps staff to build a better understanding of a person's behaviour support needs.

Currajong Disability Services is a not-for-profit community based organisation servicing Parkes, Forbes and Condobolin and surrounding areas within Central West NSW. CDS provides a diverse range of specialist disability services designed to sustain and enhance independence and quality of life for people with mixed abilities.

The sector is undergoing significant change from a funding, regulatory and policy perspective having to adapt existing service models to a market-based system as a result of the introduction of the NDIS.

The Department of Family and Community Services agency Ageing Disability and Home Care (ADHC) will no longer provide direct supports by the time the full transition to the NDIS is completed in June 2018. Of particular concern to CDS is no longer having access to ADHC behaviour specialists and other clinicians for advice and guidance when developing and approving positive behaviour support plans.

CDS recognises the significant impact that such changes will have on its future capacity to support people with complex needs and as a result has collaborated with Westhaven Association, Dubbo to access a range of measures for up-skilling front-line staff teams and creating opportunities to share access to clinicians, training, resources, mentoring and networking activities.

Staff who are valued and empowered to learn new skills, make decisions, be creative are more likely to be able to provide care and support from a person centred approach. Staff thrive on making a difference and being recognised for achievements. The challenge for each staff member at CDS is to learn from their experiences and adjust to changing circumstances to ensure that the people we support reach their goals and improve their outcomes.

To assist in our preparation for supporting an increased number of people with complex behaviour support needs, we have partnered with Westhaven Association Behaviour Specialist team under a mentoring arrangement and developed the CDS positive behaviour support policy and practice manual. This manual provides support and guidance to smaller organisations that do not have access to in-house behaviour specialists and will no longer be able to call on the services of ADHC specialist staff.

CDS and Westhaven would like to acknowledge funding received from NDS, under the 2014 NSW Organisation Transition Fund to ensure staff have the skills and knowledge to work with people with significant and complex support needs, share resources, and build mentoring and networking opportunities within the region.

Currajong Disability Services
Positive Behaviour Support Policy Document – July 2015

1 POLICY BACKGROUND.

Currajong Disability Services (CDS) is a locally based not-for-profit incorporated association, providing services in the Parkes, Forbes and Condobolin areas. CDS is a professional specialist disability service offering high quality programs and support services designed to sustain a person's independence and quality of life.

All services provided at CDS are person-centred, and designed in consultation with the person. Individuals are encouraged and supported in service planning, to ensure their rights and personal opinions and values are respected.

It is within this framework of person-centred planning, that all behaviour support is provided. The guiding principles of person-centred planning are outlined as follows (*further details in **CDS Person Centred Planning Policy***): -

1. The Person is at the centre of planning.
2. The Inclusion of other family members, supporters and other appropriate service providers is always actively supported.
3. The personal goals and strengths of the person will be the focus of planning and service provision design.
4. Plans developed will always be subject to a program of regular ongoing monitoring and reviews.
5. Supports are provided to each person to ensure they have access to best practice information and choices. Staff supporting each person are supported in a similar way with appropriate training.

1.1 Legislative Matters:

The NSW Disability Inclusion Act 2014 (NSW) provides the legislative basis for the provision of services to people with a disability in NSW.

The United Nations Convention on the Rights of Persons with Disabilities (2006), ensures protections for all persons with disability.

The NSW Disability Services Standards – Updated (April 2014), provides a set of six standards that all disability service providers must meet.

NSW Family & Community Services – Ageing Disability & Home Care Policy & Procedures;

- Positive Approaches to Behaviour Support (PABS) – via the Practice Improvement Framework (Jan 2015)
- Behaviour Support Policy (Revised March 2012)
- Behaviour Support: Policy & Practice Manual – Part 1 & 2 (Jan. 2009)

1.2 Support Systems:

CDS has in a place a range of systems that provide support to all persons who may be required to implement behaviour support and intervention plans. These support systems include: -

- CDS Orientation & Induction process

- CDS Policies & Procedures Manual
- CDS Staff Training Schedule
- CDS Staff &Team Meeting Procedures
- CDS Staff Supervision & Performance Review Procedures.
- CDS Staff Grievances Procedures.

CDS also has in place a range of systems to support the long term sustainability and quality of our services to people. These systems include: -

- Person Centred Support Plans.
- Positive Behaviour Support Plans
- Alternative Communication systems, e.g. Picture symbols, iPads.
- Access Agreements to outside Behaviour Support Specialists.

1.3 Person Centred Planning:

CDS promotes the development of services which are person-centred and outcomes –focussed. In this practice, the person is always at the centre of service delivery. This means that CDS staff will work hard to ensure the person's lifestyle, skills, relationships, preferences, aspirations and other significant features are incorporated into their plans.

Behaviour support will always be provided in appropriate, respectful and meaningful ways, within the person's whole-of-life framework. By focussing on outcomes, supports developed by CDS will be able to be adjusted in line with the person's changing needs.

1.4 Positive Approaches to Behaviour Support (PABS):

CDS promotes a positive approach to behaviour support. This means our services are based on a comprehensive assessment and analysis of the meaning and function of a behaviour within the person's whole-of-life context.

The goal of Positive Approaches to Behaviour Support is not just reducing specific behaviours; this approach recognises that "problem behaviours" often result from our failure to provide tailored and comprehensive skilled support. The reduction of the behaviour is mainly achieved by creating a responsive environment and building new skills, rather than simply "stopping" the person doing it. Usually more than one type of intervention is needed. It aims to support the person to achieve and maintain a quality of life, and to build skills and understanding among the support staff.

The eight Principles and Themes of Positive Approaches to Behaviour Support are outlined in the ***"Premier Practice Improvement Framework v4.0 Participant Workshop Handbook"*** *pp14-15.*

1.5 Restrictive Practices:

CDS is committed to the principle of always using the *least restrictive alternative* when selecting behaviour support interventions. This means that we select options that are the least intrusive and least disruptive of a person's life, and that represent the minimal change from a normal pattern of living.

CDS is aware that some behaviour intervention strategies have the potential to restrict or remove a person's normal freedoms. These will only be considered under exceptional circumstances. CDS also understand that certain practices are defined as "Restricted Practices". These require specific forms of consent, authorisation and monitoring, as per the *Restricted Practices Guidelines* set out in the ***Positive Behaviour Support Procedures Manual (PBSPM).***

2 UNDERSTANDING THE PERSON TO BE SUPPORTED.

When an issue arises about a person's behaviour, staff at CDS understand their first response is to review the current understanding of that person. It is recognised that all behaviours are attempts by people to communicate. People with disabilities often have difficulties communicating their needs. The resulting frustration will often lead to what others see as problem behaviours. Thus support staff have the primary responsibility to try to properly understand the purpose or function of that person's behaviour.

2.1 Behaviours of Concern & Risk:

In the past, a range of terms have been applied to the behaviours that are the subject of specific Behaviour Policies. At CDS we support the use of the term "Behaviours of Concern". We use this term because it reminds us that we have the concern, and we need to respond appropriately to support the person. We understand a "Behaviour of Concern" as per the following definition: -

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Any behaviour that is a barrier to a person participating in and contributing to their community (including both active and passive behaviours) and that undermines, directly or indirectly, a person's rights, dignity or quality of life, and poses a risk to the health and safety of a person and those with whom they live and work.

(Budiselik, M. et.al, 2010. in "Evidence based psychological interventions that reduce the need for restrictive practices in the disability sector. A practice guide for psychologists", Australian Psychological Society, Melbourne.)

The above definition helps us as service providers, to make an important distinction in our work. The use of the word "risk" reminds us that there is a distinct process for assessing and managing risk. That process is separate to the process of assessing a behaviour of concern and providing appropriate supports for that behaviour. This Behaviour Support Policy deals only with that second distinction, not the issue of risk. Processes related to **risk** are explained in: -

- CDS Workplace Health & Safety Policy
- CDS Client Risk Management Policy

CDS staff understand that when a person's behaviours of concern are being dealt with under "Risk Management" guidelines, that this process alone will not meet our Behaviour Support requirements. All persons with identified behaviours of concern, need to have those behaviours reviewed in their whole-of-life context. To do this, CDS staff need to develop a comprehensive Positive Behaviour Support Plan.

2.2 Ensuring a Positive Lifestyle & Supportive Environment:

Every person we support at CDS will need a comprehensive and individualised framework of support. An appropriate framework is one that will allow each person to function with confidence. To develop the best framework of support, we will match the supports with the person's assessed needs and profile.

To assist staff to develop the best profile for each person, a range of tools are available and will be selected from and used as appropriate. Tools available include: -

- Lifestyle & Environment Review, & Action Plan (LER)
- Lifestyle Management Plans (LMP)
- Quality of Life Domains & Indicators (QoL)

3 UNDERSTANDING THE PERSON'S BEHAVIOUR OF CONCERN.

Because we understand that all behaviours represent a communication function for that person, we cannot simply plan to eliminate or minimise it.

Best practice here at CDS requires us to firstly work to understand the function of each behaviour in the life of the person. This understanding will need to include medical, psychological, behavioural, social and historical perspectives.

3.1 The Positive Approach to Behaviour Support (PABS):

This process of Positive Approaches to Behaviour Support has been referred to earlier under 1.4 in this Policy. Here we refer to it again to remind us who work at CDS supporting people with behaviours of concern. Positive Approaches to Behaviour Support is the fundamental process we follow in trying to gain a comprehensive understanding of the behaviour of a person.

The Positive Approaches to Behaviour Support approach incudes the stages of Assessment, Plan Development, Plan Implementation and Plan Monitoring & Review. Our approach to developing behaviour supports relies on us having an understanding and practice, that sees the inter-connectedness between the person and their personal, physical and social environments.

3.2 The Process of Assessment of the Behaviour of Concern:

When an issue is raised about a person and their behaviour of concern, our first response at CDS is to review and address any possible support deficiencies. This means we will have acted in accordance with 2.2 of this Policy, Ensuring a Positive Lifestyle and Supportive Environment. Sometimes our response to these issues will not result in the elimination or minimisation of the behaviour. At this point CDS will initiate the development of more formal and intensive strategies of support.

Our first step in developing these more formal strategies of support, will be to carry out a thorough assessment. This assessment process will involve the gathering of relevant data. Data collection forms can include tick charts, ABC charts, incident reports and daily observation notes. Data Forms currently used by CDS are found in the ***Positive Behaviour Support Procedures Manual (PBSPM).***

Once sufficient data has been collected, staff will then work together to analyse the information. The aim of this Functional Analysis will be to determine the possible function and circumstances of the behaviour. This view on the function of the behaviour will then form the basis for developing the initial Positive Behaviour Support Plan.

4 PLANNING BEHAVIOUR SUPPORT FOR THE PERSON.

In line with matters referred to earlier in this Policy, CDS will plan behaviour support strategies with a whole-of-life focus. Strategies planned will not just focus on reducing the behaviours of concern, but also on ways to enhance the person's quality of life. At CDS, we have identified only one situation where this practice can be varied. This is when a person with no known history of behaviours of concern, suddenly initiates such a behaviour. In this circumstance, staff involved can immediately develop some Reactive Strategies as per that section of the ***Positive Behaviour Support Plan (PBSP)***. This information will be known as an ***Interim Incident Response Plan***, and must be

authorised as per the Positive Behaviour Support Plan (PBSP). This interim period will not exceed 3 months. Once the behaviour of concern is manageable, staff will then follow the process of developing the full Positive Behaviour Support Plan (PBSP).

4.1 Goal Setting in the Context of Quality of Life:

To ensure we develop appropriate goals for our behaviour support plans, we will first review the person and their behaviour in the context of the Quality of Life Domains. We will seek to identify which of those domains are most affected by the person's behaviour of concern. This will give us a framework in which we can then develop specific individual goals.

In developing our goals for the behaviour strategies, we will have two primary concerns. First, the goals must be written in observable and measurable terms.

Second, the goals must specify the conditions and criteria for performance that will reflect the normal independent behaviour expected. All goals we set will be subject to the ***SMART*** Check.

4.2 Developing a Multi-Element Support Plan:

At CDS, we understand that the most effective behaviour plans are those built around a number of multi-elements or domains of the person's life.

Our Positive Behaviour Support Plan (PBSP) document provides for a focus on both Proactive (Preventative) and Reactive (Responsive) strategies. It also identifies four multi-elements or domains to be reviewed; i.e. Ecological Supports, Positive Interventions, Focussed Interventions & Incident Responses.

Our Positive Behaviour Support Plan (PBSP) documents will outline strategies that are designed to give the appropriate level of behaviour support according to the person's needs. Each strategy will be clearly linked to the gaol-statements as defined under 4.1 of this Policy. In addition, all strategies will reflect the broad guidelines and issues recorded in the person's ***Individual Service Plan/Agreement*** with CDS.

Reactive Strategies will also be developed, so support staff and the person all know what is to happen when a behaviour of concern is exhibited. The primary object of these strategies is to avoid any escalation of the behaviour, and to stop or minimise it as soon as possible. These reactive strategies will match behaviours with identified staff responses. The following information will be documented under the Reactive Strategies section of the Positive Behaviour Support Plan (PBSP): -

1. An explanation for the strategies in the plan.
2. Specific preventative measures.
3. Incident response strategies linked to specific behaviours within the incident cycle.
4. Post incident measures and procedures.

Restricted Practices may on occasions need to be included in a Positive Behaviour Support Plan or IPRP. These practices are identified in the ADHC Document ***"Behaviour Support: Policy & Practice Manual (OSP 2009)***. These practices will only be used when the prescribed authorisation and consents are given. These practices are: Exclusionary time-out, Physical restraint, Psychotropic medication on *prn* basis, Response Cost, Restricted access and Seclusion for person's 18 years and over.

At CDS we have a *Restricted Practice Authorisation Process*, which is detailed in the ***Positive Behaviour Support Procedures Manual (PBSPM.*** Before agreeing to use any Restricted Practice, CDS will consult with an identified Behaviour Support Practitioner for additional advice. We will always

seek to identify the least restrictive strategy that is likely to achieve the planned outcome. We also understand that there are a range of practices that are classified as Prohibited Practices. We will never use these as they are illegal. Examples include Aversion, Over-correction, Chemical restraint and Seclusion of children/young people under 18years.

5 MAKING THE POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) WORK FOR THE PERSON.

We understand the development of a Positive Behaviour Support Plan (PBSP) is only one step in a continuous process. At CDS we are committed to managing the implementation, monitoring and review of every Positive Behaviour Support Plan (PBSP). We do this so we can respond positively when people and situations change, and aspects of the Positive Behaviour Support Plan (PBSP) need to be adjusted.

When a Positive Behaviour Support Plan (PBSP) is completed, it will be checked by appropriately trained staff to ensure it meets the basic clinical guidelines. "Appropriately trained" means a staff person who has completed at least the PPIF On-line Training Module, or who has Quality Management skills. Our current Positive Behaviour Support Plan Clinical Guidelines Checklist will be found in the Positive Behaviour Support Procedures Manual (PBSPM).

5.1 Implementing the Positive Behaviour Support Plan (PBSP):

At CDS, we understand that the implementation phase of a Positive Behaviour Support Plan (PBSP) is very critical to the success of the entire Plan. To this end we will provide appropriate support and training to all people involved in implementing the Positive Behaviour Support Plan (PBSP). This training and support will aim to achieve two outcomes. One, that each implementer person implements the Plan in the same way. Two, that each implementer person understands the importance of consistency as a guiding principle.

To ensure the quality and maintenance of the implementation of a Positive Behaviour Support Plan (PBSP), CDS will identify a staff member to be the Co-ordinator person for the implementation of a Positive Behaviour Support Plan (PBSP). This Co-ordinator will work with all implementers

to identify deficiencies in skill levels, commitment and understanding. They will then inform the Manager of the appropriate support and training needed.

The training and support provided will acknowledge that all Implementers need to see and understand the following aspects of the Positive Behaviour Support Plan (PBSP);

1. That it is practical & "doable".
2. That it is desirable.
3. That it is a good fit in the situation.
4. It is in the person's best interest.
5. It is improving the person's quality of life.

Some practical ways we will help implementers at CDS will include: -

- Using specific, individualised *Action Plans.* Current samples of these can be found in the Positive Behaviour Support Procedures Manual (PBSPM).
- Providing both specific and generic Behaviour Support training opportunities.
- Using some form of "*Reliability Testing".* (see Positive Behaviour Support Procedures Manual (PBSPM).

