Witham Prospect School

Positive Behaviour Support Policy

Relevant Legislation and Guidance

- Keeping Children Safe in Education (Statutory Guidance for Schools and Colleges) (latest version) – DFE.
- Working Together to Safeguard Children – A guide to multi-agency working to help, protect and promote the welfare of children (revised latest version) – HM Gov.
- Lincolnshire Safeguarding Children Board: Policy and Procedures Manual (live manual)
- The Education (Independent School Standards) Regulations 2014 (latest available revised): Part 4 – UK Gov.
- The Children's Homes (England) Regulations 2015: Part 2 (7) "The Children's views, wishes and feelings standard" and Part 4 "staffing"
- Mental Capacity Act 2005
- Challenging Behaviour National Strategy Group Charter (2010)

Applies to:

The whole school, staff, volunteers and pupils. Human Resources Manager and senior leaders involved in the recruitment and selection process. All members of Witham Prospect School staff who are working with children and young people and adults (18 years and over) whose behaviour is described as challenging. Members of the Board of Directors for oversight and monitoring the use of restrictive interventions.

Related Documents:

- Safeguarding (Child Protection) Policy
- Behaviour Policy
- Sherwood Intervention Policy
- Mental Capacity Policy
- Anti-Bullying Policy

Availability:

This policy is made available to parents/carers, staff and pupils via the School website or upon request from the school office. It is communicated to new applicants through the recruitment and application process and forms part of the application pack.

Monitoring and Review:

This policy will be monitored and refined on a continuous basis and reviewed annually by either the Directors or a member of the Senior Leadership Team or earlier if changes in legislation, regulatory requirement or best practice guidelines so require.

Author:	Gemma Collins	Signed:		Date:	February 2025
Approved:	David Collins	Signed		Date:	February 2025
Version:	6 (February 2025)	Review date:	February 2026		

Contents: **Page:**

INTRODUCTION TO POSITIVE BEHAVIOUR SUPPORT

What is 'positive Behaviour Support'?

Positive Behaviour Support is a term that is frequently used by care providers and training professionals. However, it is often misunderstood or misinterpreted and added to policies and physical intervention training courses as more of a 'tick box' exercise without the provider having an in-depth knowledge and understanding of what Positive Behaviour Support actually is and how to implement this in practice.

Witham Prospect School understands Positive Behaviour Support to be:

'An understanding of the behaviour of an individual. It is based on an assessment of the social and physical environment in which the behaviour happens, includes the views of the individual and everyone involved, and uses this understanding to develop support that improves the quality of live for the person and others who are involved with them'.

Taken from the BILD Positive Behaviour Support Jargon Buster, available at: www.bild.org.uk/pbs

The overall aim of Positive Behaviour Support (PBS) is to improve the quality of the person's life and the quality of life for those around them.

Positive Behaviour Support (PBS) is a person-centred framework for providing long term support to individuals who have or may be at risk of developing behaviours that challenge. The overarching values of PBS are to provide support that promotes inclusion, choice, participation, and equality of opportunity. PBS means that people receive the right support at the right time.

PBS is not a quick fix. PBS means that people receive the right support at the right time. The right conditions need to be created and maintained so people can achieve the quality of life that they want and deserve to have. Successful implementation needs a whole organisational approach and ongoing commitment

Behaviours of concern always happens for a reason and may be the only way a person can communicate an unmet need. Positive Behaviour Support (PBS) helps us to understand the reason for the behaviour so that we can better meet people's needs, enhance their quality of life and reduce the likelihood of the behaviour becoming inherent.

Witham Prospect School is fully committed to ensuring that the principals of the PBS framework are engrained in our approach to supporting our pupils and as such all PBS plans will:

- Consider the life histories of our pupils, including their physical and emotional needs and the impact of any traumatic or adverse life events.

- Create physical and social environments that are supportive and capable of meeting the needs of the children and young people therefore, reducing the likelihood of challenging behaviours.
- Ensure that a functional behaviour assessment has been undertaken to enable us to develop an understanding of the challenging behaviour displayed by an individual. Our PBS plans will be based on an assessment of the social and physical environment and broader context within which the behaviour occurs, how the behaviour has developed and how it is maintained.
- Be developed in conjunction with other professionals and include multiple evidence-based approaches and treatments to ensure a range of perspectives and involvement.
- Be proactive and preventative and aim to teach people new skills to replace the challenging behaviours.
- If necessary, the plan will include the use of restrictive interventions. The plan will detail the type of restrictive intervention permitted for that individual and in what circumstances and will always be the least restrictive option to ensure the safety of the individual and others. In all cases, where restrictive interventions are included in an individual's PBS plan there will be a plan around how to reduce reliance on restrictive interventions.
- Provide support staff with the tools required for the development, implementation, and evaluation of effective support.

Positive Behaviour Support is an approach which incorporates the safe use of reactive strategies (and may include restrictive interventions) alongside a broad array of targeted, proactive and preventative approaches. The sole purpose of any reactive strategy is considered to be nothing more than to make a situation safe and return a person to a state where they can resume engagement in their regular lifestyle.

The British Institute of Learning Disabilities (Bild) has identified five signs that good PBS is happening in an organisation as follows:

1. Personalisation
The support would be personalised.
There would be evidence that consistent actions were being taken to enhance the quality of life and wellbeing of the person. These actions would have been created or agreed with the person and written into a plan. The actions would support the person to be engaged in activities that were meaningful to them and would enable them to experience an ordinary life within their own community.

2. A psychological understanding of behaviour
The support would be based on the psychological understanding of how that person learns and what the behaviour of concern means for a person.
Practitioners would use standardised assessment tools to inform function-based interventions that are practically applied to the benefit of the individual. Any assessment

would consider the person's history and their unique and individual characteristics including their strengths, any cognitive differences, emotional and physical needs and any traumatic life events.

3. Active implementation

The support would be well planned, implemented and monitored.

There would be clarity around every person's role and responsibilities together with evidence of good leadership at the service and organisational level. Support would be progressive and developmental for the individual and all other people involved. This would include the teaching and learning of new skills. Any restrictions deemed necessary would be kept under continual review and the least restrictive approach would always be taken.

4. Evidence based

The support would be based on different kinds of data collected and analysed at all levels in the system.

Data, both hard and soft, would be used to inform assessment, to evaluate intervention, and to monitor and improve the quality of life and wellbeing of the person and others. Information should be collected from the person themselves and their families and supporters to see if things have got better for them.

5. Multicomponent interventions

Support would be implemented at different levels and in different ways.

We would see proactive strategies to prevent or reduce the triggers and events that evoke or maintain the behaviours of concern. Interventions would be designed to support personal development and the learning and maintaining of new skills.

