COMMUNITY LIVING DURHAM NORTH

POSITIVE BEHAVIOURAL SUPPORT

Policy No: B-25 (Service Delivery)

Effective Date: June 30, 2011
Last Revision: September 29, 2015
Last Review: December 11, 2019

Rationale:

To ensure that people who have challenging behaviours are treated with compassion and respect, and to make certain that all efforts to change a person's behaviours are, first and foremost, about improving the quality of his or her life.

Policy Statement:

Where a person has challenging behaviours, intervention strategies must be part of his Personal Support Plan. This behavioural plan will be developed by the support team, including its manager, in conjunction with the person and, where appropriate, the person's family. Where possible and if necessary, a professional behavioural consultant will also be involved.

Each plan will take as its starting point the belief that there are underlying reasons for difficult or dysfunctional behaviour. And it will be a "positive" behavioural plan because rather than trying to discourage the target behaviour, it will try to reduce its frequency by making positive changes in the person's life. The plan will focus on changing the person's environment, or it will seek to teach him new communication or coping skills, or it will try to give him more control over some aspect of his life, in the expectation that this kind of quality of life improvement will reduce his level of anxiety or frustration and thus reduce the frequency or intensity of the behaviour.

The Behavioural Plan is developed over time, and positive behavioural supports are a process. Where they have not yet succeeded, and the person himself, or others, are at risk, it may be necessary to adopt a restricted practice that limits the person's behaviour or his freedom of movement.

However, even in this situation, positive behavioural supports will provide the framework for all interventions. The restrictive measure selected must always be the least intrusive of the strategies likely to succeed, it must be approved in accordance with Regulation 299/10, its effectiveness must be monitored and it must be formally reviewed at least twice in each 12-month period.

Internal References:
B-4 Personal Support Plans
B-16 Supporting People who have Challenging Behaviours
B-18 Rights Review Committee

Approved by: Colin Kemp for the Board of Directors Date: September 28, 2015

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Procedure No: B-25-1	Effective Date: June 30, 2011
The Behaviour Support Plan	Last Revision: December 11, 2019
	Last Review: July 26, 2024

- Before implementing a behavioural intervention, there must be a thorough functional assessment as a first step towards developing an understanding of the underlying function of the person's behaviour, and of how the behaviour may serve the person as a means of communication.

- The plan must describe and define the target behaviour that needs to be reduced or eliminated, and the strategies or activities that will be used to bring that about, including the teaching of new skills. This in turn will involve an outline of the desirable behaviours that will hopefully replace the undesirable ones, and the strategies for establishing or increasing these desirable behaviours. The plan must be sufficiently detailed that new team members will, by reading it, understand the interventions and be able to implement them.

- During implementation of the plan, the target behaviour will manifest itself, so a feature of the plan must be a crisis plan. This crisis plan addresses how to de-escalate the dangerous behaviours while reducing risk of harm to the person and those around him. The plan may need to include an intrusive practice, so safeguards around its approval and review must be built in, and it can never stand alone as a means of controlling the person; it must be an adjunct to a positive Behaviour Support Plan.

- A professional behavioural consultant may be involved in developing the plan, but it will be a collaborative work that also includes the person, his family, the staff support team and its manager. When it is agreed that a plan is necessary, one will be put in place as quickly as possible, given the need to consult and collect data, and also the fact that behavioural services are not always immediately available.

- If the person or those who act for him are not involved, he (or they) must consent to its implementation. It must be noted, however, that there may be times when CLDN will require a behaviour support plan as a condition of providing service.

- Related to the behaviour support plan is the annual meeting with the person/family and the signing of the Support Agreement. This document gives consideration to the use of intrusive behavioural interventions included in the person's Behaviour Support Plan. The Support Agreement will ask the questions: Does the primary contact person wish to be notified each time an intrusive measure is employed? Does this person want to be notified about some interventions and not others? If he does not wish to be apprised of each

intervention, as it occurs, what is the ideal schedule of regular updates that we could provide? The person's/family's responses are documented in the Support Agreement.

- The parties must also be made aware that CLDN will nevertheless consult with the individual and receive consent prior to notifying the primary contact person. If the person does not provide consent, then the contact person will not be notified and comments will be added to the AIMS incident report. If the person does not have the capacity to provide consent, then the contact person is notified.