CDS supports and values the input of all involved persons into the planning and implementation of any Behaviour Support Plan. Behaviour support is understood by us to be a core part of the support we are required to provide to all persons receiving our services. We also acknowledge that formal Behaviour Plans require us to work within clinical guidelines. To this end, any changes to a Positive Behaviour Support Plan (PBSP)and its Implementation processes can only occur in accordance with the guidelines set out in each Positive Behaviour Support Plan (PBSP). This is to ensure the Plans are given a realistic opportunity to be implemented, and their overall goals and focus are not compromised.

Positive Behaviour Support Plan (PBSP) developed by CDS will always be implemented initially on trial basis. This trial period will be specified in the Positive Behaviour Support Plan (PBSP), and will generally be for a 2-3-week period. All staff involved and the Coordinator person will work closely with one another and the person during this time. Any adjustments identified will be made at the end of the trail. The adjusted Positive Behaviour Support Plan (PBSP) will then be implemented until the scheduled review occurs. This is to ensure maximum consistency in our support to the person.

5.2 Monitoring the Positive Behaviour Support Plan (PBSP):

All Positive Behaviour Support Plans (PBSP) at CDS will have specified ways of monitoring their effectiveness. The monitoring requirements specified in a Positive Behaviour Support Plan (PBSP) are always regarded as a compulsory part of the daily work requirements of staff involved with that person.

Monitoring will include consideration of areas such as the person's context or environment, practical constraints, resource limitations, and other factors that may impact on the implementation of the Plan, or the person. Information recorded through the monitoring processes will always form the basis for any decision making regarding changes to the Plan.

Monitoring at CDS will include a review of documents such as: -

- Incidents Reports
- Restricted Practice Reports
- Individual program feedback sheets
- Team meeting minutes
- Other specific data collection forms
- Clinical reports

5.3 Reviewing the Positive Behaviour Support Plan (PBSP):

The purpose of our Review process is to allow us to make affective decisions about the Positive Behaviour Support Plan (PBSP). This will enable us to check that the person's goals set out in the Plan are being supported by the behaviour strategies.

We view our Positive Behaviour Support Plans (PBSP) as documents that will need to change over time, to enable us to maintain appropriate support to the person. Review periods will be set out in the Positive Behaviour Support Plan (PBSP), initially being short time periods (1-2weeks), then extending as the Positive Behaviour Support Plan (PBSP) is assessed as having a positive impact.

In this Review process, all data and reports gathered as part of the Monitoring requirements will be looked at. Staff involved in implementing the Positive Behaviour Support Plan (PBSP), plus the Coordinator and other persons identified in the person's Individual Service Plan/Agreement will be invited to join this process. Whenever this group of people have difficulty making decisions, then

CDS will request input from a Behaviour Support Specialist. New ideas and new information that might impact on a Positive Behaviour Support Plan (PBSP) are always welcome by CDS, and will be included in the next review process.

The outcome of each Review will be clearly documented. Outcomes will be one of three types; The Positive Behaviour Support Plan (PBSP) is positive and will continue, or, Goals are achieved and Closure will occur, or, no progress and Plan will be suspended whilst changes are made. Closure in this context means that the person's goals in the Positive Behaviour Support Plan (PBSP) have been achieved and the person is no longer identified as having behaviours of concern. At this point the Positive Behaviour Support Plan (PBSP) ceases, and support for that person continues under their ISP/A guidelines.

6 WHEN THE PERSON NEEDS EXTRA SUPPORT.

CDS understand there may be occasions when a person's behaviours of concern are of such intensity and severity, that additional support will be needed from outside our agency.

6.1 The Support Capacity of CDS:

CDS is a non-government disability agency that provides a range of services to people with disabilities. CDS does not provide a specialist Behaviour Support Service. This means that at CDS, our capacity to support people with significant behaviours of concern, is limited.

The level of knowledge and skill regarding behaviour support at CDS is supported at a basic level through the following processes: -

- CDS Orientation & Induction Process.
- CDS Behaviour Support Policy.
- Minimum staff Qualification is Certificate IV in Disability – this course includes units on Behaviour management.
- Selected staff will complete the "Premier Practice Improvement Framework"
- Online learning module provided by ADHC (June 2014)
- CDS will support selected staff to attend specific behaviour related courses, as provided by outside providers.
- Team Meetings will have time allotted to behaviour management issues.
- Training will be provided to assist staff to reflect on their personal capacity and readiness to support people with behaviours of concern.

6.2 Behaviour Support Specialists:

As noted above, CDS does not offer a specialist Behaviour Support Service. Therefore, we do not employ people as Behaviour Support specialists.

Consequently, CDS has developed an agreement with another disability NGO which does employ a Behaviour Support specialist. This person is available upon request, to provide clinical input at any stage of our PBSP process. Details of *Accessing the External Behaviour Support Specialist,* can be found in our Positive Behaviour Support Procedures Manual (PBSPM)**.**

In addition, CDS may consult with families and recommend a referral to a Specialist Behaviour Support Clinic and or a Consultant Clinical Psychologist or Psychiatrist. CDS will maintain a register of such specialist services. Entries onto this register will be subject to a recommendation by ADHC/FACS or by another reputable NGO or by another family of our service.

Input sought from these Behaviour Support Specialists, must always be in the context of the persons' ISP & PBSP as supplied by CDS. This is to ensure that all clinical advice can be accommodated within the environment and resources of CDS. If CDS are required to implement the advice, then it must fit within the framework of this Policy.

6.3 Other Support Specialists:

CDS understands that a range of other Allied Health specialists may be available for consultation regarding particular people, their needs and their environments. These specialists will include, Physiotherapists, Occupational Therapists, Speech Pathologists and Mental Health workers.

These allied health workers will be sourced either through local Health Department Community facilities, or through specialist disability NGOs or through recommended registered private providers. As with the Behaviour Support specialists, these Allied Health staff would provide their input only within the framework of this Policy.

PROCEDURES

The CDS Behaviour Policy aims to ensure all direct care staff, integrate positive person-centred behaviour support into their everyday interactions with clients.

1. The Positive Behaviour Support Procedures guide staff through a sequence of 21 Questions which includes direction to an appropriate response for an observed behaviour of concern.

    a. For example, whenever any staff person observes a Behaviour of Concern, the staff person can begin at Question 1 and work through the question sequence as far as necessary.

2. For each Question, a set of Actions are identified, and these inform the staff person of what must occur before making a response of Yes or No to the Question.

3. Actions may include reading or reviewing attached information sheets, and completing attached forms.

4. In addition, each Action advises of the appropriate staff person to perform that Action, and a recommended timeframe for completion.

5. By following this set sequence of questions, staff will ensure that they always begin with positive behaviour support options. They will also be minimising the need to introduce formal Positive Behaviour Support Plans and Reactive Strategies.

6. The following pages consist of the 21 Procedural Questions.

CURRAJONG DISABILITY SERVICES INC.

QUESTION 1. DOES THIS PERSON HAVE A BEHAVIOUR OF CONCERN (BOC)?

Policy Ref: 2.1 Behaviours of Concern

To Answer YES to this question you must have: -

⇒ Followed the Actions listed below: -

Action	Who	Timeframe
Write down, in one or two sentences, a description of the person's concerning behaviours.	Concerned Support Worker (CSW) / Customer Service Advisor	Immediately
Share this description with other experienced staff and your Team Leader. Are they concerned?	Other experienced Care Staff & Leader	ASAP
Read the Policy Definition of a Behaviour of Concern	Concerned Support Worker (CSW)	ASAP
Read the attached notes from the PPIF Manual, p.20.- following	Concerned Support Worker (CSW)	ASAP
Then answer this question.	Concerned Support Worker (CSW)	ASAP

Answer 1.

YES; Go to Q/ 2.

NO; Complete the following Actions: -

Action	Who	Timeframe
Continue to offer positive support to the person.	Concerned Support Worker (CSW)	Ongoing
Continue to carefully observe their behaviour	Concerned Support Worker (CSW)	Ongoing

WHAT IS BEHAVIOUR OF CONCERN (BOC)

Many people with disabilities have difficulties expressing their needs appropriately, and often feelings such as frustration, or early experiences of trying to get their needs met unsuccessfully can lead them to learn that they have to behave in quite extreme ways to get other people to respond. These behaviours are often called "challenging behaviours".

More recently, it has been argued that the term "challenging behaviour" should be replaced by "behaviour(s) of concern" in order to shift focus from the "challenge" that must be met by the person's support system, to a focus on the response required by those supporting the individual to better meet his or her needs (e.g. Chan et al. (2012).

"Behaviour of concern" is the term that will be used for the remainder of this module and is defined as:

> *Any behaviour that is a barrier to a person participating in and contributing to their community (including both active and passive behaviours) that undermines, directly or indirectly, a person's rights, dignity or quality of life, and poses a risk to the health and safety of a person and those with whom they live or work (Budiselik et al, 2010).*

Examples of behaviours of concern include (McVilley, 2002):

- Being withdrawn or inattentive, for example, appearing shy, fearful, consistently tired, easily distracted, and lacking motivation.
- Performing repetitive or unusual behaviours that occur so frequently that they impede other daily activities, for example, pacing, rocking, twirling, or sucking fingers or objects.
- Enacting self injurious behaviours that have the potential to cause physical harm, for example, head banging, pulling own hair, picking at skin, pulling out hair.
- Being disruptive, i.e., behaviours that interfere with the activities of others, for example, clinging, teasing, interrupting, yelling and arguing.
- Being destructive to property, for example, hitting, throwing or burning.
- Being hurtful to others, i.e., behaviours that can cause physical or psychological harm to others, for example, hitting, kicking, punching, etc.
- Being uncooperative, i.e., refusals to comply with (apparently) reasonable requests, for example, to perform chores, to take turns in a group, to adhere to the law.
- Enacting behaviours that others find offensive, i.e., behaviours that offend, embarrass or upset others, for example, swearing, spitting, inappropriate social touch, public masturbation.

Attached notes from the PPIF Manual, p.20.

WHY IS IT OF CONCERN?

Behaviour may be of concern to the support people of a person with a disability including the system and resources within the system. It may not however be a concern to the person who is engaging in it, because for them it "represents a way in which a person with restricted abilities (and even more restricted power) can exercise some control over their world. Many instances of behaviour of concern can be seen as adaptive, functional and communicative" (Emerson, 2000).

It is vital to keep in mind that behaviours of concern may have an additional impact because of the way it makes observers feel. When confronted with any of the behaviours) mentioned above people may feel anger, fear, disgust, sadness and irritation. If they are unable to overcome these emotions or at least see through them to a better understanding of the person and the reason for their use of that behaviour, intervention and even assessment will be skewed.

PREMIER PRACTICE IMPROVEMENT FRAMEWORK V4.0

DEVELOPED BY SAL CONSULTING P/L FOR SBIS (JUNE, 2014)

QUESTION 2. IS THIS PERSON CURRENTLY EXPERIENCING A POSITIVE LIFESTYLE AND SUPPORTIVE ENVIRONMENT?

Policy Ref: 2.2 Ensuring a Positive Lifestyle and Supportive Environment.

To Answer YES to this Question, you must have: -

⇒ Reviewed evidence from the person's Individual Plan, their Daily Routine, and their Lifestyle & Environment Action Plan.

Answer 2.

YES; Go to Q/ 3.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the attached information sheets on "Positive Lifestyle & Supportive Environment" and "Lifestyle & Environment Review/Plan" - from PPIF pp. 22-30 - following	Concerned Support Worker (CSW)	Immediately
Initiate a Lifestyle & Environment Review of this person. See "Lifestyle and Environment Review & Action Plan" Form - in Attachments.	Concerned Support Worker (CSW) & Leader	Within 2 days
Implement the Lifestyle & Environment & Action Plan.	All Care Staff	Min. of two weeks
Then Answer this question	Concerned Support Worker (CSW) & Leader	Two weeks after L&EAP implemented.

POSITIVE LIFESTYLE AND SUPPORTIVE ENVIRONMENT

The world and life presents each person with many complex and varied challenges. Each person requires some framework of support. This support is the help each of us need to manage the aspects of the world and life where we (1) don't readily have the necessary skills or abilities, (2) don't have the capacity to cope, (3) haven't attempted something before, (4) become confused, anxious, scared or distressed, (5) become agitated, or angry, (6) don't understand, (7) etc.

For example

1. George is a person with a physical disability (e.g. cerebral palsy). He is able to self- manage most things in his life. However he can not service his own wheel chair. He needs specific supports to do this. Without such supports he would become unable to manage other daily tasks or participate in his lifestyles choices / activities. He would be isolated and vulnerable.
2. Alan is freelance journalist always jetting about the world chasing some headline I news story. However Alan can not manage his finances. He needs specific supports to do this. Don, his accountant provides these supports. With out them Alan would be unable to meet his taxation, mortgage or personal saving and investment choices / goals.

Everyone needs specific supports of some kind, not simply the concrete type of support listed (i.e. wheelchair servicing and accountancy support) in the examples above but in a range of areas or contexts.

People require a framework of support. Without the supports one needs we are vulnerable.

People with disabilities are particularly in need of well constructed and well delivered supports based upon their assessed needs and profiles.

Every person we support requires a framework of support that will allow the individual to operate assuredly. Certainty, reliability and solidity (or robustness) are primary features of a good ecology. Ecology (a broad term) is the term used to include the medical, physical, social and activity contexts in a person's life.

To develop a framework of support we need to gather all the information possible to achieve a good understanding of those factors that have shaped the development and current functioning of the person with a disability.

This understanding is really important to make sure we are able to provide the right supports to the person. To do this it is useful to build a "profile" of the person with a disability which involves developing an understanding of the person's characteristics - in other words, the things that "make them the person that they are". This helps us to consider whether the person's ecology and lifestyle is a good "fit" or whether specific actions or supports are required to reflect the person's strengths, preferences and capabilities.

Ecological contexts to consider include:

Ecological context	Considerations	Examples of Ecological / Lifestyle supports or requirements
Biological physical	• Health I medical conditions • Mobility • Sensory issues • Genetic conditions • Factors associated with specific syndromes (e.g. ASD) • Medications	• Health Care plans • Mobility aids I assistance • Medication management plans • Hearing I visual aids • Sensory "diet" • Manual handling plan
Cognition I Learning	• The person's memory • Ability to attend or concentrate • How the person processes information • Preferred learning style	• Visual supports • One on one instruction I tuition • Specific learning environment • Teaching methodologies • Memory aids I supports • Scheduling
Mental Health I Emotional	• Specific psychiatric diagnoses (e.g. schizophrenia) • Mood disorders I depression • Anxiety • Grief I bereavement	• Medication • Counselling • Mental Health Plan • Emotional support • Incident Response Plan • Specialists e.g. psychiatrist
Communication	• The person's ability to understand others • The person's ability to make themselves understood	• Visual routines • Augmentative communication systems • Interaction guidelines

Ecological context	Considerations	Examples of Ecological / Lifestyle supports or requirements
Specific Life Experiences	• Experiences of trauma or abuse • Family relationships I social support • Recent life changes (e.g. change of placement)	• Medication • Counselling • Mental Health Plan • Emotional support • Incident Response Plan • Specialists e.g. psychiatrist
Physical Environmental	• Assistive devices I aids • Temperature • Density of people • Noise levels	• Modified environment • Small group activities • Time away • Chill out area
Social ecology	• Circle of support • Opportunities for interaction • Quality of interactions	• Interaction guidelines • Scheduled one to one time • "Talk" time • Peer mentor I buddy
Activity Ecology	• Scheduling of activities • interest of activities • Level of difficulty	• Routine and scheduling • Opportunities for choice • Level of support
Skills and interests	• The person's capabilities • The person's areas of support • The person's preferences, likes and interests • The person's dreams and aspirations	• Person Centred Planning • Lifestyle Management Plans • Meaningful engagement

LIFESTYLE AND ENVIRONMENT REVIEW

There are many different types of behaviours of concern, and what behaviour a person displays depends on who they are as an individual (their profile), and the way the "ecology" responds to their behaviour. "Ecology" in this situation means the whole environment, including physical environment, and the people in the environment.

As discussed in the previous chapter, like all of us people with a disability require an appropriate framework of support so that their ecology and lifestyle "fits" with their preferences, skills and capabilities.

When behaviour of concern emerges this can often mean that either a) we haven't managed to get the right fit" or b) an element (or elements) of the person's support framework has broken down.

Example:

Bill has an intellectual and physical disability; however, he can do most things without assistance. He enjoys his independence although he requires time to complete activities and prompting / reminding about what comes next on his routine. Morning times are a busy period where Bill must shower, dress, have breakfast, make lunch etc Because they are often running late Bill's parents try to

help him through his routine. When they do this Bill will stop following requests and will refuse to complete routine or self care tasks. If feeling pressured or "stressed" 81/l might push or slap his parents.