Coping strategies would be prioritised and there would be evidence that the environment had been altered to ensure it was the best possible fit for the person. There would be some reactive strategies to help people keep safe when needed. Support would be based on assessed need and may utilise a range of evidence-based therapies.

Taken from: *Centre for the Advancement of PBS | Five signs of good PBS,* available at: http://www.bild.org.uk/capbs/

Witham Prospect School aims to meet all of the five signs of good PBS practice and as such has developed robust procedures and processes to ensure that we provide our pupils with PBS plans that include an evidence based assessment of the behaviour of concern and is focussed on improving quality of life and reducing the use of restrictive practice.

IDENTIFYING BEHAVIOURS OF CONCERN

A definition of Challenging Behaviour

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

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

Witham Prospect School has adopted the term 'behaviour of concern' as our preferred term, but you may also hear the terms, 'challenging behaviour', 'behaviours that challenge', and 'distressed or risky behaviour'.

The term 'behaviour of concern' or 'challenging behaviour' is used as a way of focussing our attention on the behaviours as challenging and as a means of communication, rather than labelling the person as the problem.

When we think about the people, we support we generally understand this to include:

Aggression e.g. hitting, biting, screaming, swearing.

Self-injurious behaviour e.g. head banging, eating inedible objects, hitting face or head.

Damage to property e.g. throwing furniture, breaking windows.

Socially inappropriate behaviour e.g. stripping, urinating, masturbating in public

But we often fail to recognise that it also includes other behaviours that are intensive enough to stop or make it very difficult for the person to be involved in ordinary activities and relationships at home and in the community, such as:

Self-stimulatory behaviours e.g. finger-flicking, teeth grinding, humming.

Stereotyped or ritualistic behaviours e.g. body-rocking, arm flapping, repetitive speech.

Obsessional behaviour e.g. putting together or taking apart objects, lining things up, positioning furniture and doors, checking light switches.

Withdrawn behaviour e.g. pulling clothing over head or eyes, fingers in ears, closing eyes, routinely sitting or standing away from other people.

Refusal or avoidance e.g. automatically saying no to requests or suggestions, avoiding opportunities to interact with others or participate in activities.

Recognising these behaviours as challenging prompts us to try to understand why the person behaves the way they do and places the responsibility on us to find constructive responses and solutions.
Witham Prospect School recognises and promotes the rights of people who express behaviours of concern as set out in the Challenging Behaviour National Strategy Group Charter (2010) and is committed to achieving these for all of the people we support.

1. People will be supported to exercise their human rights to be healthy, full and valued members of their community with respect for their culture, ethnic origin, religion, age, gender, sexuality and disability.
2. People have the right not to be hurt or damaged or humiliated in any way by interventions. Support and services must strive to achieve this.
3. All people we support who present behaviours of concern have the right to have their needs identified at an early stage, leading to co-ordinated early intervention and support.
4. All families have the right to be supported to maintain the physical and emotional wellbeing of the family unit.
5. All individuals have the right to receive person centred support and services that are developed on the basis of a detailed understanding of their support needs, including their communication needs. This will be individually-tailored, flexible, responsive to changes in individual circumstances and delivered in the most appropriate local situation.
6. People have the right to a healthy life and be given the appropriate support to achieve this.
7. People have the same rights as everyone else to a family and social life, relationships, housing, education, employment, leisure.
8. People have the right to supports and services that create capable environments. These should be developed on the principles of positive behaviour support and other evidence-based approaches. They should also draw from additional specialist input as needed and respond to all the needs of the individual.
9. People have the right to receive support and care based on reliable and up to date evidence.

Behaviours of concern are often perceived as a ‘problem’ or ‘illness’ to be ‘treated’, ‘cured’ or ‘stopped’ and this can lead to the use of withdrawal of opportunities, punishment, or sanctions. This is unethical (often illegal) and potentially damaging for these individuals. We need to look beyond the behaviour, understand what the behaviour is communicating and then provide appropriate person-centred, holistic support to enable individuals to achieve their full potential.

All staff have a responsibility to report any concerns about individual or collective responses to behaviours of concern immediately to their line manager.

BASIC FUNCTIONAL BEHAVIOUR ASSESSMENT

What is a Functional Behaviour Assessment?

A Functional Behaviour Assessment (FBA) is a broad term used to describe a number of different methods that allow researchers and practitioners to identify the reason a specific behaviour is occurring.

These assessments are used to identify why a behaviour of concern such as self-injury, aggression towards others or destructive behaviours occurs.

Although there are different methods for carrying out functional assessments, they all have the same goal: to identify the function of the behaviour of concern so that an intervention can be put in place to reduce this behaviour and/or increase more adaptive behaviours.

Functional Behaviour Assessment or Functional Analysis?

The terms "functional assessment" and "functional analysis" are sometimes thought to be the same thing but they are not; a functional analysis is one specific type of functional assessment that must be undertaken by a trained professional.

There are ethical considerations that have to be taken into account prior to undertaking 'functional analysis' as this method may be considered unethical, where deliberate manipulations are made that effectively encourage the client to engage in the target behaviour. This may be unethical because if you consider a child who engages in self-injury or aggression towards others, there is the question of whether it is acceptable to deliberately test different antecedents and consequences that will lead to the child injuring themselves or another person.

O'Neill et al (1997, p.61) state that 'before carrying out manipulations involving such behaviours, we need to determine the level of potential risk and decide whether taking those risks is justified by the potential outcomes.'

It is therefore vital that clear processes are followed to ensure that anyone involved with the child (the child themselves if possible, parents, staff, practitioners etc.) and any legal review boards or committees within the authority must be consulted and informed consent obtained before any assessment is carried out. Strategies would also have to be developed to protect the individual and those conducting the assessment.

At Witham Prospect School we have a Behaviour Specialist as well as several trained practitioners. The practitioners are able to undertake basic functional behaviour assessments under the supervision of the Behaviour Specialist. In most cases this will be sufficient to enable us to identify the function of a child's behaviour of concern. However, there may be certain behaviours that require further investigation or require alternate areas of expertise e.g., input from clinical/educational psychologists. In such circumstances, following

consultation with placing authorities and all professionals around the child, appropriate referrals would need to be made to the relevant (most likely external) qualified professional/department.

Prior to undertaking a functional behaviour assessment, it is important to consider if there are any medical or physical conditions that are causing the behaviour of concern, especially if there has been a noted recent increase in the frequency or intensity of the behaviour. For example, sinus or ear infections, mouth ulcers, allergies, toothaches, constipation etc. may induce or worsen a behaviour of concern. Identifying a medical or physical cause for the behaviour will enable the staff to obtain appropriate medical intervention for the child and therefore behavioural interventions will not be unnecessarily implemented and to the detriment of the child.