- It may happen that a person who has challenging behaviours receives support from CLDN and from another service provider. In that case, procedures will be developed (and perhaps formalized, as in a memorandum of understanding) to ensure that the strategies outlined in the behaviour support plan are carried out in a consistent manner.

- In developing the plan, the risks and benefits of various possible approaches will be considered, and among those likely to succeed the least intrusive approach must be the one articulated in the plan.

- CLDN has in place a Rights Review Committee (see policy B-18) to provide oversight and advice in all situations where intrusive behavioural supports are being used.

Procedure No: B-25-2	Effective Date:	May 28, 2012
Definitions in Ontario Regulation 299/10	Last Revision:	
	Last Review:	July 26, 2024

- Compliance with Reg. 299/10 and with associated policy directives hinges upon an understanding of the definitions used in that document.

- *Challenging behavior* is defined as "behavior that is aggressive or injurious to self or to others, or that causes property damage… [and] limits the ability of the person… to participate in daily life activities and in the community."

- A *crisis situation* is defined as a circumstance where:

  - Challenging behavior places the person at immediate risk of harming himself or others or of causing property damage;
  - Attempts to deescalate the situation have been ineffective; or
  - The behavior is new or unprecedented in its intensity such that the behavior support plan does not effectively address it.

- A *physical restraint* is a holding technique, used by a staff member on a supported person, that restricts the latter's ability to move freely. But it does not include a restriction of movement, physical redirection or physical prompting, ***if*** the restriction, redirection or prompting is brief, gentle and part of a behaviour teaching program.

Procedure No: B-25-3	Effective Date: June 30, 2011
Prohibited Practices	Last Revision: July 8, 2024
	Last Review: July 26, 2024

The following is a list of punitive measures that can never be part of Positive Behavioural Supports:

- Corporal punishment: The application of any painful stimuli to the body as a penalty for certain behaviours. This may include shocking, over-correction (enforced repetitive behaviour), pepper sauce, water in the face, or aversive sounds.

- Psychological or Verbal Abuse

- Restriction of Contact with Family or with Significant Others

- Denial of Basic Needs: Denial of food or drink, sleep, shelter, bedding or access to bathroom facilities. Fasting before a medical procedure is an obvious exception.

- Limiting of a Person's Mobility: Removal of crutches, glasses, hearing aids or wheelchair to limit mobility for the purposes of behavior modification.

- Withholding Funds

- Unauthorized Use of a Restricted Measure (i.e. of a physical or chemical restraint). See below.

- The Ministry permits but "restricts" the use of Mechanical Restraints - while excluding from its definition of such restraints devices worn much of the time to prevent personal injury, such as a helmet to prevent head injury during seizure activity, or straps to hold a person upright in a wheelchair. It also restricts or seeks to limit the appropriate use of Secure Isolation/ Confinement Time-Out, while excluding from its definition of this kind of restraint an apartment where the person may live on his or her own.

- CLDN prohibits the use of mechanical restraints, as these are defined by the Ministry.

Procedure No: B-25-4	Effective Date: June 30, 2011
Restricted Practices	Last Revision: July 26, 2024
	Last Review:

The following practices may be introduced into the framework of Positive Behavioural Supports, but they must be viewed as temporary adjuncts, and they can only be used given appropriate levels of authorization, careful controls and regular reviews.

- Psychiatric Medications: These drugs, sometimes called psychotropics, are used to stabilize or improve mood, mental status or behaviour. Obviously, they must be prescribed by a physician, often a psychiatrist, and generally the initiative is taken by the physician. Sometimes, however, physicians will prescribe a psychotropic in response to a suggestion made by staff.

  These drugs have powerful effects on mental functioning and on general health, and in some circumstances the medication may be considered a chemical restraint.

  The recommended dosage cannot be exceeded; PRN's cannot be used as a punishment; and they cannot be administered to make it easier to support the person, or as a substitute for meaningful supports.

  When a PRN psychotropic medication is prescribed for a person supported residentially by CLDN, the Rights Review Committee will be advised and a review schedule will be established (see policy B-18).

- Restrictions on Rights: This occurs when a staff team utilizes the power imbalance to interfere with an individual's autonomy, rights, activities or privacy in ways that cross the line ordinarily found in consenting relationships between adults. Again, the Rights Review Committee will be advised. The Committee will review the rationale for putting the intrusive practice in place, the suggested time frame for maintaining it, and the plans set out to ensure that it will be removed.