Match or mismatch? What could Bill parents do?

One of the tools that we can use to appraise lifestyle / ecological "fit" is called a "Lifestyle and Environment Review" (LER).

- An LER is a planned and organised process that has the assumption that some aspect of the person's life is not working or not meeting their current needs. Behaviours of concern should always be viewed within the context of the person's life.
- The aim of the LER is to review an individual's lifestyle and environment with the intention of maximising their quality of life and minimising the need for behaviours of concern.
- Making changes to a person's life based on the information contained in the LER may be all that is required to eliminate behaviour of concern.
- An assessment to gain an overall picture of each person's capabilities in all life domains and to plan future placement and support needs.
- A global "picture" of the person's life from their perspective. This includes what they may need, feel and want.
- The purpose of the LER is to systematically examine every aspect of a person's lifestyle and develop a plan. The intent of such of plan is to ensure that the lifestyle of the person with behaviours of concern is normalised, age appropriate and satisfying so that the person will have less need to resort to behaviours of concern.
- The LER and the resulting Action Plan (see below) serve as the first step in dealing with the behaviours of concern.
- If behaviours of concern are present, the emphasis of the LER is to create an environment where no one has to resort to behaviours of concerns in order to express their needs and an environment where people feel secure.
- An LER should produce documented actions, responsibilities and time frames to address any identified gaps or "mismatches" in the person's ecology or lifestyle. This action plan should be reviewed regularly by the support team and barriers to implementation addressed.

LIFESTYLE MANAGEMENT PLANNING

What can we do to achieve a better life for the person now and into the future ...?

A Lifestyle Management Plan is a document that changes, grows and develops with the person as greater understanding of how the person communicates and requires daily support is shared by those who know them well and is documented for greater support to the person with a disability.

Lifestyle Management Plans provide an opportunity to gather information for the person to use in any situation to make sure that all those providing them with support have an understanding of who they are, what their strengths and needs are. This information is gathered in a dynamic way with the person, their family and others. This information is not static - it changes and grows as the person is able to demonstrate, communicate and change as they mature.

Lifestyle Management planning was developed in the late 1980s and focuses on:

- Finding out what was important to the person.
- Learning about the health, safety and risk factors related to the person and to those who know and care about them.
- Discovering what is important to keep the person healthy and safe.
- Finding out how someone can be supported in having a balance between being happy and being safe, while making the best use of funding and resources.
- Describing what has been learned in a way that is easily accessible to those who will help the person get what is important to them.

The person's typical life patterns (by day, month, year) are looked at, as well as their reactions to situations and to other people. Conversations and other means are used to identify:

- The essentials - things that must happen if the person is to achieve their lifestyle and maintain their well-being.
- Who and what is important - things that will make a significant difference, without which quality of life would be significantly decreased.
- Pleasures - things that the person would like to have (or not have) in their life to make it more pleasurable.

Lifestyle Management planning provides an opportunity for the person with a disability and their family to influence the nature and type of services they receive. This way LMP's can be used to identify what the support people should be doing, and training needs to arise out of any gaps between what the person needs and wants and the skills and knowledge of the people who are supporting the person with a disability.

The person's plan is established through listening to, and engagement with the person and their support network to facilitate identification of their goals, dreams and aspirations.

While focusing on the person, facilitation of planning and then implementation of key elements of the plan rely on effective case management.

The plan confirms expectations and defines the goals, objectives and responsibilities of all participants. The plan establishes measures, timeframes and review points for achieving each goal and activity.

QUALITY OF LIFE (QOL)

The concept of "Quality of Life" has been increasingly applied to people with intellectual disabilities. The notion (as distinct from actual practice) of promoting a positive and valued "Quality of Life" underpins person-centred service delivery including Positive Approaches Behaviour Support.

Internationally there has been debate on an agreed definition of quality of life for people with an intellectual disability for two decades or more. Broadly, quality of life is "about having a life that is rich and meaningful to each individual" (Brown and Brown, 2003).

The key task then is to define what Qol may be each individual and measuring it meaningfully.

There is increasing recognition of the need to consider Qol domains and outcomes when supporting individuals with behaviours of concern and this will be discussed further in subsequent chapters.

Beadle-Brown (2006) has highlighted eight key QoL domains and associated indicators summarised below:

Quality of life domain	Indicators	Quality of life domain	Indicators
Social Inclusion	• Community integration/participation supports (services and satisfaction with them. • Social inclusion • Acceptance • Residential environment • Status • Role (lifestyle and adaptive behaviours of concern)	**Emotional Well-Being**	• Contentment (with work, residence, supports, satisfaction with community, satisfaction with services etc) • Emotional well-being (general, personal, psychological well-being) • Self-concept • Freedom from stress • Spirituality • Happiness
Physical Well-Being	• Health (safety, healthy environment, physical condition etc) • Recreation • Nutrition • Mobility • Leisure • Health care • Physical well-being • Activities of daily living	**Self-determination**	• Autonomy • Self-direction • Choices • Personal control • Resident influence • Decisions • Self-advocacy
Interpersonal Relations	• Interactions (at work, with carers etc.) • Support (e.g. social networks) • Family • Intimacy • Affection • Friendships (affiliation and decreased loneliness)	**Personal Development**	• Education and habilitation • Fulfilment • Skills • Purposeful activity • Personal competence • Advancedment/development
Material well-being	• Employment • Social economic status • Financial • Shelter • Ownership • Transport • Security	**Rights**	• Privacy/respect • Civic responsibilities • Freedom • Activities related to local and national governments (e.g. partnership boards) • Basic human rights • Citizenship (voting etc.) • Access • Due process

QUESTION 3. ARE WE ABLE TO ACCURATELY IDENTIFY THE FUNCTION THIS BOC HAS FOR THIS PERSON?

Policy Ref: 3. Understanding the Person's Behaviour of Concern.

To Answer YES to this Question, you must have: -

⇒ Written down what you believe is the function of this Behaviour of Concern for this person.

⇒ Have had your view supported by a number of other experienced staff.

Answer 3.

YES; Go to Q/ 6.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read about the "Eight Principles & Themes of the Positive Approach to Behaviour Support" (PABS) as per the PPIF Handbook pp14-15 - following	Concerned Support Worker (CSW) & Leader	Immediately
Initiate the Positive Approaches to Behaviour Support process for this person, by going to Question 4	Leader	ASAP

POSITIVE APPROACHES TO BEHAVIOUR SUPPORT

Positive Approaches to Behaviour Support (PABS):

- Involves a proactive, assessment-based approach that is consistent with the science of behaviour and person-centred action.
- Examines not only the person but also their life contexts.
- Encourages collaboration among families and professionals from a variety of disciplines (e.g., person centred planning, group action planning, listening).
- Is dynamic and responsive, expanding in response to a growing research base and adapting to the community.
- Is effective in promoting positive durable lifestyle changes for people with significant behavioural challenges.
- Is about skill and capacity building for everyone involved.

Positive Approaches to Behaviour Support brings together values and commitment with evidence based methods and skills. In the past behavioural approaches have been guilty of treating people mechanistically - of looking only at the behaviour and not the lifestyle of the person. Positive Approaches to Behaviour Support aims to avoid this and recognises that to do so we have to draw on the skills and knowledge of everyone involved and to work constructively, creatively and responsively together.

The goal in Positive Approaches to Behaviour Support is not just reducing specific behaviours; the approach recognises that "problems" often reside in not providing tailored and comprehensive skilled support. The minimisation of the behaviour is primarily achieved by the creation of responsive environments and building new skills, rather than simply attempting "to stop" the person. It usually requires more than one type of "intervention" .It aims to support people to "get a life" and keep a life and to build skills and understanding in those supporting the person.

Like person-centred planning, positive behaviour support has been able to get people and services out of a rut. Like person centred planning, positive behaviour support benefits from skilled facilitation, commitment, and technical applied skills.

Principles and Themes of Positive Approaches to Behaviour Support (Cook and Radler, 2003)

1. **Lifestyle improvement**: Positive Approaches to Behaviour Support is founded on a philosophy of respect for the person and a desire to help achieve more agreeable lifestyles that meet personal aspirations and decisions.
2. **Functional assessment**: Interventions are based on an understanding of the person's interactions with others and the environment, the functions or underlying reasons the behaviour may serve and the communicative messages it may contain.
3. **Strengths-based**: Goals are focused on strengthening and building on the person's existing skills and supporting patterns of adaptation, rather than directly suppressing unwanted behaviour or focussing on the correction or teaching of things the person does least well.
4. **Person-centred**: Goals and strategies are centred around the person's needs and aspirations, the least restrictive techniques possible are used, with skill acquisition and choice making built into interventions that lead to outcomes that are meaningful and purposeful for the person involved.

5. **Empowerment**: Interventions emphasise teaching and supporting replacement skills that are pro-social and empower the person by performing the same functions for the person as the behaviours of concern.
6. **Multiple components**: Positive Approaches to Behaviour Support acknowledges the influence of health, medical perspectives, disability issues and the ecological context. PBS considers and incorporates all variables into a unique support plan in ways that combine evidence- based information and strategies with social values.
7. **Partnerships**: unique plans and strategies are developed and adapted for the context through collaboration and partnerships between all significant stakeholders and support workers. Plans address the needs and competencies of families and carers as well as the people they support, and include strategies to strengthen partnerships for information, decision-making, implementation and mutual support.
8. **Promote and support**: Interventions emphasise enabling strategies for families and support people to:
    a. promote and support positive behaviour;
    b. minimise the likelihood of issues occurring in the course of everyday activities; and
    c. calmly support the person through incidents that may arise, with the aim of reducing impact and escalation of issues that do occur.
9. **Systems change**: Strategies often include systems change if positive support is to be maintained and for positive behaviour to endure over time. Such strategies may include ecological (e.g . changing or modifying some aspect of the person's environment), procedural (e.g. changing or adapting how supports are provided or delivered to the person), activity (e.g. addressing the range or type of activities available to the person) and personnel changes (e.g. reviewing rostering practices or staff training).

QUESTION 4. HAVE WE WORKED OUT WHAT DATA WE NEED TO COLLECT, SO WE CAN ACCURATELY ASSESS THIS PERSON'S BOC?

Policy Ref: 3.2 The Process of Assessment of the Behaviour of Concern.

To answer YES to this question, you must have: -

⇒ Discussed specific data needs with a number of other experienced staff.

⇒ Have selected appropriate formats from the templates in Attachments.

Answer 4.

YES; Implement Data Collection Immediately & Go to Q/5.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read notes on Data Collection from the PPIF Manual pp 37-39- following	Leader	Within 1 week
Review the attached Star Chart Recording Information sheet- following	Leader	Within 1 week
Implement Data Recording using the Star Chart template – in Attachments.	Leader	Within 1 week
Then answer this Question	Leader	Immediately

COLLECTING INFORMATION (DATA) ABOUT THE BEHAVIOUR

Gaining a picture of the situations in which the behaviour of concern or behaviours of concern occurs is assisted by gathering information and data collection. Sources of information might include:

- Records: This might assist in obtaining insights into factors that influence a person's behaviour. Sources might include: diagnostic and medical records; assessments; previous behaviour support programs; incident reports etc.
- Interviews: This involves gathering information through discussion with key people involved in supporting the person regarding his or her behaviour such as family members, friends, direct care staff or the person themselves.
- Observation: This involves watching and then recording patterns of behaviour and events in the environment as they are actually occurring to discern patterns and influencing factors.

DATA COLLECTION

Data collection is about writing down or recording each situation in which the behaviour of concern occurs.

Why collect data:

- To understand HOW often the behaviour is occurring.
- To understand WHEN the behaviour is most / least likely to occur.
- To understand with WHOM the behaviour is most / least likely to occur. To understand WHAT generally happens when the behaviour occurs.
- To help you know if your intervention is making a difference.

Rules when collecting data

- Collect baseline data to enable comparisons. Don't make data collection too complicated.
- Only collect information you need, but make sure that you get the information you need from the data you want to collect.
- Remember that you have to analyse the information you have collected.
- Keep it simple and quick for them to complete. Great charts are useless if you don't have compliance from the people who are going to be completing them.
- Feed back the information in a summarised and analysed form to those collecting the data and to those for whom the information is being collected.

STAR CHART

TIPS FOR COMPLETING A STAR CHART

Record only what you observe yourself.

Record only those behaviours that are on the agreed list of target behaviours.

Record the target behaviour as soon as possible after it was observed by you.

DATE	TIME	SETTING Where? Who was there? What was happening?	TRIGGERS What happened immediately before the incident	ACTION What did the person do? Describe Incident	RESPONSE What happened then?	DURATION & FREQUENCY
		Describe where the incident took place and where the person had been. Detail what the environment was like (e.g. hot, cold, crowded, busy with activity) Detail what the person was engaged in prior to the behaviour (e.g. making a drink, watching TV, interacting with others, reading, listening to music)	Describe who was with the person and what they were doing, or not doing at the time. Was the person's routine disrupted? Was the person unwell? Was the person attempting to communicate and need or want?	Describe precisely what happened. What did the behaviour look, sound and feel like? Write it like directions for a stage play. So someone who has never seen the behaviour could clearly imagine what the behaviour episode looked like.	What steps did you take to de-escalate the person? What strategy did you employ? (e.g. active listening, relaxation, redirection, negotiation).	

QUESTION 5. HAVE WE FULLY ANALYSED THE DATA, SO WE CAN FORMULATE A VIEW ON THE FUNCTION OF THIS BOC FOR THIS PERSON?

Policy Ref: 3.2 The Process of Assessment of the Behaviour of Concern.

To Answer YES to this Question, you must have: -

⇒ Analysed 10 days of recorded data.

⇒ Completed a Functional Analysis.

Answer 5.

YES; Go to Q/ 6.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the notes on Analysing Data in "Factors that Influence a person's Behaviour" – PPIF Manual pp39-41 & "Behaviour" notes pp3-6 – following.	Concerned Support Worker (CSW) & Leader	1 Day
Analyse the Data after 10 Days of Recording.	Leader	Within 2 days
Discuss results with experienced staff.	Leader & experienced staff	Immediately
Complete a Functional Analysis Form - in Attachments.	Leader	Within 2 days
Then Answer this Question	Leader	Immediately

FACTORS THAT INFLUENCE A PERSON'S BEHAVIOUR

There are 5 main elements we need to consider when supporting a person who exhibits behaviours of concern. Understanding these groups is important so you can work out the reasons why the behaviour is happening, and so you can predict when it is likely to happen again.

These groups are:

The person's 'Profile' (as discussed in the previous Chapter)	**Antecedent Events**
Setting Events	
Triggers	
Describing behaviour objectively	**Behaviour(s) of concern**
What happens afterwards	**Consequent Events**

SETTING EVENTS

Setting events are those "situations or circumstances" which when they happen "set the scene" for the person to use behaviours of concern.

e.g. Charlie doesn't cope very well with big crowds due to his profile which includes a diagnosis of Autism and ADHD, - he becomes agitated and is likely to run around, and may push or swear at other people in his path.