Basic Functional Behaviour Assessment Process

At Witham Prospect School we believe that in order to understand the function of a child's behaviour of concern we need to undertake a basic functional behaviour assessment so that the interventions that we put into place as part of an individual's Positive Behaviour Support Plan are function based interventions. There would be little benefit to the child or the team supporting the child if we did not first try to establish the function of the behaviour before agreeing interventions as part of their PBS plan. By undertaking the functional behaviour assessment, we are gathering information and evidence in a systematic way which adds knowledge and understanding to the interventions that we put into place for the individual.

Form and Function

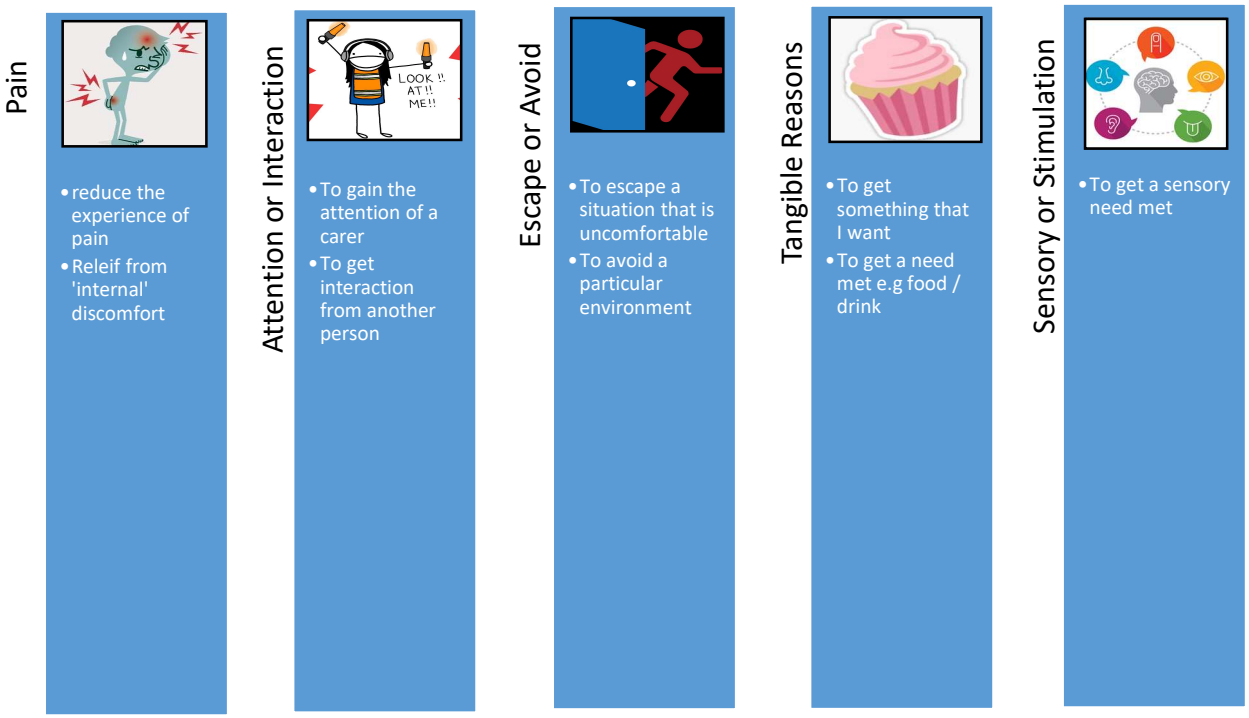
The **form** of behaviour is what it looks or sounds like. For example; *the child/young person throws a glass onto the floor.*

The **function** of behaviour is its purpose, that is, what helps the child or young person access or avoid. For example; *the child/ young person throws a glass onto the floor to get is to pay attention to the fact that he is thirsty.*

If we can understand the function of a child's behaviour, then we are able to identify replacement behaviours that will serve that function in more acceptable and less risky ways. For example; if a child's behaviour of concern is throwing a cup onto the floor it may be easy to conclude that this behaviour is to get attention from the staff member. However, completing a functional behaviour assessment which looks closely at what is happening before the behaviour occurs and what happens immediately after the behaviour (how do staff respond) might reveal that the staff always respond by making the child a drink and therefore the function of the behaviour may not be to gain staff attention but to obtain something tangible (a drink). In which case, the individuals PBS plan should include some pro-active strategies that include providing the child with a more effective way of communicating their need for a drink. It is important that staff are responsive to this in order that the replacement

behaviour e.g. using an object of reference (in this case it may be appropriate to use the cup as the object of reference) becomes a more effective way of obtaining the drink.

Functional behaviour assessment will help to identify and describe the function(s) of the behaviour (the reason the behaviour happens) which will come under one of the following categories:



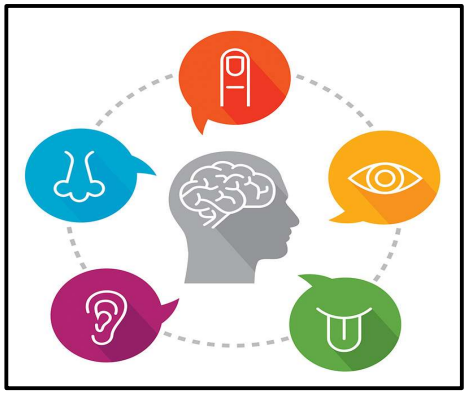
The strategies identified within the PBS plan should be different depending on the function of the behaviour.

Take the example of a child or young person hitting care staff:

If the child/ young person is trying to get your Attention by hitting: 	• Teach the person how they can get your attention/the attention of others in a more appropriate way. This could be by teaching them a sign, a vocalisation or to gently tap your hand/arm • Make sure you notice when the person is trying to get your attention appropriately and respond as soon as you can. This will help to reinforce the behaviour you want • If the person goes to hit you, use a phrase such as "Gently" or "Hands down". Teach the person what this means • Interact with the person regularly, giving them plenty of opportunity to get positive attention • Where possible ignore the hitting

If the child/ young person hits others to Escape/Avoid something or someone: 	• Give the person an effective way to stop something they don't like; to remove them from a situation or person they don't like. This could be a sign/word or photo card to say "Finish" or "Home" • Teach them to make choices and a way to say "yes" and "no" • Introduce them to a situation/activity gradually to help them become used to it • Use humour as a way to distract the person • Notice when they are displaying 'early warning signs' that they may be becoming unhappy or anxious • Change the way you ask them to do something

When the person hits others to get something Tangible: 	• Teach the person how to communicate they want a drink/toy/DVD etc. • Give them what they've asked for as soon as they've asked appropriately. Give lots of praise. • Make sure they have regular access to what they need • Teach them how to get something for themselves where possible. Make sure the person knows where their magazines are kept or that juice is found in the fridge and make sure there is a cup in a cupboard they can easily reach • Make sure they are not left without food or drink for too long, or without something meaningful to do (offer these regularly) • As far as possible ignore the hitting • If the situation escalates and people are at risk, give them what they want (Strategic Capitulation).