  The committee will ensure that program staff have considered every option that might prove less restrictive. And, while the restriction remains in place, it will ensure that this review is conducted at least once in each 12-month period.

- Physical Restraints: Physical restraints, as defined above, may be carried out only for the purpose of preventing the person from physically injuring himself, herself, or others. And, there must be a clear and imminent risk that such an injury will occur. See B-25-5 below.

- Secure Isolation or Confinement Time-Out Rooms (CTO): Secure isolation or confinement time-out (CTO), is an example of intrusive behaviour intervention set out in Ontario Regulation 299/10 as a "designated, secure space that is used to separate or isolate the person from others and which the person is not voluntarily able to leave."

  If, in a particular scenario, a person is exhibiting challenging behavior, and the actions being used by staff to address the behavior fall within the meaning of "intrusive behavior intervention" as defined in Ontario Regulation 299/10 and, in particular, staff take steps that accord with "secure isolation or confinement time-out" then the agency should consider the scenario as an example of "secure isolation or confinement time-out" in accordance with the regulation and policy directive definitions.

The following details must be documented in the Behaviour Support Plan for anyone who may be placed in Secure Isolation or Confinement Time-Out:

- Continuous Monitoring while in CTO
- Interval Monitoring tracking protocols (documentation)
- Duration/Maximum Time of CTO
- At what point CTO should be stopped
- Record keeping requirements
- Notification process for key staff

The behavior support plans are evaluated and reviewed twice in a 12-month period with updates being provided to clinicians at least annually. Unless there is provision for Confinement Time-Out in an individual's behaviour support plan, the incident must be reported as a Serious Occurrence. If CTO is used for a person who does not have a behavior support plan this incident must also be reported as a Serious Occurrence.

The Confinement Time-Out space cannot be a person's bedroom. The space must be adequate size, properly ventilated, heated and cooled, adequately illuminated and free from objects that could be used by the supported person to hurt themselves. Staff must be able to constantly supervise the supported person while they are in CTO via window/video camera etc.

In the event that a supported person is in Confinement Time-Out, Management will be notified immediately. Staff will document the incident on an AIMS restraint incident report, including start times and end times. Staff will provide continuous monitoring of the supported person as described by their Positive Behaviour Support Plan. Staff will document their observations every 15 minutes on the AIMS Incident Report throughout the entire duration of the CTO. A person's guardian will be notified of the CTO via their preferred contact method described on form B-25 *Support Agreement.*

After any incident involving Confinement Time-Out, a debriefing process must be conducted amongst all involved, staff and supported people. Debriefing should occur within 48 hours of the incident. Debriefing with staff is documented on form *C-3b Post incident debriefing form - staff,* when completed this form is filed in staff's personnel file. Debriefing with supported people is documented on form *C-3a Post incident debriefing form - supported person,* when completed this form is filed at the home. If debriefing is refused by staff management will document the refusal on staff's communication logs. If debriefing is refused by a supported person, management will document the refusal on an AIMS service activity. In certain circumstances there may have been external persons present during the incident, i.e. contractors/parents/health care provider. In these cases, management will reach out to the external person to debrief/discuss the incident. The conversations will be documented on an AIMS service activity. If debriefing is not able to occur within the initial 48 hours, the reason(s) will be documented on the individualized debriefing forms once completed.

Procedure No: B-25-5	Effective Date: February 1, 2010
Restrictions on the Use of Physical Restraints	Last Revision: May 28, 2012
	Last Review: July 26, 2024

- Physical restraint may only be carried out as a last resort in crisis situations. Given the above definition of a "crisis situation," this is to say that a physical restraint can only be used for the purpose of preventing the person from physically injuring himself, herself, or others. There must be a clear and imminent risk that such an injury will occur, and informed attempts to de-escalate the situation must have been made and must have proven ineffective.

- Physical restraint must never be applied for the purpose of punishing the person.

- A physical restraint may be carried out only after it is determined that less intrusive interventions are, or would be, ineffective in preventing the imminent risk of injury.

- A physical restraint may be carried out only by direct care staff members who have received specific training and education, to be described below. Also, any particular holding technique may be used only by direct care staff members who have received specific training in that technique, through an approved training program.