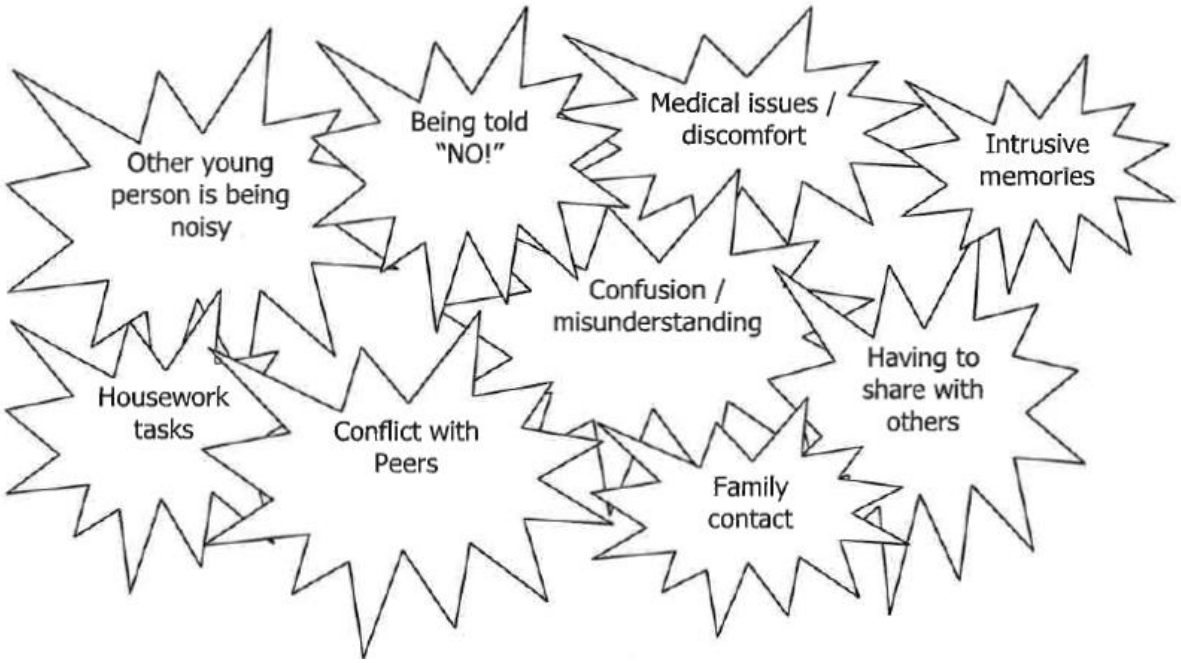
Common setting events which may result in the person displaying behaviours of concern include the following:

- Medical and health issues (e.g. having a cold, toothache, medication etc.).
- Physical environment (e.g. noise, temperature, crowding).
- Activities (e.g. Certain jobs or activities, having to do things at a certain time, or having to perform at a certain level, being able to make choices and feel in control, how fast the activity is happening).
- Social Setting (e.g. peers, friends, being "picked on" or being treated with respect etc.).
- The person's skills and abilities (and / or issues) within the setting they are in. (e.g. cognitive skills deficits such as problem solving, coping skills, planning etc.).

TRIGGERS

A "trigger" is an event that happened directly before the behaviour starts, that appears to make the behaviour happen. It is important to understand that although it is good to be able to identify common triggers for the person you are supporting, the other factors (such as the profile and the setting events) are in fact more important to understand. Also, remember that triggers for a person are not always things that we can "see" - they may be things that are happening inside the person such as a thought, pain, a memory etc.

How many of these triggers apply to people with a disability you know?



DESCRIBING BEHAVIOUR OBJECTIVELY

In order to gather data consistently and monitor the outcomes of interventions, specific target behaviours and objectives must be identified. Target behaviours should be defined in observable and measurable terms (in terms of what you see or hear) rather than being based on mental states or processes. To assist in describing behaviours objectively consider the following questions:

- What does the behaviour look and sound like?
- How often does it occur?
- How severe is the behaviour?
- What level of risk does it pose to the person and/or others?

CONSEQUENT EVENTS

Consequent events for behaviours of concern are those "outcomes / results" which happen for (and to) the person when they use behaviours of concern. It is important that you remember that not all consequent events "reinforce" behaviours of concern. Generally speaking however, consequent events are the "outcomes I results" that make it more likely that the behaviour will happen again. Consequent events give behaviours value. General types of consequent events include:

- Getting out of situations the person finds unpleasant / difficult.
- Getting access to sensory or emotional input that the person wants or needs.
- Providing more sensory or emotional input for the person.
- Making the person feel like they are in control.
- Reducing the level of difficulty that the person is experiencing with some interactions or demands.

HOW TO BE A DETECTIVE AND FORMULATE A VIEW

Interpreting a person's behaviours of concern relies on the information gathered via the behaviour assessment (whatever the technique used).

Possible functions of behaviours of concern include:

- To obtain some positive thing or experience, i.e., to request something tangible or to request social interaction or attention.
- To avoid some negative thing or experience, i.e., to avoid or escape certain situations or events.
- To meet a physical or emotional need, i.e., to reduce personal stress or to attempt to gain control over aspects of their lives or to occupy themselves, e.g., it looks, feels, tastes, smells good and provides pleasure.
- To express or communicate a physical or emotional need, for example, pain, discomfort, boredom, loneliness or confusion or to express emotion, to gain reassurance or praise.
- Because no one has shown them another way to achieve their goals.
- Because this way has previously enabled them to achieve their goals.

BEHAVIOUR

All behaviour is a form of communication. For example, the behaviour may emerge as a response to their own life stories, a reaction to experiences of abuse, isolation, rejection, frustration, or a lack of support at earlier stages of development. For some people the behaviour can be attributed to their experience with social support or housing.

IDENTIFYING THE COMMUNICATIVE FUNCTION OF THE BEHAVIOUR

To support and appreciate a client's behaviour and the message it is communicating, you must understand the message from the client's point of view. You can then provide a more adaptive means of communicating this message in the future. For example, a person engages in behaviour that others find challenging to:

- Obtain something positive.
- Avoid something negative.
- Meet a physical or emotional need.
- Express or communicate a need.
- To gain control over their life.
- Reduce arousal or anxiety.
- The client may do this because:
- No one has shown them another way.
- This way has been effective in achieving what they want.
- They have tried a different way and no one has responded to meet their needs.
- They are driven by biochemical or neurological factors currently beyond their conscious control such as mental illness, drug use, unrecognised pain or discomfort, or a medical issue.

BEHAVIOUR OF CONCERN

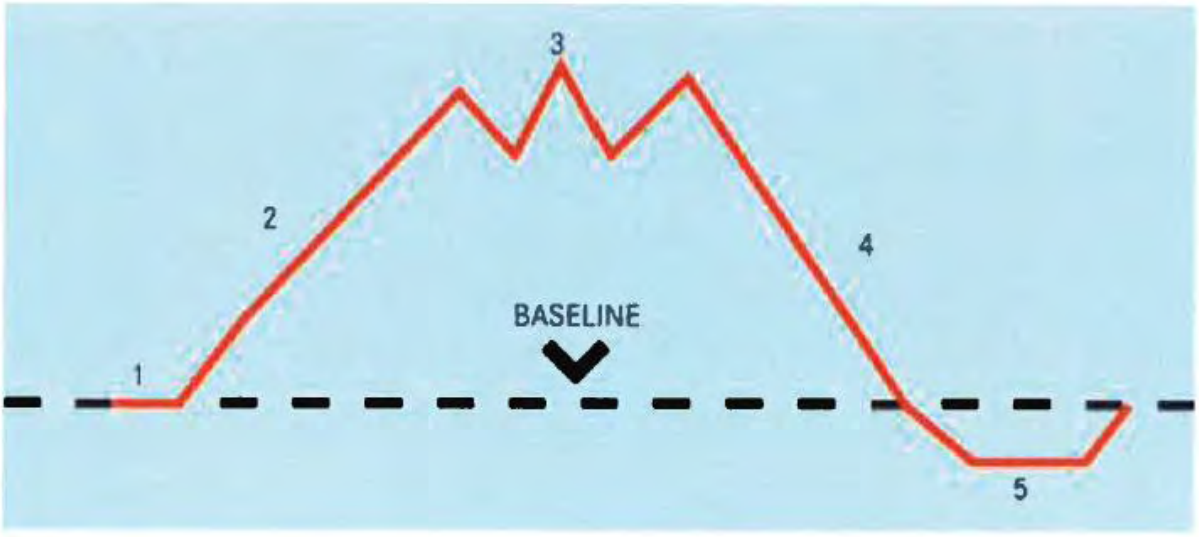
Behaviour of concern is defined by Eric Emerson, Professor of Disability and Health Research UK, 1995, as: "Behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed or is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities, services and experiences." People using behaviours of concern are sometimes described as having high support needs or complex needs. They may be perceived as people with unmet needs. People with intellectual disabilities have a much higher prevalence of behaviours of concern (in the order of 40%) compared to the general population because communication and cognitive difficulties may compound the presentation. Common types of behaviours of concern include:

- Self-injurious behaviours (such as hitting, head butting, biting).
- Aggressive behaviour (such as hitting others, screaming, spitting, kicking).
- Inappropriate sexualised behaviour (such as public masturbation or groping).
- Behaviour directed at property (such as throwing objects and stealing).
- Stereotyped behaviours (such as repetitive rocking or echolalia).

These behaviours can be challenging for a service provider. Such behaviours are likely to limit the person's ability to participate in daily life and to enjoy potentially life-enriching experiences. The behaviour of some people may be so disruptive and harmful that families and services have extreme

difficulty in meeting the person's needs, or even understanding what their needs are. Behaviours of concern can be viewed as occurring in a cycle of:

1. Trigger
2. Escalation
3. Build Up
4. Climax
5. Wind Down
6. Recovery



Analysis of this cycle provides a foundation for strategies to minimise the triggers, encourage more appropriate behaviours in response and encourage a more appropriate response. The behaviours set a challenge to services to improve the way they operate. The term was first used to encourage service providers and the community to develop better services, supports and attitudes to address the behavioural difficulties demonstrated by some people with a disability.

WHAT CAUSES INFLUENCES BEHAVIOUR OF CONCERN?

Behaviours of concern are often exhibited as a consequence of a person's experience of:

1. **Impairment**. The loss of their body structure or of a physiological or psychological function.
2. **Limitations on their daily activities**. The range of frequency, variety, duration and/or degree of independence or self-determination.
3. **Limitations to their participation in society**. Including their opportunities for social interaction and relationships i.e. the form, frequency, duration and perceived quality of their interaction with significant others.

These three factors need to be considered when developing strategies which address a client's behaviours of concern.

It is extremely rare that the behaviour of any person can be explained by a single factor or cause. All behaviours have underlying causes which may be biological, psychological, sociological or environmental. This is referred to as the bio psychosocial model. All these factors combine to effect the person's development, including their cognitive, emotional and social functioning.

Frequently behaviour will occur for a number of interrelated reasons and so in order to understand the behaviour we need to understand the reasons or contributing factors underlying that behaviour.

- What their needs, wishes and personal preferences are.
- Where they are at the time.
- Who they are with or not with at the time.
- What others are doing to and for them.
- What pressures and demands they are experiencing.
- How well they understand what is happening or expected of them.
- How responsive people are to them.
- What skills they have to meet their needs independently of others.
- What alternative behaviours they have to express their needs.
- Their family, cultural or religious background and subsequent beliefs and values.
- Their individual biochemistry and genetic makeup.

SOCIALLY INAPPROPRIATE BEHAVIOUR

While not all actions are behaviours of concern, all behaviour is communicating a message. However, when your clients use socially inappropriate behaviour it is not always easy to understand the message that behaviour is communicating.

The behaviour may be a way of telling us they are annoyed, want to leave or want to avoid non-preferred events. The environment may be disagreeable for the client, aggravating them in some way and they want to escape. They may begin inappropriate social behaviour like fondling their private parts, singing loudly when others are being quiet, or using inappropriate language, gestures or sounds.

One third to half of studies show that it is possible to teach your client how to say 'stop' or 'no' in an appropriate way, for others to understand. They can learn to use gestures, manual signs, a PECS card or an electronic board which has a message that says 'stop'. All these methods teach your client how to communicate their objection without using socially inappropriate behaviours.

Understanding the cause of a behaviour is vital to help the client change behaviours, as the answer can be as simple as changing their environment.

MISTAKEN AND-ALTERNATIVE INTERPRETATIONS OF BEHAVIOUR

COMMON MISINTERPRETATION	ALTERNATIVE INTERPRETATION
Attention seeking For example: people follow staff or family members around the house, touch others inappropriately, attempt to pass objects at seemingly inappropriate times; tease others; interrupt others or act in a way that is found to be 'annoying'.	Initiating relationships - they want friends Seeking company - they are lonely Seeking reassurance - they are scared Seeking help or support - they lack skills or confidence Personality issues
Self-stimulating For example: people rock, twist or play with their fingers and toes; slap their face or their legs persistently; twirl around; poke at their eyes; hum or sing inappropriately .	Bored, overwhelmed or over stimulated and may need to calm Unable to identify or initiate an alternate activity Syndrome specific behaviours, possibly related to neurological problems Health and medical needs
Self-injuring People pick at their skin, cut themselves with sharp objects, place objects in their body cavities, pull their hair out, eat or drink to excess.	Nervous Anxious Depressed Psychiatric issues Bored/Boredom
Non-compliant People do not do things as they are asked to do them, when they are asked, or do not finish things they start.	Not interested Not understanding Not being asked the right way Not having sufficient skills Not having sufficient stamina (tired) Recalling bad memories of a past experience
Disruptive People talk or make noises at inappropriate times, yell, interfere with the work or activities of others or break things.	Frightened Scared Stressed Lacking understanding of the situation
Aggressive People throw objects or hit out at others.	Not knowing what is expected of them Frustrated or even threatened The requirements of the current situation exceed their skill or level of tolerance Other attempts to communicate are not responded to or

QUESTION 6. HAVE WE SET REALISTIC & DETAILED GOALS FOR THIS PERSON, SO WE CAN DEVELOP APPROPRIATE BEHAVIOUR SUPPORT STRATEGIES?

Policy Ref: 4.1 Goal Setting in the Context of Quality of Life.

To answer YES to this question, you must have: -

⇒ Written the goals down and have shared them with other experienced staff.

⇒ Checked them against the Policy Guidelines.

Answer 6.

YES; Go to Q/7.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the notes "Quality of Life Domains" PPIF p.29 & "Formulating Goals…" PPIF P.53. - following	Concerned Support Worker (CSW) & Leader	1 Day
Write down your Goals for this Person, in the PBSP Section "Positive Proactive Prevention/Skill Development Strategies." – in Attachments	Leader	Immediately
Check that they meet the Policy Guidelines (4.1).	Leader	Immediately
Have them reviewed by experienced staff for being realistic.	Experienced staff	Within 2 days
Then Answer this Question	Leader	Immediately

EIGHT KEY QUALITY OF LIFE DOMAINS & THEIR INDICATORS (BEADLE-BROWN 2006) PPIF

QUALITY OF LIFE DOMAIN	INDICATORS	QUALITY OF LIFE DOMAIN	INDICATORS
Social Inclusion	Community integration/participation supports (services and satisfaction with them. Social inclusion Acceptance Residential environment Status Role (lifestyle and adaptive behaviours of concern)	Emotional Well-Being	Contentment (with work, residence, supports, satisfaction with community, satisfaction with services etc) Emotional well-being (general, personal, psychological well-being) Self-concept Freedom from stress Spirituality Happiness
Physical Well-Being	Health (safety, healthy environment, physical condition etc) Recreation Nutrition Mobility Leisure Health care Physical well-being Activities of daily living	Self-determination	Autonomy Self-direction Choices Personal control Resident influence Decisions Self-advocacy
Interpersonal Relations	Interactions (at work, with carers etc) Support (e.g. social networks) Family Intimacy Affection Friendships (affiliation and decreased loneliness)	Personal Development	Education and habilitation Fulfilment Skills Purposeful activity Personal competence Advancedment/development
Material well-being	Employment Social economic status Financial Shelter Ownership Transport Security	Rights	Privacy/respect Civic responsibilities Freedom Activities related to local and national governments (e.g. partnership boards) Basic human rights Citizenship (voting etc.) Access Due process

FORMULATING GOALS

In formulating goals there are two primary considerations:

Goals must be stated in observable and measurable terms, and

Goals must specify the conditions and the criteria for performance that reflect the normalised and independent performance expected

Therefore, goals must be clear, unambiguous and sufficiently detailed (i.e. not vague). Well-constructed goals are characterised by five essential components:

S	=	**Specific**: Goals should address the 5 W's - who, what, when, where and why
M	=	**Measurable**: Goals should include numeric or descriptive measures that define quantity or quality etc.
A	=	**Achievable**: Goals should be realistic and attainable for the person with a disability
R	=	**Relevant**: Goals should be meaningful and functional for the person with a disability
T	=	**Time framed**: Goals should identify a target time frame for goal attainment or for specific actions required to work towards the goal

QUESTION 7. HAVE WE PREPARED A COMPREHENSIVE POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) FOR THIS PERSON?

Policy Ref: 4.2 Developing a Multi-Element Support Plan.

To answer YES to this question, you must have: -

⇒ Completed all parts of the CDS PBSP document template.

⇒ Had it checked by other experienced staff.

Answer 7.