Where a person hits to get their Sensory needs met: 	• Ask for a referral to a specialist Occupational Therapist (OT) who can do a sensory assessment to clarify specific sensory needs • Be creative! Get a drum, box, cushion or other thing that they could hit • Try out different objects to see which they prefer, then use these to create new activities • Use preferred items to help you engage with the person • Make sure the person can get their sensory needs met, but in a way that will not isolate them further or leave them engaging in a self-stimulatory behaviour for too long. • If people have self-stimulatory activities that are very important to them, try and support them to have at least some meaningful routine/structure in their day, so that the self-stimulatory behaviour doesn't 'take over'

The following process must be undertaken when completing a basic functional behaviour assessment:

POSITIVE BEHAVIOUR SUPPORT – A Whole School Approach

Positive Behaviour Support aims to enhance a person's quality of life, ensure that otherwise unmet needs are better met and to reduce the impact of the behaviour of concern. This is achieved through the use of:

- **Person centred tools and planning** to ensure the person is living the best life they possibly can. This involves assisting a person to develop personal relationships, improve their health, to be more active in their community and to develop personally.
- **Skilled assessment** in order to understand probable reasons why a person presents behaviours of concern; what predicts their occurrence and what factors maintain and sustain them (Functional Behaviour Assessments).
- **Positive Behaviour Support Plans** which have been informed by a robust assessment in order to ensure a consistent and shared proactive approach to meeting the person's needs.
- **Proactive Strategies** to improve challenging environments and quality of life and that wherever possible people are supported to develop alternative approaches by which they can better meet their own needs.
- **De-escalation techniques**, to be used by support staff when a person starts to become anxious, aroused or distressed.
- **Reactive strategies** to be used when the person's agitation further escalates to the point where behaviours are presented which place either themselves or others at significant risk of harm. These may include the use of restrictive interventions.
- A **monitoring and review plan** is also required to evidence changes and ensure rigorous reviewing and continually development of effective approaches.

DEVELOPING A POSITIVE BEHAVIOUR SUPPORT PLAN

Effective delivery of Positive Behaviour Support requires a collaborative partnership between staff, other specialists, families, and the people we support. All work including assessment, planning, and reviewing should be as inclusive as possible.

As is the case for any form of care and support planning, Positive Behaviour Support Plans should ordinarily only be implemented with the consent of the person we support. If the person we support is assessed to lack the capacity to consent or disagree in accordance with the provisions of the Mental Capacity Act (2005) and associated Code of Practice this should be fully documented and the Best Interests decision making processes used to determine the appropriate content of the Positive Behaviour Support Plan.

A PBS plan provides carers with a step by step guide to making sure the person not only has a great quality of life but also enables carers to identify when a child or young person is becoming distressed, potential triggers to the distress and also how and when to intervene to prevent the behaviour of concern happening or escalating.

As previously stated, a good PBS plan is based on the results of a functional assessment of the behaviour of concern. The plan should contain a range of strategies that not only focus on managing the incidents of behaviour in the safest possible way but also include ways to ensure that the person has access to the things that they need to prevent the behaviour of concern occurring. These strategies are referred to as Proactive Strategies and Reactive Strategies.

Proactive strategies are intended to make sure the person has got what they need and want on a day to day basis and also includes ways to teach the person appropriate communication and life skills.

Reactive strategies are designed to keep the person and those around them safe from harm. They provide a way to react quickly in a situation where the person is distressed or anxious and more likely to display challenging behaviour.

Proactive Strategies see page 16-17

A range of changes we can make in the person's environment, in the ways that we communicate, in staff attitudes and in risky situations to reduce the need for the challenging behaviour.
This might include:

- Making the day more understandable for the person
- Teaching the person alternative ways to get what they need
- Increasing the range of activities and interactions available to the person
- Changing the way we support the person to be involved in activities
- Rethinking our interpretations of behaviour as intentional
- Responding effectively to signs of anxiety

Active Strategies -see pages 17-18

What we do to prevent warning signs from escalating into an incident.

- Distraction/diversion/change environment
- Give in
- Give space
- Engage in some taught relaxation

Reactive Strategies see pages 18-19

What we do to manage the challenging behaviour when it happens to keep people safe and get things back to calm as soon as possible.
This might include:

- Distraction
- Removing demands or reducing expectations
- The use of agreed restrictive interventions
- Reassurance

It must not include punishment

Post incident strategies – see page 19

What we do to support the person to return to proactive support and continue with the rest of their day. This might include:

- Reassurance
- Talk about what happened (if the person would like)
- Move on to the next activity

A good behaviour support plan has more Proactive strategies than Reactive ones. This helps to ensure that the focus of the plan is not just on the challenging behaviour but provides ways to support the person to have a good life, enabling the person to learn better, more effective ways of getting what they need.

A functional assessment of the behaviour will be undertaken for individuals expressing behaviours of concern. The person completing the functional behaviour assessment will require evidence of the behaviour and the context in which it occurs. Staff working directly

with the child or young person will be required to record the behaviour on ABC (Antecedent, Behaviour, Consequence) charts or other similar recording form suitable to the situation as this will help to identify what the function of behaviour might be. Information from completed recording charts can help to identify strategies to include on the Positive Behaviour Support Plan. Thinking about what already works is also very useful.

The following steps are to be undertaken when developing the PBS plan:

Step 1: Define the Behaviour of Concern (Form)

Firstly, we need to think about the behaviour of concern that we want to address. A clear definition of the behaviour will help others to identify when the behaviour occurs. It is helpful to record four things about the challenging behaviour:

1. appearance – what the behaviour looks like
2. rate - how often it occurs
3. severity - how severe the behaviour is
4. duration - how long it lasts.

For example:

Tony slaps the left side of his face with his left hand. He does this most days, but it is more frequent when he feels unwell or tired or when there is a change to his activity planner. Tony is often left with a red mark on the left side of his face. Depending on the reason he is doing this it can happen once or repeatedly for 10 minutes or more.

Step 2: Function of the behaviour (Function) – see Functional Behaviour Assessment Section

The Positive Behaviour Support Plan should include strategies that can be put into place to help the child or young person, where possible these should relate to the different functions of behaviour that have been identified.

The strategies identified should be different depending on the function of the behaviour.