- When a physical restraint is carried out, one must always use the least amount of force necessary to restrict the person's ability to move freely.

- During physical restraint, the person's condition must be continually monitored and assessed for signs of distress.

    - change in breathing pattern (rapid respiration or shortness of breath)
    - excessive perspiration (suggesting heightened stress level)
    - changes in facial colouring (flushed or very pale)
    - disorientation, distinct from pre-existing agitation (that might suggest interruption of oxygen supply).

- Physical restraint must be stopped immediately when there is no longer a clear and imminent risk that the person will physically injure himself or others, ***or*** when a risk arises that the physical restraint itself will endanger the health or safety of the person.

- The use of physical restraint in circumstances other than those specified here, or without taking the required precautions, will be treated as abuse and is disciplinable.

- After a person has been physically restrained, a debriefing process must be conducted among all those involved in the restraint. The supported person must be a part of this process, and may be de-briefed along with the other participants, or separately. This question, and other process matters, should be determined in a way that will best accommodate the person's psychological and emotional needs and cognitive capacity. This debriefing exercise is an opportunity to reflect upon, and learn from, the factors that may have precipitated the behaviour, or the events that may have led up to the use of a restraint, and it is conducted among all staff involved in the episode.

- Debriefings must be documented and conducted within a reasonable time period (i.e. within two business days) after the behavioural episode or restraint. If this is not possible, the debriefing must take place as soon as it is possible (and the documentation must record why an earlier debriefing was not feasible).

- After any use of a physical restraint, the Ministry's Serious Occurrence protocol must be followed.

- If a physical restraint is performed on a support person who is not already being assisted by a clinical behavioral program, a referral will be immediately made to the DSO in order to access a behavioural consultation.

- The agency trains its direct care staff in the use of the *Safe Management* – a module developed by Pryor Linder & Associates, in Oakville, Ontario. *Safe Management* is Ministry-approved for use with both children and adults. In using this module, and these trainers, CLDN is exceeding provincial norms. Pryor Linder staff have visited some of our residential programs and have customized *Safe Management* approaches to some of the people that we support.

- *Safe Management* training is provided to new hires during the agency's initial four-day orientation process.

- The individual employee's *Safe Management* certificate must be updated every eighteen months; otherwise he or she becomes ineligible to work in a group home. The agency has developed the capacity to train internally, and refresher courses will be offered to its employees in a timely manner at no cost. Given that training is offered in a timely manner, and more than once, the agency will consider the employee, who works in a group home, to be personally responsible for his own timely re-certification, and hence for his own job security.

Procedure No: B-25-7	Effective Date: March 14, 2022
Nest Cam Technology	Last Revision:
	Last Review: July 26, 2024

- If a location has a Nest Cam, the person's positive behavioural support plan will specify why and how the Nest Cam is being utilized.

- If a CLDN location has a nest cam in use then a clearly marked sign on the entrance door will be put up to inform all employees of the use of the nest cam.

- All positive behavioural plans are developed by a professional behavioural consultant, and if that consultant is employed by Lakeridge Community Supports Services then a nest cam may be advised to assist in the ongoing clinical assessment and treatment of a person.

- The use of Nest Cam technology is to observe and record for the purpose of clinical assessment and treatment for the duration of service. Any information collected for this purpose will be stored until the clinician is able to formulate their findings into a report or until the service is terminated.

- Prior to any audio or audiovisual recordings of a person in any setting, Lakeridge Community Support Services requires that the person or their substitute decision maker sign off on "an Audio and/or Audio Video Recordings of Clients waiver." This is a Lakeridge form that is forwarded to Lakeridge, once signed, and kept in their files. In the case of a minor, the parent or legal guardian must sign.

- The recordings of the Nest Cam are only viewed when an incident report has been reported to the behavioural consultant, at which time observation of strategies utilized by the employees will be evaluated and then discussed as a team. The main purpose of the Nest Cam is to collect data and educate the support team on the best strategies to be utilized to get a desired outcome.

- The Nest Cams are streamed live and record constantly throughout the day unless turned off. Again the main purpose for the Nest Cam is for treatment and clinical purposes only, however, if Lakeridge staff observe something they consider to be unprofessional or illegal they will notify the CLDN Program Manager and the recording will be viewed for further investigation.

Approved by: Glenn Taylor Date: July 26, 2024
CEO