YES; Go to Q/ 8

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the notes, "Design of Behaviour Support Plans" - ADHC BSPPM1.p73-74 - following.	Concerned Support Worker (CSW) & Leader	Immediately
Review the CDS PBSP Template - in Attachments.	Leader	Immediately
Prepare the PBSP & check it with other staff.	Experienced staff	3 days
Then Answer this Question.	Leader	Immediately

DESIGN OF BEHAVIOUR· SUPPORT PLANS

DEFINITION AND PURPOSE

The Behaviour Support Plan (BSP) is a document or series of linked documents that outline strategies designed to deliver a level of behaviour support appropriate to the needs of a Service User. A BSP is to have a preventative focus and is usually required also to have a responsive focus . The plan should reflect the level of complexity, assessed needs, parameters and context of the Service Agreement.

The BSP is required to support the Service User by providing:

- Realistic, measurable and person-centred goals based on a comprehensive
- Behaviour Assessment Report;
- Positive support strategies which address these goals;
- Time lines and outcome indicators for each goal;
- Response strategies and protocols;
- Clearly stated roles and responsibilities for effective implementation of support strategies;
- Recommendations for sustainable service delivery; and
- Schedule for review.

PROCESS

The BSP should draw on the findings of the Functional Analysis and provide guidelines for structured support for each behaviour and across each domain identified in that assessment. Strategies must be clearly linked to clearly stated person- centred outcomes and should be supported by evidence as provided in the BAR.

It is important that the BSP is developed in collaboration with the Service User, their family/guardian/advocate as necessary, communication partners, and other significant stakeholders. This approach is critical to ensuring shared ownership of the plan thereby engendering sustainability and resilience of the support system.

The BSP should consist of multiple elements including positive practices, interaction guidelines for carers and professionals, training and skill development, systems support, response protocols and other recommendations related to person-centred outcomes.

Where the quality of life of others is directly affected by a proposed support strategy, they should be identified as a stakeholder for the purposes of collaborative process.

Table 10: Elements of a multi-element Behaviour Support Plan (BSP).

No.	**Element**	**Description**
1	Ecological I environmental strategies	These are strategies that address the contextual features related to the presentation of a challenging behaviour.
2	Positive behaviour support practices	These may include teaching or encouraging functionally-related or equivalent skills , coping skills, anger management etc.
3	Focussed support strategies	These are designed to reduce behaviour in the short term. Strategies might include: • Differential Reinforcement of Other Behaviour (DRO); • Differential Reinforcement of Alternative • Behaviour (DRA or Alt+R) ; • Differential Reinforcement of Low rates of Behaviour (DRL); • Stimulus Control; • Stimulus Satiation; and • The use of medication in the
4	Incident Prevention and Response Plan (IPRP)	This provides: • A brief summary of positive support strategies designed to prevent the onset or escalation of identified challenging behaviours; and • Response strategies for use by carers in the event of crisis, designed to manage risk safely and effectively.

The BSP is generally aimed at achieving outcomes for the Service User such as:

- Beneficial change to environmental factors;
- Development of appropriate skills which are functionally equivalent to the identified challenging behaviours;
- Reduced reliance on the identified challenging behaviour(s) for enhanced performance of a particular function; and
- Appropriate, unobtrusive response and enhanced management by carers presented with challenging behaviours.

The BSP must be accessible to key stakeholders, in a format and/or language that is easily understood by all carers/implementers/communication partners and decision makers.

The BSP must be informed by the findings and recommendations of the current communication profile of the Service User. It is crucial that any Augmentative and Alternative Communication (AAC) strategies are embedded into the BSP as appropriate. These strategies should be determined by a Speech Pathologist and articulated in a written report. In addition, where MC strategies are recommended, these should be very familiar to, and in daily use by, all carers as well as the Service User

QUESTION 8. HAVE WE IDENTIFIED ANY RESTRICTED PRACTICES IN OUR PBSP?

Policy Ref: 4.2 Developing a Multi-Element Support Plan

To answer YES to this question, you must have: -

⇒ Full awareness of the content of the Attachment document, **"Restricted Practice Awareness Facilitators Guide" v2.3 Feb 2013, pp 5-9 - following**

Answer 8.

YES; Follow the series of Actions listed below;

NO; Go to Q/ 9.

Action	Who	Timeframe
Prepare an "Application for the Authorisation of a Restricted Practice". Template - in Attachments.	Leader or Concerned Support Worker (CSW)	Within 1 week
Obtain consent to share information from the client/person responsible per RPA consent requirement (ADHC BSPPM1 p.30)	Leader	
Complete RPAP Checklist 1 General Practice. In Attachments.	Leader	
Also complete where needed • **RPAP Checklist 2 General requirements for an RP** • **RPAP Checklist 3 Exclusion and/or Seclusion** • **RPAP checklist 4 Physical restraint** • **RPAP Checklist 5 Psychotropic medication PRN**	Leader	
Submit the completed Application to the Restricted Practice Authorisation Panel (RPAP) Convenor and include Outcome Summary Template, relevant checklists and the signed consent form.	Leader	Immediately
Respond as necessary to any feedback from the RPAP.	Leader	Within 2 days
If authorised, go to Question 9	Leader	Immediately

THERE ARE 6 RESTRICTED PRACTICES

- Exclusionary Time Out
- Physical Restraint
- The administration of a PRN psychotropic medication
- Response Cost
- Restricted Access
- Seclusion

EXCLUSIONARY TIME OUT (ETO)

ETO is where a person is denied access to reinforcement by forcibly removing the person from one setting to another for a period of time. They are unable to leave the setting and are under supervision for the designated period of time

The practice must be:

- Part of a planned strategy
- Time limited
- Support behaviour change
- Recorded.

Examples of Exclusionary Time Out (ETO)

- A person is required to stay in their room to calm down...
- A person is escorted to the backyard away from what is making them agitated and the ability to leave is prevented ...

The exclusionary time out must be part of an Incident Prevention and Response Plan (IPRP), or multi-element behaviour support plan. This means that you should attempt to implement other redirection strategies before using Exclusionary Time Out.

Exclusionary Time Out is used for persons who calm down when they have some time away from what is making them agitated. It is not a punishment, but a 'circuit breaker', removal from what triggers the agitation.

If Exclusionary Time Out is a successful strategy to calm a person down, then they should be encouraged to use the strategy themselves when they feel agitated. If a person uses 'time out' as a coping strategy without being forced to leave by staff it is not a Restricted Practice, as the person is making their own choice to leave.

PHYSICAL RESTRAINT

Intentionally restricting a person's voluntary movement or behaviour beyond what is reasonable to ensure

- safety,
- prevent harm or
- comply with legal requirements

Examples of Physical Restraint

- 2 people physically holding a person so they can't lash out and hurt someone...
- Holding a person's arm when crossing the road when they clearly do not want someone touching them but will walk in front of a car if not stopped...
- Seatbelt buckle cover...
- Placing a person in a bean bag or chair that they can't get out of ...
- Any unwanted touch constitutes a Restricted Practice...

1. Describe an occasion where you have used Physical Restraint when supporting a person. Why was it necessary?
2. Focus on the INTENT of the Restricted Practice when given an answer, i.e. why was the practice used.
3. If participants have not ever used Physical Restraint, ask them to come up with a scenario that would be a Restricted Practice, or provide them with your own examples.

ADMINISTRATION OF PRN PSYCHOTROPIC MEDICATION

The use of Psychotropic Medication on a prn basis is a considered a restricted practice. (refer to ADHC Behaviour Support Policy revised 2012 pg 12)

Psychotropic medication refers to medication which affects:

- Cognition (person's thinking/perception)
- Mood
- Level of arousal
- Behaviour

Psychoactive medications such as androgen - reducing medications are included.

- PRN stands for 'Pro Re Nata', which is Latin for 'as the circumstance arises'.
- PRN medication is additional to a person's routine medication.
- It has to be prescribed by a treating Psychiatrist or Paediatrician who will detail specific circumstances under which to use the PRN medication.

RESPONSE COST

This is a practice of withholding positively valued items or activities from a person in response to a particular behaviour or set of behaviours.

Examples of Response Cost

- Access to a computer game or TV program is denied due to a person yelling and screaming
- A person has to come home from community access activity if they display certain behaviour, e.g. grabbing a member of the public...
- A person has their stereo taken away if they play their music too loud after 11pm...

A response cost practice has to be part of a planned response to a behaviour of concern, it can not be a reaction to a behaviour.

Withheld items must not include: money; personal possession's; attendance at school or day placement; access to employment; access to family or a support person; or denial of food, shelter, comfort or ready access to toilet facilities. Response costs that interfere with a person's wellbeing or identified support needs are prohibited.

1. Describe a time when you have used response cost with a person you support.
2. Discuss answers with participants. Point out that Response Cost practices work best if linked with a reward scheme for the individual. If participants struggle to come up with an answer, share one of your own.

RESTRICTED ACCESS

Is using physical barriers or imposing limits or boundaries beyond normally accepted community practice. It could be placing restrictions on a person's independent access to items/activities/experiences.

Examples of Restricted Access

- Placing a lock on the fridge or kitchen door to prevent someone from over eating...
- Locking the front door or garden gate to prevent someone from running away...
- Not letting a person hire a DVD with a violent or sexualised content because they mimic what they see...
- Permanently refusing someone access to the local pool because of
- potential risk of safety to themselves or others...
- Keeping someone in 'line of sight' is also a form of Restricted Access, as the person is limited to areas where a support worker can see them...

Consider the Intention of the Practice

Staff must consider the intention of the Restricted Access, i.e. what issue -- does the restriction address? For example:

- Locking the front door to prevent someone from running away IS a Restricted Practice... Locking the door to prevent strangers from entering the house IS NOT a Restricted Practice as long as people can exit at anytime they choose.
- Locking the knife drawer due to a person's violent behaviour IS a Restricted Practice... Or locking the knife drawer due to a person's physical impairment risking injury without correct supervision is IS NOT a Restricted Practice.

SECLUSION

Where a person over the age of 18 years is isolated on their own in a setting from which they cannot leave. This should only be a short term response to a crisis in order to manage the risk of harm.

The use of seclusion as punishment, or reasons of convenience, or due to resource limitations is prohibited.

Example of Seclusion

- Everyone leaves the house when a person is out of control. They return when the person has settled.

1. Describe an occasion where Exclusionary Time Out {pg5) or Seclusion has been used with a person you support.
2. Discuss the effectiveness of the strategy used, i.e. did it actually calm the individual down, how did the person show that they were calm, what did they do to calm down, etc.
3. If participants struggle to answer, the facilitator can share a personal experience of when either seclusion or Exclusionary Time Out was effectively used to help a person calm down.

3.2.1 CONSENT AND AUTHORISATION REQUIREMENTS FOR A RESTRICTED PRACTICE

The use of a Restricted Practice must be informed by strict guidelines which provide clear conditions and limitations on their use. These conditions and limitations should be detailed in a documented Behaviour Support Plan (BSP) or Incident Prevention and Response Plan (IPRP) which requires:

a) appropriate informed consent;[1] and
b) authorisation by an internal restricted practice authorization mechanism.

3.2.1(A) CONSENT REQUIREMENTS

In the context of Restricted Practices consent is the permission given by the Service User (where they have the capacity to consent) or person(s) with appropriate legal authority for the use of a specific practice as a component of an overall behaviour support strategy.

Consent requirements for Restricted Practices are summarised in Table 5: RPA Consent Requirements.

Consent for Children (under the age of 18 years)

For children who are not the subject of a court order reallocating parental responsibility, consent for the use of a Restricted Practice as a component of behaviour support should be obtained from the parent or guardian.

For children who are under the parental responsibility of the Minister for Community Services, consent for the use of a Restricted Practice as a component of behaviour support must be obtained from the person with parental responsibility. This consent must be documented in the child or young person's case plan. The Behaviour Support Plan must be approved by the Director, Child and Family, DoCS. This approval must be recorded on the DoCS form "Authorisation for Designated Agency for use of a restricted practice in a Behaviour Management Plan".

Psychotropic Medication in Behaviour Support of Children

For children who are under the parental responsibility of the Minister for Community Services, consent for the use of psychotropic medication as a component of behaviour support must be sought from DoCS.

Where a carer has been given written consent from DoCS for the use of psychotropic medication as a component of behaviour support, this consent must be documented in the child or young person's case plan. The Behaviour Support Plan must be approved by the Director, Child and Family, DoCS. This approval must be recorded on the Docs form *"Authorisation for Designated Agency for use of a restricted practice in a Behaviour Management Plan".*

It is important to note that psychotropic medication prescribed to manage challenging behaviours on a prn basis is considered a Restricted Practice by DADHC.

1 Refer to the NSW Children and Young Persons (Care and Protection) Act (1998); the NSW Guardianship Tribunal's Position Statement: Behaviour Intervention and Support in Applications Relating to a Person with a Disability; and Behaviour Management and Guardianship as appropriate.

It is also important to note that while parents are allowed to reasonably chastise their children (unless under the parental responsibility of the Minister for Community services or subject to a Court Order), they cannot consent to another person doing this or agree to the use of any behaviour management technique that constitutes an assault or wrongful imprisonment.

CONSENT FOR YOUNG PEOPLE[2] AND ADULTS[3]

Where the Service User does not have the capacity to consent to the use of a Restricted Practice as a component of an overall behaviour support strategy, and where there is no person(s) with appropriate legal authority to consent on their behalf, a legally appointed Guardian may be required. In such cases specific authority to consent to the use of Restrictive Practices may be granted to a Guardian by the Guardianship Tribunal.

Only a legally appointed guardian with a Restrictive Practices function can give consent to the use of a Restricted Practice as a component of behaviour support of an adult or young person (aged "16 years or over). In the event that there is no legal guardian with that function, information should be sought immediately from:

The Guardianship Tribunal

2a Rowntree Street, Balmain NSW 2041

Telephone:	(02) 9556 7600
Fax:	(02) 9555 9049
Tollfree:	(02) 1800 463 928
email:	gt@gt.nsw.gov.au
Website:	www.gt.nsw.gov.au

Consent of the guardian to the use of a Restricted Practice is legal only for the time specified by the guardian.

If the legality of a practice or strategy is unclear, a guardian should have power to consent. In the event that there is no legal guardian with that function, information should be sought immediately from the Guardianship Tribunal.

There is no need to appoint a guardian:

- For restraint as part of risk management or safety, unless the Service User or someone else is objecting to the practice or strategy; or
- Where minimum force or confinement is used in a crisis to prevent harm.

[2] Aged 16 – 18 years and over and not under the care of the Minister for Community Services
[3] Aged 18 years and over

PSYCHOTROPIC MEDICATION IN BEHAVIOUR SUPPORT OF YOUNG PEOPLE AND ADULTS

Written consent is required for ALL medical & dental treatment. This may be provided either by:

- the patient (i.e. the Service User) where they have the capacity; or •
- the Person Responsible under the Guardianship Act.

Although medication prescribed to manage challenging behaviours does not constitute a restrictive practice as defined by the Guardianship Tribunal, consent to such use of medication must be conditional on its use in the context of a Behaviour Support Plan[4].

It is important to note that medication prescribed to manage challenging behaviours on a prn basis is considered a Restricted Practice by DADHC.

Psychotropic medication requires consent as for Major Medical (or Dental) Treatment.

- The Person Responsible can consent if the patient does not object
- If there is no Person Responsible, or if the patient (Service User) objects then only the Guardianship Tribunal can consent.

Note: Androgen-reducing medications prescribed to control behaviour, while not psychotropic, fall under Special Medical (or Dental) Treatment. Only the Guardianship Tribunal can consent to this.

Questions in relation to the Guardianship Act 1987 or the process of guardianship should be directed to the Guardianship Tribunal on (02) 9556 7600 or on the website of the Guardianship Tribunal **www.gt.nsw.gov.au**

The consent of the person(s) with appropriate legal authority does not release the Service Provider from the ethical imperative to establish and maintain a Restricted Practice Authorisation mechanism which evaluates, authorises and monitors all instances of the use of a restricted practice by its staff.

[4] Guardianship Tribunal Position Statement (March 2006)

TABLE 5: RPA CONSENT REQUIREMENTS

Service User	Practice		
	Exclusionary Time Out (ETO), Physical Restraint, Response Cost, Restricted Access	**Seclusion**	**PRN Psychotropic medication**
Children (under 18 years) not subject to court order reallocating parental responsibility	Parent or guardian	PROHIBITED	Parent or guardian
Children (under 18 years) subject to court order reallocating parental responsibility	Person with parental responsibility	PROHIBITED	Person with parental responsibility
Young people (16-18 years)	Guardian with a restrictive practices function	PROHIBITED	Either: a) The Service User where they have the capacity; b) The Person Responsible; or c) The Guardianship Tribunal where the Service User objects.
Adults (18 yrs and over)	Guardian with a restrictive practices function	Guardian with a restrictive practices function	Either: a) The Service User where they have the capacity; b) The Person Responsible; or c) The Guardianship Tribunal where the Service User objects.