Step 3: Proactive "Green" strategies

Proactive strategies are the 'green' part of the Positive Behaviour Support Plan and aim to support the child or young person to stay happy and calm. Proactive Strategies are designed to meet the individual's needs without them needing to rely on the behaviour of concern. This part of the plan should include any strategies that are aimed at reducing the chances that the behaviour will happen, and should focus on all aspects of the person's life including keeping healthy and fit, (as opposed to just focusing on the behaviour of concern).

It is important to include information about what the child or young person likes and has shown interest in. Wherever possible, consult with the individual and people that know them well and really interested and enthusiastic about them. The longer the 'likes list' the better!

The aim is to try and support the person to stay in this phase as much as possible. It is important to think about what it is that helps the person to feel calm and relaxed, such as:

- Environment
- Communication & body language
- Preferred activity or object or person
- Predictable routine and structure
- Feeling well and happy
- Interaction styles – how do you talk to the person?

The green phase is where boundaries are put in place to teach the child/ young person what is and isn't acceptable in different situations. For example, masturbating is acceptable in the person's bedroom but not in the family sitting room or out in public.

The green phase is a good time to teach new skills, develop effective ways of communicating and use rewards and incentives to reinforce the behaviour that you want. Think about what the person looks like or does that lets you know that they are in this phase:

"She will smile and giggle a lot when she is happy. She interacts with people more when she is mellow and may try to get them involved by gently hitting her thighs in a particular rhythm which she expects them to copy or clapping."

Step 4: Early Warning Signs "Amber" strategies

The 'amber' strategies will describe what to do in response to the early warning signs, to help you intervene as early as possible, before the person resorts to the behaviour of concern.

Behaviours are often described as being spontaneous ("It happened without any warning"). However, further assessment may reveal that the person shows some reliable signals that all is not well prior to engaging in the behaviour.

These signals may be subtle, but will often include observable signs such as increased pacing, changes in vocalisations, facial expressions or body language. By clearly defining the behaviours seen at the amber stage, carers can be cued in to the need to take immediate action, and thereby avoid moving on to 'red'. Many behaviours of concern occur because the early warning signs are not recognised or because we fail to change our own behaviour once the signs become evident.

Amber strategies: At this stage the person may be starting to feel anxious or distressed and there is a chance that he/she may challenge you in some way. Here we need to take quick

action to support the person to return to the Green "Proactive" phase as quickly as possible to prevent behavioural escalation.

Things that can help:

- Take away the trigger
- Not responding to, or 'ignoring' the behaviour
- Giving the person what they want (strategic capitulation)
- Humour – sing something, dance on the table! – use your imagination
- Redirecting/distracting
- Asking what is wrong (look at the context of the time of day, where the person is etc.)

Again, think about what the person you care for looks like when they are becoming agitated and distressed. For example:

"She shows angry facial expressions and she does not smile. She will start to aggressively pull at the flannel/paper that is in her hands and find more things to hold in the same hand. If you asked for something that she is holding when she is in amber behaviour, she will not give it to you."

Step 5: Reactive "Red" Strategies

A reactive plan describes what you should do, or how you should react, in response to behaviours of concern. Reactive strategies are a way to manage behaviour as safely and quickly as possible, to keep the person and those around them safe.

Ideally a reactive plan should include step-by-step advice on how to reduce the chance that the behaviour will escalate and put people at risk. It should be informed by a functional assessment and guided by the principle of implementing the least intrusive and least restrictive intervention first.

More restrictive interventions (such as physical restraint) should be a last resort.

Physical interventions, and medication that is used solely to calm people down, are generally not considered a good long-term solution. Use of these should be recorded to help identify when to review the plan. Witham Prospect School has signed the Restraint Reduction Network's Pledge, showing our commitment to supporting and delivering services that aim to reduce and wherever possible eliminate the use of restraint and restrictive practice within our services.

Red strategies: This is where behaviour of concern occurs and we need to do something quickly to achieve safe and rapid control over the situation to prevent unnecessary distress and injury.

During this phase, it is important to:

- Appear calm
- Use low arousal approaches – talk in a calm, monotone voice
- Do not make prolonged eye contact
- Be aware of your own body language
- Do not make any demands of the person or keep talking to them
- Distraction and redirection (e.g. using a technique such as a guided walk to remove the person from the room to keep them and others safe)

When the behaviour escalates to "RED" and an incident of challenging behaviour is occurring, the signs will be much more obvious than in the amber phase e.g.

"She bangs her head on the door/wall in the house or the headrest/window in the car."

Step 6: Post Incident Support "Blue" Strategies

This section should specify the procedures to be followed after an incident for both the person and their carers.

For the person, this section should specify any immediate behavioural actions that need to be implemented following incidents for example:

- giving the person more space
- engaging in an activity
- procedures for ensuring their physical and emotional safety (e.g., via physical checks and supportive counselling/reassurance giving).
- Procedures for carers in terms of any immediate medical checks and emotional support

Blue strategies: This is where the incident is over and the person is starting to recover and become calm and relaxed again. We still need to be careful here as there is a risk of behaviour escalating again quickly.

During this phase, it is important to:

- Make no demands
- Help the person to recover
- Move to different environment if appropriate

When a person is calming down and recovering from an incident of challenging behaviour, think about what they look like and what they do or sound like. For example:

"She makes a noise that sounds similar to "uuuuuuuu," in a questioning voice while quickly moving just the top of her head from left to right. She may give eye contact or raise her eyebrows while doing this."

Step 7: Agreeing the Plan

Positive Behaviour Support Plans should be created with input from all people involved with the person's care, including family carers, and whenever possible, the person should also be involved in this process. The plan should record who has been involved in its discussion and agreement, to ensure a broad range of views have been taken into account.

Step 8: Reviewing the plan

Behaviour Support Plans should be 'living documents. This means that information in the plan should change to reflect changes in the person's behaviour or an increase in other skills.

Plans should be regularly reviewed and updated (for example. every 6 months) as once risks have been identified and behaviour strategies agreed to help minimise those risks, it is important to get feedback of how effective the strategies are and to reflect on their impact on the person and those caring for them.

However, there should also be a 'contingency' plan with clear guidelines when the plan should be reviewed more urgently if required. For example, the Plan should be reviewed if self-injury increases or if physical interventions/reactive strategies (such as restraint or PRN medication) are being used regularly. The section below 'Restrictive Interventions' provides further detail on types of restrictive interventions and Witham Prospect School's approach to reducing the use of restrictive intervention.

Restrictive Interventions

Definition

Restrictive interventions are defined as:

Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

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

Key Requirements

Where **restrictive interventions** are included in the Positive Behaviour Support Plan, the registered person is required to:

1. Be aware of Witham Prospect School and any local or health authority policies that minimise the use of restrictive practices, as well as ensuring that when they are used it is in a safe and ethically acceptable manner.

2. Ensure decisions about what restrictive interventions should be used are for a given situation and for a specific individual and take account of any underlying physical health conditions that may increase the risk of harm.

3. Ensure the use of restrictive interventions is authorised by the Senior Leadership Team and at least one qualified Sherwood trainer and recorded and reviewed in accordance with this standard. Any agreed physical interventions included within an individual's PBS plan must be fully risk assessed and authorised by Sherwood Training and Consultancy (see Sherwood Policies).

4. Ensure staff are trained in accordance with this standard

5. Provide a report, in December each year, which summarises the use of restrictive practices in the school, outlines the training strategy, techniques used and reasons why. This report and it's accompanying Action Plan is made available to the Executive Directors, Senior Leadership Team, Placing Authorities, the people we support and their family carers.

6. Ensure whenever restrictive practices have been used the staff involved are invited to take part in a supportive debriefing and post incident review process.

7. Ensure that reviews of Behaviour Support Plans are included within their internal audit programmes.

Types of Restrictive Intervention

Restrictive interventions refer to 'the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. Restrictive interventions can take a number of forms which are defined below.

1. Physical restraint (PR)

Any direct physical contact, where the intention is to prevent, restrict or subdue movement of the body of another person e.g. holds, restraints.

NB: *this does not include any other form of physical contact which may be considered as appropriate in terms of supporting people in their everyday life e.g. providing physical prompts to support an individual to dress or undertake a daily living task; offering an individual physical contact as a means of socially appropriate interaction, comfort or support.*

2. Mechanical restraint (MR)

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control e.g. straps, splints, gloves/mitts.

NB: *this does not include devices recommended by a medical practitioner or therapist for therapeutic purposes (e.g. a device or support used to relieve or correct an orthopaedic problem, or a wheelchair strap being used to ensure the person is correctly positioned), required by law (e.g. the wearing of a seatbelt in a vehicle) or those used for the persons safety*

If a device (e.g. wheelchair strap) is being used primarily for these reasons but is also being used to control an individual's behaviour (e.g. to stop them getting out of the wheelchair) then it must be considered to be a form of mechanical restraint and the steps outlined in this policy followed.

3. Chemical restraint CR

The use of medication which is prescribed (including prescribed PRN medication), and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

NB: *routinely prescribed medication to reduce behaviour must be administered and recorded in accordance with the Medication Policy.*

4. **Seclusion (SC)**
   The supervised confinement and isolation of a person, away from other people we support, in an area which the person is prevented from leaving. Its sole aim is the containment of severely challenging behaviour which is likely to cause harm to others e.g. removal to a calming room, placing the person in a quiet room.

Seclusion is not something that forms part of policy or practice at WPS. However, if it is used in extraordinary circumstances, a Multi-Disciplinary Team meeting must ensue and include the placing authority as well as any professionals working with the young person to decide on the best course of action.

Use of Restrictive Intervention in Witham Prospect School.

While the primary focus of our work in supporting people whose behaviour is challenging is on the use of positive proactive approaches and de-escalation, it is recognised that where a person's behaviour places themselves or others at imminent risk of significant harm and de-escalation strategies have not prevented a crisis, a restrictive intervention may be necessary as a proportionate and reasonable response to the risk posed.

The use of restrictive interventions to manage behaviours carries risks and should only be used as a last resort. If it is not applied appropriately it can result in pain, physical injury and emotional distress to all concerned. The inappropriate use of restrictive interventions is unethical, and in some cases illegal.

The choice of intervention will be informed by the person we support's preferences (if known), any particular risks associated with their general health (again if known) and an appraisal of the immediate environment. However, where the choice of intervention defined by the person's preference does not conform with safe techniques the need for safety will override this.

Planned use of restrictive intervention:

Where a person we support presents challenging behaviour which requires a restrictive intervention as part of an existing pattern of behaviour, the Positive Behaviour Support Plan must detail the method of intervention to be used by whom and in what circumstances as well as the broader range of strategies that address the behaviour. This will have been agreed in advance by a multi-disciplinary team.

Wherever restrictive interventions are included in a Positive Behaviour Support Plan, it must be clear that:

a. there must be a necessity to act in order to avoid harm to the person or others
b. the nature of restrictive intervention must be proportionate to the potential harm to the person or others
c. the practice must be the least restrictive option that will meet the need
d. any restriction should be imposed for no longer than absolutely necessary
e. what is done, why and with what consequences must be recorded in an open and transparent manner

Unplanned Use of restrictive interventions:

Unplanned restrictive interventions may be necessary when a person we support behaves in an unexpected way which presents a significant risk to the person themselves or others and/or serious damage to property. In these situations, members of staff retain their duty of care and their responses must be proportionate to the circumstances. Staff must use the minimum of force for the shortest period of time necessary to prevent injury and maintain safety consistent with training they have received. Any unplanned use of restrictive interventions must be reported directly to the Registered Person in written form and trigger a full review of the Positive Behaviour Support Plan, which should be updated to include contingencies in case of any recurrence as well as any necessary amendments to proactive and reactive strategies, or one put in place if there isn't an existing plan.

Unethical and Illegal Interventions:

- Restrictive interventions must never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation.
- There must be no planned or intentional restraint of a person in a prone/facedown position on any surface, not just the floor.
- The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.
- Staff must not use seclusion other than for people detained under the Mental Health Act, 1983
- Restrictive interventions should only ever be used as a last resort.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
- Any restriction should be imposed for no longer than absolutely necessary
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent

If anyone witnesses any of the actions above, they must report it immediately using written form to and send it to the Registered Person

THE LAW AND THE USE OF RESTRICTIVE INTERVENTIONS

Applying a restrictive intervention without consent or lawful authority or justification could make individuals, their line managers and the organisation liable to civil and criminal actions for assault, battery, breach of contract, negligence, false imprisonment, ill treatment or neglect.

The use of any restrictive intervention must be consistent with:

- our legal obligations
- responsibilities of Witham Prospect School staff
- the rights and protection afforded to the people we support under the law.

Duty of Care

All staff have a 'duty of care' to the people they support. In general terms, this requires them to take reasonable care to avoid acts or omissions that are likely to cause harm to another person. In relation to restrictive interventions, these should, be undertaken in the best interests of the person being supported, be the least restrictive option, be reasonable and proportionate to the risk.

Human Rights Act (1998) & European Convention of Human Rights (1950)

The Human Rights Act 1998 brings the rights outlined in the European Convention of Human Rights (1950) into English Law. It is likely that the inappropriate use of restrictive practices would potentially contravene:

- Article 3: prohibition on inhuman and degrading treatment;
- Article 5: right to liberty
- Article 7: no punishment without law; and
- Article 8: right to a privacy

Mental Capacity Act (2005) applies to young people aged 16 and over

Staff should seek a person's consent if they are proposing to change the way they support that person. This means that staff must explain any proposed procedure in an accessible and easily understandable way to enable the person to make their own decisions. They should support the person to ask questions and to weigh up information relevant to the decision to be made.