3.2.1(B) AUTHORISATION REQUIREMENTS

A Restricted Practice may be recommended for use as a component of a behaviour support strategy only within the context of a documented Behaviour Support Plan (BSP) or Incident Prevention and Response Plan (IPRP) which has been developed in accordance with DADHC work practice requirements for behaviour support services[5].

In addition to consent, any recommendation for the use of a Restricted Practice requires formal authorisation via mechanism which considers the appropriateness of a documented support plan or strategy. This mechanism should operate at arm's length from the contributors to the documented support plans or strategies. Its role is to evaluate the recommendation within the context of work practice requirements.

[5] Behaviour Support: Policy and Practice Manual (January 2009), Part 1 (B) – Work Practice

The purpose of the mechanism is not to create obstacles in the face of "common sense", but rather to ensure that documented support plans or strategies which contain the use of a Restricted Practice:

1. Can be clinically justified;
2. Are authorised within the context of DADHC work practice requirements;
3. Include provision for appropriate consent; and
4. Can be safely implemented and monitored.

All Service Providers are expected to develop and maintain an RPA mechanism that addresses the above purpose in order to manage the use of Restricted Practices and maintain rigorous standards within their own service. Each RPA mechanism should be governed internally by the Service Provider and be responsible for:

- Transparent evaluation of formal RPA Submissions for all support plans and strategies which include a Restricted Practice;
- Issuing of formal decisions to either grant or decline Restricted Practice Authorisation (RPA) in relation to RPA Submissions; and
- Monitoring the use of RPAs.

Within DADHC this mechanism is known as the Restricted Practice Authorisation Panel (RPAP). Further details of the DADHC RPAP and associated processes are provided in the DADHC Behaviour Support: Policy and Practice Manual, Part 2.

A Restricted Practice Authorisation (RPA) must be strictly time-limited and may not exceed a validity period of twelve (12) months. Documented plans which contain the use of a Restricted Practice may not be implemented without a current RPA and appropriate consent. The Behaviour Support Practitioner who develops the documented support plan or strategy is responsible for preparing the RPA Submission[6].

The use of a Restricted Practice must be closely monitored to safeguard against potential abuse, and should be replaced with a less restrictive strategy as soon as possible.

Where an RPA is granted it must be time-limited. The use of a Restricted Practice must be closely monitored to safeguard against potential abuse, and should be replaced with a less restrictive strategy as soon as possible.

Restricted Practice Authorisation (RPA}:

1. Does NOT constitute consent;
2. Does NOT replace the requirement for consent; and
3. Is NOT sufficient in itself to sanction the use of a Restricted Practice.

[6] This may also be done by the manager responsible for delivery of behaviour support to the Service User

QUESTION 9. ARE WE IMPLEMENTING THE RESTRICTED PRACTICES IN-LINE WITH OUR REQUIREMENTS FOR RESTRICTED PRACTICES?

Policy Ref: 4.2 Developing a Multi-Element Support Plan?

To Answer YES to this Question, you must have: -

⇒ Checked the Restricted Practice Outcome Summary.

⇒ Checked the Reviews of the Restricted Practice usage.

Answer 9.

YES; Go to Q/ 10.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the "Requirements for Restrictive Practices" guidelines". – following.	Concerned Support Worker (CSW) & Leader	Immediately
Ensure appropriate documents are prepared for this RP. Use checklists 1-5 and Outcomes Summary, RP Action Plan and Record of RP Use Template – in Attachments.	Leader	Within 2 days
Check that all staff involved know of their recording requirements	Leader	Within 1 day
Then Answer this Question	Leader	Immediately

REQUIREMENTS FOR RESTRICTED PRACTICES

- It must form a part of a documented Behaviour Support Plan (BSP) or Incident Prevention and Response Plan (IPRP) which incorporates positive strategies and approaches
- As part of the BSP or the IPRP strategy the Restricted Practice includes:
    - Description of the practice/strategy
    - Expected outcomes for related to the practice/strategy
    - Rationale for the use to the practice/strategy and why positive approaches are unable to achieve the desired outcomes
    - Implementation guidelines
    - Data collection process
    - Review process for the practice
    - Fade out strategies proposed
- All are familiarised with the operational aspects of the practice understands the specific purpose for the strategy, are competent to implement it, and have relevant support with the system
- A Restrictive Practice may only be considered after a range of less restrictive options have been trialled and evaluated

All Restricted Practices strategies must be documented and reported

EXCLUSIONARY TIME OUT AND SECLUSION

To minimise harm during Exclusionary Time out and Seclusion

There needs to be:

- Means of easy observation
- Adequate light and ventilation
- Comfortable temperature
- Easy access to toilet

Procedural requirements of Exclusionary Time Out and Seclusion

- Review incident and use of ETO or seclusion within 24 hrs. of each use
- The review should include:
    - The person and their advocate
    - The behaviour support practitioner
    - Representative of staff
    - Unit manager and other line managers
    - Other stakeholders as appropriate

Requirements for Response Cost & Physical Restraint

A register is maintained to record;

- Date, time and location
- Brief description of environment and events prior to using the strategy o Description of the behaviour
- Detail of other less restrictive strategies attempted and the outcomes o Reason for use of strategy

- Duration
- Those involved in the implementation of the strategy
- Name and position of staff directing use of strategy
- Outcome
- Evidence of support & counselling for young people and children

REQUIREMENTS OF ADMINISTRATION OF PRN PSYCHOTROPIC MEDICATION

- The Administration of PRN Psychotropic Medication requires an established PRN Protocol be established with the prescribing psychiatrist / paediatrician.
- The PRN Protocol is part of the Behaviour Support Plan or Incident Prevention and Response Plan.
- The contribution or benefit derived from the medication should be regularly reviewed with the treating psychiatrist/paediatrician with the person who wrote the behaviour support plan

Administration of psychotropic medication contrary to the documented PRN Protocol is prohibited.

A PRN Protocol is essential. This document will detail:

- The name and contact details of the prescribing psychiatrist/ paediatrician
- The chemical and brand name of the medication
- Name and contact details of the person giving informed consent for the prn medication
- The circumstances I conditions under which the medication may be administered
- Instructions regarding the dosage, including the maximum permissible in a 24-hour period
- When, why and how to administer
- The purpose of the prn medication and the desired outcome
- The likely timeframe between administration of the drug and the onset of the beneficial effect
- Possible side effects/ adverse effects/ symptoms of overdose
- Complications I interactions with other medications
- Monitoring, recording, response and reporting instructions must be made available to all staff who administers the medication.

There should be a schedule of regular reviews by the treating Psychiatrist/Paediatrician.

Administration of psychotropic medication contrary to the instructions of the prescribing psychiatrist or paediatrician, or contrary to a documented PRN Protocol, is prohibited.

The use of a Restricted Practice needs to be closely monitored to safeguard against abuse, and replace with less restrictive strategies as soon as possible.

QUESTION 10. HAVE WE HAD OUR PBSP CHECKED BY A COMPETENT PERSON AGAINST OUR PBSP CLINICAL GUIDELINES CHECKLIST?

Policy Ref: 5 Making the PBSP Work for the Person.

To Answer YES to this Question, you must have: -

⇒ sighted the completed PBSP Clinical Guidelines Checklist for this PBSP.

Answer 10.

YES; Go to Q/ 11.

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the Policy Ref.	Concerned Support Worker (CSW) & Leader	Immediately
Identify within your staff, an "Appropriately Trained" person, as per the Policy. If no available person on staff, then you will need to arrange to access the external Behaviour Support Specialist • **Policy Ref: 6.2** • **See Attachments to Q.18.**	Leader & Quality Officer	Within 5 days
Ensure this person has a copy of the full PBSP & the CDS Clinical Guidelines Checklist - following.	Leader	Within 2 days
Respond to any feedback from the appropriately trained person.	Leader	Within 2 days
When Checklist has been satisfactorily completed and signed by the appropriate person, then go to Question 11.	Leader	Immediately

CHECKLIST FOR ASSESSING THE POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP), AGAINST THE CLINICAL GUIDELINES OF CURRAJONG DISABILITY SERVICES.

Name of Person who Developed this PBSP: _____

PBSP Developed to Support (Name): _____

Date of this PBSP: __/__/__

Indicate whether or not there is evidence that this PBSP includes the following components: -

	Component	**Response**		**Comment**
1	Realistic, measurable and person-centred Goals based on documented evidence.	Yes	No	
2	Positive support strategies that support these Goals.	Yes	No	
3	Timelines and outcomes indicated for these Goals	Yes	No	
4	Response strategies and guidelines for using them.	Yes	No	
5	Defined roles and responsibilities for effective implementation of strategies.	Yes	No	
6	Recommendations to help CDS sustain the strategies.	Yes	No	
7	Review Schedule	Yes	No	
8	Incorporates the outcomes of the Functional Analysis.	Yes	No	
9	Provides structured guidelines to support each behaviour.	Yes	No	
10	Provides structured guidelines for support across all Domains identified .	Yes	No	
11	Has strategies supporting person-centred outcomes.	Yes	No	
12	Has been developed with input from the Person and their family/ guardian etc.?	Yes	No	
13	Has been developed with input from other significant stakeholders	Yes	No	

Which of the following Elements are included in this PBSP?

	Element	Response		Comment
14	Person-Centred Goals	Yes	No	
15	Ecological Supports	Yes	No	
16	Positive Interventions	Yes	No	
17	Proactive & Skill Development Strategies	Yes	No	
18	Incident Response Plan	Yes	No	
19	Communication Strategies	Yes	No	

This Checklist must be completed by the Quality Officer, or an external Behaviour Support Specialist:

Name of Person Completing Checklist: _____

Position: _____

Date Checklist Completed: ___/___/___

Signature: _____

QUESTION 11. HAVE WE IDENTIFIED THE STAFF PERSON WHO WILL ACT AS THE IMPLEMENTATION COORDINATOR (IC) FOR THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?

Policy Ref: 5.1 Implementing the Positive Behaviour Support Plan (PBSP).

Answer 11.

YES; Go to Q.12

NO; Complete the following Actions: -

Action	Who	Timeframe
Read the Policy Statement.	Concerned Support Worker (CSW) & Leader	Immediately
Meet with all staff & managers involved with this Positive Behaviour Support Plan (PBSP), to decide who should be the Implementation Coordinator (IC).	Leader	Within 5 days
Ensure the Implementation Coordinator has read the Policy item, and is aware of the Attachments to Questions 12 & 13.	Leader & IC	Within 2 days
Then answer this Question	Leader	Immediately

QUESTION 12. HAS THE IMPLEMENTATION COORDINATOR ASSESSED THE NEEDS OF STAFF TO ADEQUATELY IMPLEMENT THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?

Policy Ref: 5.1 Implementing the Positive Behaviour Support Plan (PBSP).

To Answer YES to this question you must have: -

⇒ checked for evidence of completed "Goodness of Fit" Surveys.

Answer 12.

YES; Go to Q.13

NO; Complete the following Actions: -

Action	Who	Timeframe
Remind the IC of the Policy notes 5.1	Leader	Immediately
IC needs to provide all staff involved with the opportunity to review the Positive Behaviour Support Plan (PBSP) and complete a feedback form such as the "Goodness of Fit" Survey – Template following	IC	Within 1 week
IC to collate feedback & complete and submit a Positive Behaviour Support Plan (PBSP) Implementation Report for Leader/ Service Delivery Manager Template following.	IC	Within 3 days
Then answer this Question	Leader	Immediately

GOODNESS OF FIT - SURVEY

Name of Person with the Positive Behaviour Support Plan (PBSP):

Person Completing this Survey:

Date Survey Completed: …. /…/….

***Notes**: This survey is for use by staff supporting the above person, and aims to improve the effectiveness of the Positive Behaviour Support Plan (PBSP)., Your responses will help improve the quality and effectiveness of this Positive Behaviour Support Plan (PBSP). Below are 20 questions about this Positive Behaviour Support Plan (PBSP) and its chances of success. First, make sure you are familiar with the Positive Behaviour Support Plan (PBSP). Then, answer each question by circling the number under the rating that matches your current opinion.*

QUESTION	NOT AT ALL	NOT MUCH	CAN'T TELL	WELL	VERY WELL
1. Do you agree this Positive Behaviour Support Plan (PBSP) takes into account your knowledge of this person and their behaviour of concern?	1	2	3	4	5
2. Does this Positive Behaviour Support Plan (PBSP) deal with what you think are the highest needs for this person?	1	2	3	4	5
3. Are you clear about what you are expected to do as part of this Positive Behaviour Support Plan (PBSP)?	1	2	3	4	5
4. Are you comfortable with what you are expected to do?	1	2	3	4	5
5. Are you comfortable with what other staff are expected to do?	1	2	3	4	5
6. Does the Positive Behaviour Support Plan (PBSP) recognise the needs of both the person and the staff?	1	2	3	4	5
7. Does the Positive Behaviour Support Plan (PBSP) recognise the needs of other service users who live or work with this person?	1	2	3	4	5
8. Do you think you have the skills to implement this Positive Behaviour Support Plan (PBSP)?	1	2	3	4	5
9. Do you think other staff have the skills to implement this Positive Behaviour Support Plan (PBSP)?	1	2	3	4	5
10. How well do you think this Positive Behaviour Support Plan (PBSP) fits with the daily routines of CDS?	1	2	3	4	5

QUESTION	NOT AT ALL	NOT MUCH	CAN'T TELL	WELL	VERY WELL
11. How well do you think this Positive Behaviour Support Plan (PBSP) fits with your values and beliefs about supporting people with a disability and their behaviours?	1	2	3	4	5
12. Does this Positive Behaviour Support Plan (PBSP) include successful strategies you have used before with this person?	1	2	3	4	5
13. Do you think this Positive Behaviour Support Plan (PBSP) will seriously disrupt aspects of CDS, resulting in stress and hardship?	1	2	3	4	5
	1	2	3	4	5
15. Does this Positive Behaviour Support Plan (PBSP) recognise and build on the strengths of the person?	1	2	3	4	5
16. Does this Positive Behaviour Support Plan (PBSP) include any needs you may have for supervision or support?	1	2	3	4	5
17. Overall, how difficult do you think it will be for you to work with this Positive Behaviour Support Plan (PBSP)?	1	2	3	4	5
18. Do you think this Positive Behaviour Support Plan (PBSP) will be effective?	1	2	3	4	5
19. Does this Positive Behaviour Support Plan (PBSP) include any emotional support you may need?	1	2	3	4	5
20. If this Positive Behaviour Support Plan (PBSP) is effective, do you think you can continue to implement it over the longer term?	1	2	3	4	5

Adapted from:

Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust 2010, A Hitchhiker's Guide for the specialist Behaviour Team (Operational Guidance), GIG CYRMU, Wales.

POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) IMPLEMENTATION REPORT:

POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) for ……

Date of Positive Behaviour Support Plan (PBSP) ……/……/……

Implementation Coordinator Name; …….

Date this Report Compiled ……/……/…….

PART A / PRACTICAL ISSUES IDENTIFIED:

Issues Identified	**Recommended Action**

PART B / INDIVIDUAL STAFF ISSUES:

Staff Names & Issues	**Recommended Action**

PART C/ LEADER OR SERVICE DELIVERY MANAGER(SDM) FEEDBACK:

Leader/ SDM Sign; Date: …../…/…..

QUESTION 13. HAVE WE TRAINED THE IMPLEMENTERS, AND DEVELOPED SPECIFIC ACTION PLANS AND RELIABILITY TESTING FORMATS TO SUPPORT THE IMPLEMENTATION OF THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?

Policy Ref: 5.1 Implementing the Positive Behaviour Support Plan (PBSP).

To Answer YES to this Question, you must have: -

⇒ sighted evidence such as Training of Implementers forms, Staff Action Plans & Reliability Testing Forms.

Answer 13.