If the person is unable to make the decision within the meaning of section 3 of the Mental Capacity Act, staff should carry out a formal assessment of the person's capacity in relation to the proposed specific intervention. The Specific Decision Making Form (Getting it Right LIS013A3) should be completed to guide and evidence this assessment. If the person is found to lack capacity then a decision about the use of the specific intervention will need to be made

on their behalf, in their best interests and recorded on the same form (See capacity to consent standard, Getting in Right LIS013(s) for more details). Best interest discussions must involve people outside of the organisation and identify where this is a restriction or deprivation of liberty.

NB: this process permits/covers restriction on liberty but does not authorise acts that deprive a person of their liberty

Deprivation of Liberty

Whether or not an act amounts to a deprivation, rather than a restriction, of liberty depends on the individual circumstances. Factors may amount to a deprivation of liberty when:

- Staff have complete control over a person's care or movements for a long period of time.
- Staff make all decisions about a person, including choices about assessments, treatment and visitors and controlling where they can go and when
- Staff refuse to allow a person to leave, for example, to live with a carer or family member
- Staff restrict a person's access to their friends or family.

If a deprivation of liberty is necessary, it can only be authorised by a procedure set out in law, which enables the lawfulness of that deprivation of liberty to be reviewed. Legal authority to deprive a person of their liberty may be obtained under the **Deprivation of Liberty Safeguards** (DOLS) in the Mental Capacity Act or the Mental Health Act.

DOLS provides a procedure for authorising deprivation of liberty in hospitals and registered care homes for adults who lack capacity to consent or disagree. The Court of Protection can authorise deprivation of liberty in other settings.

The Mental Health Act (1983)

The Mental Health Act (1983) provides authority to lawfully detain and assess and treat individuals in hospital for a mental disorder, whether or not they have the capacity to consent or disagree to their admission or that treatment.

The Mental Health Act authorises deprivation of liberty if the person meets the criteria for being detained for the purpose of assessment and/or treatment for mental disorder, even in the absence of their consent. Guidance can be found in the Mental Health Act Code of Practice.

Health & Safety Law (1974)

The Health & Safety at Work Act establishes that employers have a duty to ensure so far as practicable, the health, safety and welfare at work of their employees and the health & safety of others that may be affected by the work of the organisation. Because the use of restrictive interventions is an activity which places both staff and the people we support at risk of physical and/or psychological harm we have a responsibility to have in place mechanisms to minimise the risk of any such harm. These include the assessment of risk and risk reducing actions and appropriate training.

Where teams or individual staff have concerns about the legal status of restrictive intervention or other strategies employed to respond to behaviours of concern, they are advised to consult the Registered Person or Safeguarding Lead for advice/guidance as soon as possible (Whistleblowing Policy).

POST-INCIDENT REVIEW – Learning to reflect on our practice

Following an incident in which a restraint (as defined above), i.e. physical restraint or mechanical restraint, is employed staff should be given separate opportunity to talk about what happened in a calm and safe environment. Once they have recovered their composure. The manager or person delegated by the manager must facilitate the post incident review. If the manager has been involved in the incident it may be appropriate for another manager to facilitate this.

The purpose of this post-incident review is to discover what happened and how it affected everyone. It should focus on acknowledging the emotional responses to the event, promoting relaxation and feelings of safety, facilitating a return to normal patterns of activity, ensuring that all appropriate parties have been informed of the event, that necessary documentation has been completed and beginning to consider whether there is a specific need for practical and/or emotional support in response to any trauma that has been suffered. Learning from the debriefing discussion should be used to review the positive behaviour support plan.

A **Restrictive Intervention Post-Incident Review Form** must be completed to record the findings and any further action required. Completed post-incident review forms should be attached to the Restrictive Intervention Incident Report, kept securely with the child/ young person's file and a copy sent to the Registered Manager.

Reporting, reviewing and reducing reliance on restrictive interventions

The use of restrictive interventions must be clearly recorded monitored and reviewed at individual, service and organisational levels. Witham Prospect School is committed to reducing the use of restrictive practice and as such we monitor all interventions closely. Each Registered Manager complies a monthly report of the use of Restrictive Interventions within their service and produces an action plan that will detail any actions that they are taking as a registered manager to investigate and address any increases in the use of restrictive interventions. This report is made available to the Executive Directors, regulatory inspectors and local and placing authorities upon request or during statutory visits.

Recording of ongoing chemical restraint as defined in section 1 will be on the MARS sheet as described in Witham Prospect School's Medication Policy. The reviewing mechanism for this will be through the annual health check with the person's GP or Consultant as per the person's health action plan.

The use of all other restrictive interventions must be recorded, using the Restrictive Intervention Incident Report on the Behaviour Watch System. This must be done as soon as practicable (within 24 hours of the incident) by the person(s) involved and a copy (along

with copies of any post-incident review forms) sent to the Registered Manager within a further 24 hours.

All records including the Restrictive Intervention Authorisation Checklist, Restrictive Intervention Incident Reports, Post-incident Review Forms, Positive Behaviour Support Plans and Risk Assessment must be maintained in the person's file and copies kept at the registered office for inspection purposes and to provide evidence for audit.

POSITIVE BEHAVIOUR SUPPORT QUALITY ASSURANCE AND MONITORING PROCESSES

Reviewing the use of restrictive interventions in Witham Prospect School must happen at various levels to ensure we continue to meet current professional standards and improve our practice.

Monthly Reviews of Restrictive Interventions

Monthly reviews are to be undertaken by the Behaviour Specialist and the Registered Managers for each service. These reviews should contain a review of the overall use of restrictive intervention within their service and a review of the use of restrictive interventions on an individual child/young person basis. Where an increase in the use of restrictive intervention has been identified for a child or young person this will trigger a review of the Positive Behaviour Support Plan for the individual. The Behaviour Specialist is expected to produce a monthly report and an accompanying action plan.

A full review would be immediately triggered in the event of:

- Unplanned use of a restrictive intervention
- Injury to a child/young person or others involved in a physical intervention
- Significant changes to individual's medication, health and/or behaviour
- the person experiencing a period of crisis and/or particular risk.

Over time, behaviour patterns will change as will the benefits and risks associated with any restrictive intervention; individual reviews should include a revised assessment of risk. Restrictive interventions must be combined with other proactive and reactive approaches, which lead to the reduction or withdrawal of the restrictive physical intervention over time.

The family or advocate of the child/young person should be invited to reviews on a regular basis and kept informed of developments, progress and difficulties. Their input into decisions concerning restrictive interventions will be encouraged.