YES; Go to Q.14

NO; Complete the following Actions: -

Action	Who	Timeframe
Schedule training responses to staff needs identified in Q.11	IC	Within 2 days
Develop and use Individual Staff Action Forms where necessary. - in Attachments.	IC	Within 1 week
Complete "Training of Implementers" Form - in Attachments.	IC	Within 2 weeks of Positive Behaviour Support Plan (PBSP) start
Read the guidelines, "Reliability Measures" – following. Then use at least one of those Reliability Measures and record results on the "Positive Behaviour Support Plan Implementer Reliability Measures Recording Form" – in Attachments.	Leader	Within 2 days
Then Answer this Question	Leader	Immediately

6.2.1 RELIABILITY MEASURES

It is important that implementer training instils a level of confidence in the application of a support strategy as intended. Success of training in can be measured through:

TABLE 12: RELIABILITY MEASURES

Measure	Description
Verbal reliability	A respondent verbally demonstrates their knowledge of a support plan in order to identify those areas where further training or development may be required.
Procedural reliability	A carer is observed performing components of a behaviour support plan in order to identify those areas where further training or development may be required.
Role play	Carers and *Behaviour Support Practitioners* role-play particular strategies and carers receive constructive feedback and encouragement.
Supervision	Supervision of staff work practices, in relation to support plan, by line management. Line managers of staff are responsible for the consistency with which staff implement strategies.

QUESTION 14. HAVE WE CHECKED THAT THE MONITORING REQUIREMENTS SPECIFIED IN THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP), HAVE CLEAR FORMATS FOR RECORDING, AND THAT STAFF ARE ABLE TO USE THEM?

Policy Ref: 5.2 Monitoring the Positive Behaviour Support Plan (PBSP).

To Answer this Question, you must have: -

⇒ Compared the Monitoring Requirements in the Positive Behaviour Support Plan (PBSP), with the Monitoring Forms provided to staff.

Answer 14.

YES; Go to Q/ 15.

NO; Complete the following Actions: -

Action	Who	Timeframe
Ensure appropriate Monitoring Forms are developed to match the Monitoring requirements set out in the Positive Behaviour Support Plan (PBSP). Sample Formats in Attachments.	Leader	Within 3 days.
Ensure a Monitoring of the Positive Behaviour Support Plan (PBSP) Implementation Strategies Form is completed - See Attachments	Leader	Within 2 days
Check with staff that they can comply with the Forms & Processes.	Leader	Within 2 days
Then answer this Question.	Leader	Immediately

MONITORING OF THE STRATEGIES TO BE IMPLEMENTED THROUGH THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)

Recording episodes of behaviour that cause harm

Immediately after any incidents of behaviour that causes harm to self or others [post debriefing], Support staff are to call the House Coordinator or the On Call Coordinator and inform them of the incident. The Support Staff is then to complete a Behaviour Incident Report form and send to the House Coordinator by the next working day. Support Staff will use Behaviour Incident Report forms, ABC note cards and Scatterplots to record the frequency, duration and intensity of the behaviour that causes harm to self or others and what occurred immediately prior to and after the behaviour that causes harm to self or others. Additionally, these forms will record any injuries [potential or actual] to Taylor, his cotenants or support team.

These situations should continue to be monitored and House Coordinator and Service Manager informed if Taylor's use of behaviour that causes harm to self or others occurs more than:

1. Twice a day in the first month [plan implementation]
2. More than once a day in the following two months;
3. More than twice a week from month four onwards

Evaluating Skill Development

The Task Record Sheets are to be kept in the house. Taylor's use of the replacement behaviour will be recorded on these sheets by Support Staff who will provide a copy of each day's Task Record Sheets to the House Coordinator each Monday. The House Coordinator is responsible for ensuring Task Record Sheets are completed each day.

The House Coordinator will record the progress of Taylor's goal achievement using weekly cumulative graphs on Taylor's progress in learning the replacement behaviour within his, home. The graphs will summarise data contained in the Task Record Sheets. These will be reported back to the Support Staff monthly at team meetings and via email to Dee Yarrs and Dr Kelp.

The House Coordinator will contact Taylor's family [Tim or Jason] monthly to discuss the strategies being used at home and Taylor's achievements monthly. This is to ensure Taylor's family are fully aware of his progress. Any additional supports or strategies put in place to support Taylor's behaviour that causes harm to self or others will be immediately verbally communicated to Taylor's entire support team by the House Coordinator [following discussion with Dee Yarrs]. Taylor's family will receive notification of such during monthly contact from the House Coordinator.

Evaluation of this plan

Support Staff and the House Coordinator will attend regular meetings to review Taylor's achievements. Taylor's Positive Behaviour Support Plan is to be reviewed initially at one month of implementation by his entire support team including Support Staff, House Coordinator and Service Manager, facilitated by Dee Yarrs. After three months of implementation there will be a comprehensive review undertaken of the plan, including all Support Staff, House Coordinator, Service Manager, and family, facilitated by Dee Yarrs. Taylor's Positive Behaviour Support Plan will again be comprehensively reviewed at nine months, including Support Staff, House Coordinator and Service Manager, facilitated by Dee Yarrs.

QUESTION 15. HAVE WE BOOKED TIMES AND PERSONNEL FOR THE REVIEW MEETINGS AS PER THE POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?

Policy Ref: 5.3 Reviewing the Positive Behaviour Support Plan (PBSP).

To Answer this Question, you must have: -

⇒ Checked the Positive Behaviour Support Plan (PBSP) Review requirements with relevant CDS & Staff Diaries.

Answer 15.

YES; Go to Q/16.

NO; Complete the following Actions: -

Action	Who	Timeframe
Check the Review requirements in the Positive Behaviour Support Plan (PBSP).	Leader	Immediately
Schedule Review Dates and Personnel as specified.	Leader	Within 3 days.

QUESTION 16. HAVE WE A CLEAR RECORDING FORMAT FOR OUR REVIEW MEETINGS?

Policy Ref: 5.3 Reviewing the Positive Behaviour Support Plan (PBSP).

Answer 16.

YES; Go to Q/ 17.

NO; Complete the following Actions: -

Action	Who	Timeframe
Check with the Policy Reference.	Leader	Immediately
Check the Review Formats in Attachments.	Leader	Immediately
Ensure Review formats are suitable for this Positive Behaviour Support Plan (PBSP) & provide copies to Review persons.	Leader	Within 2 days
Then answer this Question.	Leader	Immediately

REVIEW OF POSITIVE BEHAVIOUR SUPPORT PLAN

Name:		Date of Birth:	

Date of PBSP:		Review Date:	

A. DATA MONITORING:

From the Evidence, is this Positive Behaviour Support Plan (PBSP) working or not? What aspects are working or not working?

B. IMPLEMENTATION:

Are there any problems raised by the Implementation Coordinator, e.g. staff and resource issues?

C. POSITIVE INTERVENTIONS & SKILL DEVELOPMENT:

Is there a need to update any of these to maintain their effectiveness?

D. GOALS:

Are the Goals for this person still realistic and achievable? Are our strategies matching these Goals?

E. NEW INFORMATION:

Has something been missed or changed? Any new info?

F. CONSULTATION:

Have a number of staff regularly implementing this Positive Behaviour Support Plan (PBSP) been consulted with for this Review? Names & positions: -

DO we need to consult with the Behaviour Support Specialist (BSS) before deciding on Outcomes? If YES, record date & comments from BSS.

G. OUTCOMES:

This Positive Behaviour Support Plan (PBSP) is having a Positive Effect. It will continue to next Review

The Goals in this Positive Behaviour Support Plan (PBSP) have been reached. This Positive Behaviour Support Plan (PBSP) is now Closed

This Positive Behaviour Support Plan (PBSP) is not supporting progress. It is Suspended whilst changes are made

Next Review Date (*if applicable*); ___/___/___

AUTHORISATIONS:

	Name	**Sign**
Support Worker Rep.		
Leader:		
Service Delivery Manager		

CONSENT:

Carer/Guardian/Service User Name:			
Relationship to Service User:			
Signature:		Date	

QUESTION 17. ARE WE IMPLEMENTING THIS POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) SUCCESSFULLY WITHIN THE CURRENT STAFF RESOURCES OF CDS?

Policy Ref: 6 & 6.1 When the Person needs Extra Help & The Support Capacity of CDS.

Answer 17.

YES; Continue to implement the Positive Behaviour Support Plan (PBSP).

NO; Go to Q/ 18.

Action	Who	Timeframe
Check the Review Notes for evidence that extra staff skills are needed, or specialist staff needed.	Leader	Immediately
Then answer this question.	Leader	Immediately

QUESTION 18. HAVE WE EVIDENCE SUPPORTING OUR POLICY COMMITMENT, THAT STAFF WILL HAVE A BASIC LEVEL OF TRAINING IN POSITIVE BEHAVIOUR SUPPORT?

Policy Ref: 6.1 The Support Capacity of CDS.

Answer 18.

YES; Go to Q/ 19.

NO; Complete the following Actions: -

Action	Who	Timeframe
Review the Policy Ref.	Leader	Immediately
Check with Management to ensure training in PBS is still being regularly supported & documented.	Leader	Within 3 days
Then answer this Question.	Leader	Immediately

QUESTION 19. HAVE WE A CURRENT PROCESS FOR ACCESSING EXTERNAL BEHAVIOUR SUPPORT SPECIALISTS, AND IS OUR REGISTER OF THEM CURRENT?

Policy Ref: 6.2 Behaviour Support Specialists.

To Answer this Question, you must have: -

⇒ Checked the "Process for Accessing External Behaviour Support Specialists" & the currency of the "Register of External Behaviour Support Specialists".

Answer 19.

YES; Initiate access to an External B.S person & Go to Q/20.

NO; Complete the following Actions: -

Action	Who	Timeframe
Review the Policy Ref.	Leader	Immediately
Support Management to update the "Process…" and/or the "Register".	Leader & Service Delivery Manager	Within 3 days
Then answer this Question	Leader	Immediately

PROCESS TO ACCESS THE EXTERNAL BEHAVIOUR SUPPORT SPECIALIST:

This Process has been developed to support our Positive Behaviour Support Policy Item 6.2. Currently CDS has an agreement with The Westhaven Association of Dubbo, that allows us to access their Behaviour Support Specialist Team.

The following process should be followed, whenever we identify the need for an External Behaviour Support Specialist (EBSS):-

1. Case Worker to inform the Manager/ Supervisor of the details of the reason to involve the EBSS. Gain verbal approval to do so.
2. Case Worker to contact by phone or email, the Westhaven Behaviour Support Specialist Team. **Current Contact Details are**:-

3. Case Worker to provide all documentation as requested by the EBSS
4. Case Worker to ensure any input from the EBSS is documented in an appropriate Part of the POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) records.
5. The EBSS will maintain their own records of time allocated to CDS, within the Westhaven Association administration system.
6. Case Worker will inform Manager/Supervisor when role of EBSS is completed.
7. The Westhaven Association may invoice CDS for the services of the EBSS, if they consider it to be appropriate.

***PROCESS Updated**; 25/09/15*

REGISTER OF EXTERNAL BEHAVIOUR SUPPORT SPECIALISTS

NAME OF BS SPECIALIST	EMPLOYING AGENCY & CONTACT DETAILS	REASONS FOR INCLUSION IN THIS REGISTER	DATE DETAILS CHECKED

QUESTION 20. IS THERE A NEED TO ENGAGE WITH OTHER ALLIED HEALTH SPECIALISTS TO SUPPORT THIS PERSON AND THEIR POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?

Policy Ref: 6.3 Behaviours of Concern.

Answer 20.

YES; Go to Q/ 21.

NO; Continue to implement the POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP).

Action	Who	Timeframe
Check In Positive Behaviour Support Plan (PBSP) Review Notes or evidence.	Leader	Immediately
Then answer this Question.	Leader	Immediately

QUESTION 21. IS THE CDS REGISTER OF OTHER ALLIED HEALTH SPECIALISTS CURRENT, AND BEING USED TO ACCESS SUPPORT FOR THIS PERSON?

Policy Ref: 6.3 Other Support Services.

To Answer this Question, you must have: -

⇒ Checked the current "Register of Other Allied Health Specialists".

Answer 21.

YES; Use the Register to access extra supports for this person and their Positive Behaviour Support Plan (PBSP).

NO; Complete the following Actions: -

Action	Who	Timeframe
Review the Policy Ref.	Leader	Immediately
Work with Management to ensure Register is updated.	Leader & Service Delivery Manager	Within 3 days
Access appropriate Allied Health Support for this person.	Leader	Within 2 days
Then answer this Question.	Leader	Immediately

REGISTER OF ALLIED HEALTH SPECIALISTS

NAME OF AH SPECIALIST & THEIR SPECIALITY	EMPLOYING AGENCY & CONTACT DETAILS	REASONS FOR INCLUSION IN THIS REGISTER	DATE DETAILS CHECKED

ATTACHMENTS

LIFESTYLE AND ENVIRONMENT REVIEW & ACTION PLAN

Name of Person:			
Date LER Completed:			
DOMAIN	STRENGTHS / GAPS IN SUPPORT	ACTIONS REQUIRED	PERSONS RESPONSIBLE & TIMEFRAME
Health / Medical • Side effects of current medications • Self-harming issues • Sensory issues • Sleep patterns • Nutrition & body weight • Dental • Muscle & skeletal issues • Mobility • Allergies • Fine motor skills			
Emotional State • Moods • Known stressors • Known psychiatric issues			

Name of Person:			
Date LER Completed:			
DOMAIN	STRENGTHS / GAPS IN SUPPORT	ACTIONS REQUIRED	PERSONS RESPONSIBLE & TIMEFRAME
Lifestyle • Balance? • Rewards • Range of daily activities • Range of venues visited • Participation in domestic routines • Skills wanted • Appropriateness of placement & programs • Self-esteem issues			
Relationships • Is valued by others? • Family situation • Identified “friends” • Cultural issues • Intimacy issues • Relationship skills			

Name of Person:			
Date LER Completed:			
DOMAIN	STRENGTHS / GAPS IN SUPPORT	ACTIONS REQUIRED	PERSONS RESPONSIBLE & TIMEFRAME
Communication • Degree of independence • Comprehension issues • Clear support systems in place if needed • Options to communicate choices • Issues in communicating with other clients			
Behaviours • Any behaviours restricting access and participation • Odd/ eccentric behaviours • Appropriate positive supports in place. • Skill development needed			

Name of Person:			
Date LER Completed:			
DOMAIN	STRENGTHS / GAPS IN SUPPORT	ACTIONS REQUIRED	PERSONS RESPONSIBLE & TIMEFRAME
Environment • Problems with building layout • People /noise tolerances • Staff changes/ compatibility • Places to retreat to • Access to basic needs like food, drink & toilet			
Life Skills • Personal care skills • Levels of support needed • Skills the person wants to learn • Does the routine enable staff to provide skill training “on the go” ?			

PEOPLE CONTRIBUTING TO THIS LIFESTYLE AND ENVIRONMENT REVIEW & ACTION PLAN		
NAME	ROLE	SIGNATURE & DATE

STAR CHART

NAME:

Date & Initials	Time	Setting **Where? Who was there? What was happening?**	Triggers **What happened immediately before the incident ?**	Action **What did the person do? Describe Incident**	Response **What happened then ?**	Duration & Frequency

FUNCTIONAL ANALYSIS OF BEHAVIOUR OF CONCERN

NAME OF PERSON WITH BEHAVIOUR OF CONCERN (BOC):	
Profile/ Diagnosis	
Setting Events	
Triggers	
Description of the BoC – Actions Observed	
Consequent Events Responses	

WHAT DO YOU THINK IS THE FUNCTION (OR FUNCTIONS) OF THIS BEHAVIOUR?	
Consider, does the behaviour result in the person:- • **Gaining social interaction** • **Escaping or avoiding something** • **Gaining access to something they like or want** • **Sensory feedback** • **Reduction of anxiety or arousal.** • **Control or empowerment** • **Other?**	

Functional Analysis Completed by: _____

Position: _____

Date: __/__/__

POSITIVE BEHAVIOUR SUPPORT PLAN

Name: _____ Date of Birth: _____

Date PBSP: _____ Review Date: _____

Does this PBSP contain any Restrictive Practices? Yes ☐ No ☐

Date of Restricted Practice Authorisation: _____

POSITIVE BEHAVIOUR SUPPORT
Identified Behaviour/s of Concern:
Behaviour Triggers:
Early Warning Signs

POSITIVE PROACTIVE PREVENTION/SKILL DEVELOPMENT STRATEGIES: MULTI-ELEMENT PLAN	
Goals	
Ecological Supports	
Positive Interventions	
Focussed Interventions	

REACTIVE INTERVENTION STRATEGIES

To support the Positive Behaviour strategies, and to use when they are unsuccessful in de-escalating behaviours, these reactive intervention strategies need to be implemented:

INCIDENT RESPONSE PLAN; Date if Interim = …./…/….

WARNING STAGE	
Behaviour	Response Strategy

BUILD UP STAGE	
Behaviour	Response Strategy

CLIMAX STAGE	
Behaviour	Response Strategy

RESTRICTED PRACTICE PARAMETERS	
Restricted Practice Type	Instructions for Implementation

ANY OTHER DETAILS

AUTHORISATIONS:

Positive Behaviour Support Plan Author:			
Position:			
Signature:		Date	

Restricted Practice Authorisation Panel:			
RPA Date		Review Date	

CONSENT:

Carer/Guardian/Service User Name:			
Relationship to Service User:			
Signature:		Date	

RESTRICTIVE PRACTICE AUTHORISATION

APPLICATION FOR RESTRICTIVE PRACTICE AUTHORISATION (RPA)

1. Details of client	
Name:	Street Address:
DOB:	
Date for review:	Suburb, State & Postcode

2. Key Support Staff	
Support Worker:	
Phone:	Email:
Leader:	
Phone:	Email:

3. Category of Proposed Restricted Practice (select)		
□ Physical Restraint	□ Psychotropic Medication (PRN)	□ Restricted Access
□ Exclusionary Time-Out	□ Response Cost	□ Seclusion

4. Prior RPA History			
Category of restricted practice	Date RPA granted	Validity period	Date of Expiry

5. Details of Doctor/ Psychiatrist/ Psychologist (if applicable)	
Name:	
Position:	
Phone:	Email:

6. Documents Attached With Submission (select)
□ Current Individual Plan **(IP)** □ Current Lifestyle and Environmental Review **(LER)** □ Protocols for monitoring use of the proposed practice □ Current POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) □ Other (specify)

7. Summary of Identified Behaviour of Concern
a) Description of Behaviour
b) Background of Behaviour

c) Identified Risk from Behaviour
8. Detailed Summary of Proposed Restricted Practice
a) Description of the proposed Practice/ Strategy
b) Expect Outcomes Related to the Proposed Practice/ Strategy
c) Rationale for the Use of the Proposed Practice/ Strategy Why are positive practices alone unable to achieve the desired outcomes
d) Ways this RP will be Monitored
e) Implementer Training
9. Submission Completed by;

Name:	Position:
Location:	Phone:
Signature:	Date:

10. Endorsement of Leader;

Name:	Position:
Location:	Phone:
Signature:	Date:

11. Details of Person To Approach for Legal Consent

Name:	
Status:	(please specify: e.g. legal guardian person responsible)
Phone:	Fax:

RPA Panel Usage:

Date of submission received:		***Name & Initial:***	
Date Acknowledged:		***Name & Initial:***	

CONSENT TO SHARE INFORMATION

Currajong Disability Service (CDS) may need to collect and share information with others about supports you need. I _____ give permission to CDS to share information about me and I understand I have the right to refuse/limit consent to sharing information at any time.

External Agency/Person/Service Type	Type of consents sought *(code)*	Approval	Consenting client signature & date
Family who aren't Guardian		☐ YES / ☐ NO	
Private Guardian		☐ YES / ☐ NO	
Trustee and Guardian		☐ YES / ☐ NO	
Advocacy Services		☐ YES / ☐ NO	
ADHC Intake & Assessment		☐ YES / ☐ NO	
Assist Respite/Accommodation options		☐ YES / ☐ NO	
Case Management services		☐ YES / ☐ NO	
Respite RCG		☐ YES / ☐ NO	
Financial Management		☐ YES / ☐ NO	
Hospital		☐ YES / ☐ NO	
Doctor / Specialist		☐ YES / ☐ NO	
Centrelink		☐ YES / ☐ NO	
Community Mental Health		☐ YES / ☐ NO	
Collection of non-identifying client statistical information for Government (MDS)		☐ YES / ☐ NO	
Other Services *Name:*		☐ YES / ☐ NO	
Other		☐ YES / ☐ NO	

Consent Codes

Medical and Emergency information	**MEI**	Behaviour support information	**BSI**
Restrictive practice information	**RPI**	Client financial information	**CFI**
General support information	**GSI**		

Signed_____ (Client / person responsible)

This consent is valid until ___ / ___ / _____ (maximum 12 months)

RPAP CHECK 1

Restricted Practice Authorisation Panel (RPAP)
CHECKLIST: General Work Practice

*Complete this Checklist for **ALL** Restricted Practice Submissions*
Element: Multi-element Behaviour Support Plan (BSP) or Incident Prevention and Response Plan (IPRP)

EVIDENCE	Select	
1. Developed and endorsed by a Behaviour Support Practitioner Comments:	☐ Yes	☐ No
2. Currency: clearly dated with schedule for review Comments:	☐ Yes	☐ No
3. Evidence of comprehensive assessment, analysis and formulation (Behaviour Assessment Report) Comments:	☐ Yes	☐ No
4. Evidence of collaboration between Behaviour Support Practitioner, Service User *(where appropriate)*, their family/carer/advocate/other significant stakeholders Comments:	☐ Yes	☐ No
5. Profile of the Service User including relevant diagnoses Comments:	☐ Yes	☐ No
6. Identifies significant aspects of the support system Comments:	☐ Yes	☐ No
7. Clear description of each targeted behaviour, including topography, impact and history Comments:	☐ Yes	☐ No
8. Description of previous interventions, strategies and related outcomes Comments:	☐ Yes	☐ No
9. Description of positive strategies and related goals/objectives Comments:	☐ Yes	☐ No
10. Clear implementation instructions for carers Comments:	☐ Yes	☐ No

Adapted from ADHC Behaviour Support Policy Manual Part 1(B) work practice 2009 & 2012
Office of the Senior Practitioner – Ageing Disability and Home Care, FACS NSW January 2009

RPAP CHECK 2

Restricted Practice Authorisation Panel (RPAP)
CHECKLIST: General Requirements for a Restricted Practice

*Complete this Checklist for ALL Restricted Practice Submissions **EXCEPT** psychotropic medication (PRN)*
Element: The restricted practice is clearly defined in the context of the multi-element BSP or IPRP

EVIDENCE	Select	
1. Description of the proposed practice Comments:	☐ Yes	☐ No
2. Expected outcomes related to the proposed practice/strategy Comments:	☐ Yes	☐ No
3. Rationale for the use of the proposed practice / strategy Comments:	☐ Yes	☐ No
4. Clearly defined roles and responsibilities Comments:	☐ Yes	☐ No
5. Clearly defined contextual variables Comments:	☐ Yes	☐ No
6. Clearly defined proposed frequency of use Comments:	☐ Yes	☐ No
7. Clearly defined monitoring requirements Comments:	☐ Yes	☐ No
8. Clearly defined reporting protocols Comments:	☐ Yes	☐ No
9. Schedule of review of the proposed practice / strategy Comments:	☐ Yes	☐ No
10. Fade-out strategies	☐ Yes	☐ No
11. Provision for appropriate consent	☐ Yes	☐ No
12. Carer training and implementation plan	☐ Yes	☐ No

Adapted from ADHC Behaviour Support Policy Manual Part 1(B) work practice 2009 & 2012
Office of the Senior Practitioner – Ageing Disability and Home Care, FACS NSW January 2009

RPAP CHECK 3

Restricted Practice Authorisation Panel (RPAP)

CHECKLIST: A. Exclusionary Time Out (ETO) or B. Seclusion

To be completed in addition to RPAP Check 1 and Check 2.
Please select below as appropriate:

☐ **Exclusionary Time Out (ETO)** ☐ **Seclusion**

Element: BSP or IPRP includes requirement for ongoing maintenance of an ETO/Seclusion record which records the following:

EVIDENCE	Select	
1. Date, time and location of each episode of implementation Comments:	☐ Yes	☐ No
2. Brief description of environment and events prior to implementation Comments:	☐ Yes	☐ No
3. Description of presenting behaviour Comments:	☐ Yes	☐ No
4. Detail of other less restrictive strategies attempted (if any) Comments:	☐ Yes	☐ No
5. Consequences/outcomes of less restrictive strategies attempted Comments:	☐ Yes	☐ No
6. Reason for use of ETO/Seclusion Comments:	☐ Yes	☐ No
7. Duration of ETO/Seclusion Comments:	☐ Yes	☐ No
8. Periodic observational notes of the presentation of the service user Comments:	☐ Yes	☐ No
9. Name and position of staff directing use of strategy Comments:	☐ Yes	☐ No
10. Name and position of staff responsible for conducting and recording observations of service user	☐ Yes	☐ No
11. Evidence of ETO/Seclusion review meetings held after each episode	☐ Yes	☐ No

Adapted from ADHC Behaviour Support Policy Manual Part 1(B) work practice 2009 & 2012
Office of the Senior Practitioner – Ageing Disability and Home Care, FACS NSW January 2009

RPAP CHECK 4

Restricted Practice Authorisation Panel (RPAP)

CHECKLIST: A. Physical Restraint or B. Response Cost

To be completed in addition to RPAP Check 1 and Check 2.
Please select below as appropriate:

☐ **Physical Restraint** ☐ **Response Cost**

Element: BSP or IPRP includes requirement for ongoing maintenance of a physical restraint/response cost record which records the following:

EVIDENCE	Select	
1. Date, time and location of each episode of implementation Comments:	☐ Yes	☐ No
2. Brief description of environment and events prior to implementation Comments:	☐ Yes	☐ No
3. Description of presenting behaviour Comments:	☐ Yes	☐ No
4. Detail of other less restrictive strategies attempted (if any) Comments:	☐ Yes	☐ No
5. Consequences/outcomes of less restrictive strategies attempted Comments:	☐ Yes	☐ No
6. Reason for use of strategy Comments:	☐ Yes	☐ No
7. Duration Comments:	☐ Yes	☐ No
8. The people involved in implementation of the strategy Comments:	☐ Yes	☐ No
9. Name and position of staff directing use of strategy Comments:	☐ Yes	☐ No
10. Consequences/Outcomes	☐ Yes	☐ No
11. Where a child or young person is physically restrained, evidence of the provision of support and counselling in each instance	☐ Yes	☐ No

Adapted from ADHC Behaviour Support Policy Manual Part 1(B) work practice 2009 & 2012
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RPAP CHECK 5

Restricted Practice Authorisation Panel (RPAP)

CHECKLIST: Psychotropic Medication Administration on PRN Basis

EVIDENCE	Select	
1. The name and contact details of prescribing Psychiatrist/Doctor comments	☐ Yes	☐ No
2. The chemical and brand name of medication comments	☐ Yes	☐ No
3. Name and contact details of the person giving informed consent for the medication comments	☐ Yes	☐ No
4. The circumstances/conditions under which the medication may be administrated comments	☐ Yes	☐ No
5. Any physical examination or investigation required prior to administrated comments	☐ Yes	☐ No
6. Instructions regarding permissible dose, how to administer it and how often comments	☐ Yes	☐ No
7. Purpose of the prescribed medication and the desired outcome comments	☐ Yes	☐ No
8. The maximum dosage permissible in 24 hour period comments	☐ Yes	☐ No
9. Possible side effects/ adverse effects (e.g. on quality of life) comments	☐ Yes	☐ No
10. The likely time frame between administration of the drug and the onset of the beneficial effect comments	☐ Yes	☐ No
11. Symptoms of overdose comments	☐ Yes	☐ No
12. Monitoring, recording, response and reporting instructions comments	☐ Yes	☐ No
13. Regular review by the treating Psychiatrist/Doctor comments	☐ Yes	☐ No
14. Involvements of Behaviour Support Practitioner in medication comments	☐ Yes	☐ No

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OUTCOME SUMMARY
APPLICATION FOR RESTRICTED PRACTICE AUTHORISATION (RPA)

1. Details of client	
Name:	Street Address:
DOB:	
Date for review:	Suburb, State & Postcode

2. Category of proposed restricted practice (*Select by clicking on relevant boxes*					
☐	Exclusionary time out	☐	Psychotropic medication	☐	Restricted access
☐	Physical restraint	☐	Response cost	☐	Seclusion

3. Category of proposed restricted practice (*Select by clicking on relevant boxes)*
☐ Full authorisation for 12 months
☐ Conditional interim authorisation *(summarise conditions below, including time frame for re-submission)*
Conditions:
☐ Authorisation not given *summarise reasons below)*
Reasons:

4. Schedule for review of authorisation	
RPA expiry date	
Earliest date for RPA review	

5. RPAP Checklists completed *(Attach all completed checklists)*		
☐	RPAP Check 1	General work practice
☐	RPAP Check 2	General requirements for a restricted practice
☐	RPAP Check 3	Exclusionary time-out/Seclusion
☐	RPAP Check 4	Physical restraint / response cost
☐	RPAP Check 5	Psychotropic medication (PRN)

6. Documentation required for next RPA review *(select by clicking on relevant boxes)*	
List all additional documentary evidence for next RPAP review meeting	
☐	A. Record of Restricted Practice Use
☐	B. Data collection summary *(e.g. Star Chart)*
☐	*C. Incident Prevention and Response Plan (IPRP)*
☐	*D. Multi-element Behaviour Support Plan (BSP)*
☐	E. Evidence of implementing training

☐	*F. Lifestyle and Environment Review (LER)*
☐	G. Other *(specify):*

7. Signatures of panel members			
Name		Position	
Signature		Date	
Name		Position	
Signature		Date	
Name		Position	
Signature		Date	

8. Endorsement of Manager, Behaviour Support *(required for interim RPA only)*			
Name		Position	
Unit/team location		Date	
Signature			

RESTRICTED PRACTICE ACTION PLAN

Person: _____ Date RP Began: ___/__/__

THE RESTRICTED PRACTICE	WHEN THE RP IS TO BE IMPLEMENTED	HOW THE RP IS TO BE IMPLEMENTED	WHERE THE RP CAN BE IMPLEMENTED	STRATEGIES TO MINIMISE THE IMPACT ON OTHERS WHEN THE RP IS IMPLEMENTED

Date this RP Approved: ___/___/___

Date for Review of this RP: ___/___/___

Signed by Leader: _____

Date: ___/___/___

RECORD OF RESTRICTED PRACTICE USE

1. Record the date, time, duration and a detailed description of the behaviour.
2. NOTE; the Total Duration of time for the Behaviour and the RP needs to be recorded.
3. Record Outcomes of the Intervention

Name of Person with the RP:		**Date:**	__/__/__
Time RP Initiated:		**Duration:**	

CATEGORY OF RESTRICTED PRACTICE (SELECT)		
□ Physical Restraint	□ Psychotropic Medication (PRN)	□ Restricted Access
□ Exclusionary Time-Out	□ Response Cost	□ Seclusion

DESCRIPTION OF BEHAVIOUR & RP IMPLEMENTATION EVENT:

This Form Completed by: _____

TRAINING OF IMPLEMENTERS - POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)

Person with POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP); …….

Date of PBSP: ___/___/__

Implementation Coordinator: ……..

	Variable	Response		Comments
1	Has Implementer training been included as part of the POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?	YES	NO	
2	Have **all** identified stakeholders been trained to implement this POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP)?	YES	NO	

Please list the stakeholders who have been trained in implementing this POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP):

Name	Role	Date Trained	Comments

Indicate which of the following training methods have been used in Implementer training:

	Variable	Response		Comments
3	Presentation	YES	NO	
4	Team/ Family Meetings	YES	NO	
5	Modelling	YES	NO	
6	Train-the-Trainer	YES	NO	
7	Multi-media / IT	YES	NO	

Indicate which of the following Reliability Measures have been included in Implementer Training:

	Variable	Response		Comments
8	Verbal	YES	NO	
9	Procedural	YES	NO	
10	Role Play	YES	NO	
11	Supervision	YES	NO	
12 Other (describe)		YES	NO	

Implementation Coordinator Sign: ……..

Date: ___/___/___

POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) STAFF ACTION PLANNER FORM

Name of Person with POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP): …… **Name of Staff Person: ……**

What I need to do?	How I will do it?	Support I will need?	When support will be given?	Who will arrange the support?

Staff Person Sign: …… **Date: …./…./….**

Implementation Coordinator Sign: …… **Date: …./…./….**

POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) IMPLEMENTER RELIABILITY MEASURES RECORDING FORM

Person with the POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP):……..

Date of POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP):__/__/__

POSITIVE BEHAVIOUR SUPPORT PLAN (PBSP) Trainer/ Implementation Coordinator:……

Reliability Measures Used (describe):

Implementer Name	Issues Identified in the Reliability Measures	Action Required

Implementer Name	Issues Identified in the Reliability Measures	Action Required

Implementation Coordinator/Trainer Sign: ……

Leader Sign: ……

Date: __/__/__