Other professionals e.g. care manager, behaviour team, psychologist, speech and language therapist should also be involved where they have ongoing involvement in the persons care planning or support.

Following all reviews a copy of the review documents, updated positive behaviour and support plans and any associated documentation must be stored in the registered managers office with the Restrictive Intervention Authorisation Checklist and the original documents kept in the child/ young person's file.

Quarterly Positive Environment Checklist

The Positive Environment Checklist is to be completed on a quarterly basis by the Registered Manager for the service. The checklist focusses on the physical, social and programmatic structure of the environment and should be used as part of a proactive, preventative approach to addressing behaviours of concern. The checklist can also be used on an individual basis to help determine whether environmental conditions are contributing to a child or young person's behaviours of concern.

The Positive Environment Checklist should be completed during the months of **March**, **June**, **September** and **December** each year and a report produced by the 20th day of the following month.

Six Monthly Evaluation Matrix for Challenging Behaviour Services

Witham Prospect School has adopted the *LDAG Subgroup PBS Standards Measure for Wales* as our monitoring tool for evaluating our services competencies in Positive Behaviour Support. This monitoring tool is recommended by Bild and is to be used by the Registered Manager of each service when assessing the services effectiveness in implementing and following the organisations approach to Positive Behaviour Support. The evaluation tool will be used to inform the service's action plan for improving our effectiveness in delivering a PBS service.

The Evaluation Matrix for Challenging Behaviour Services should be completed in **June** and **December** each year and the report and action plan must be made available to the Board of Directors by the 20th day of the following month.

Annual PBS standards audit

Witham Prospect School has adopted the *LDAG Subgroup PBS Standards for Wales* as our audit tool for measuring our competence in meeting the PBS standards. This audit will be undertaken at each service on an annual basis by Debbie Hardy, PBS Coach. A report will be

produced and shared with the Registered Manager and the Executive Directors to assist in policy implementation and review, strategy planning and service quality auditing.

The PBS standards audit should be completed during the month of **June** each year and the report and action plan must be made available to the Board of Directors by the 20th day of the following month.

Annual Reducing Seclusion and Restraint Monitoring

The Checklist for Assessing your Organisations Readiness for Reducing Seclusion and Restraint will be undertaken on an annual basis by a Director of Care or Education. This checklist will identify how well each service is performing in its overall goal in reducing the use of restraint and restrictive practice.

The checklist is to be completed in **December** each year and a report and action plan is to be completed and shared with the Board of Directors by the 20th day of the following month.

All audits undertaken by the service must be made available to the Board of Directors, Commissioners, Ofsted and local and placing authorities upon request and during statutory visits.

TRAINING AND STAFF DEVELOPMENT

Levels of Training

All training in challenging behaviour, positive behaviour support and restrictive interventions (including refresher training) will:

- Promote independence, choice and inclusion to establish environments that enable the people we support to have maximum opportunities for personal growth and emotional well-being.
- Recognise that whenever possible interventions should only be used in a way that is sensitive to and respects cultural experiences of the people we support and their attitudes towards physical contact.
- Ensure responses to challenging behaviour encompass a range of strategies and provide safe and effective support.
- Cover associated legal aspects and issues around consent.
- Be face-to-face and content agreed with the PBS Coaches team.

Training has been separated into the following courses:

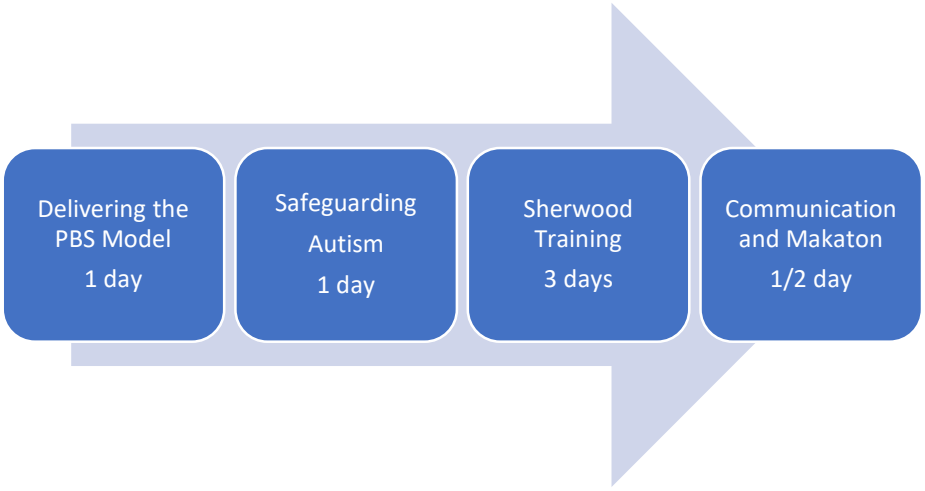
Staff	Course Length	Course Title	Course Content
Non-contact staff and Direct Contact Staff	2 days	Level 2 Sherwood Training in breakaway and self protection skills.	**Level Two – Breakaway/self-protection skills** **NB this training must be:** ▪ **Accredited by BILD** **Course content:** ▪ Individual rights ▪ Defining restrictive practices/interventions ▪ Key legislation & lawful use of restrictive interventions ▪ Principles of minimum force & least restriction ▪ Reactive Strategies ▪ Breakaway and self-protection techniques **Refresher requirement – every 12 months**
Direct Contact Staff	3 days	Level 3 Sherwood Training in PBS and Physical Intervention	**Level Three – Specific Physical Intervention (includes level 1&2)** **NB this training must be:** ▪ **Tailored to the specifically to the needs of the individual's we support** ▪ **accredited by BILD**

			Course content ▪ Gradients of control to ensure safe practice ▪ Risks to health & well-being ▪ Monitoring well-being during a physical intervention ▪ Responding to a health emergency ▪ Post-incident support/debriefing ▪ Recording ▪ Reviewing and reducing the use of restrictive interventions ▪ Physical skills – as assessed by service training audit and approved **Refresher requirement – every 12 months**

Staff Induction

Staff inductions will include training in PBS for all staff entering the organisation that will hold a direct contact role. This will assist in the implementation of our PBS Model and ensure that the PBS model is instilled in our staff team from the offset.

All agreed that the following courses will be covered during new staff inductions in the following sequence:



Trainer Requirements

PBS courses

Trainers must:

- Have extensive experience of working with children and young people (and adults) with severe learning disability who present behaviours of concern.
- Have detailed, practical knowledge of positive behaviour support
- Have practical knowledge of physical interventions
- Be conversant with Witham Prospect School policies and procedures
- Have a working knowledge and practical experience of Active Support, Communication, Person Centred Thinking and Planning.
- Have completed the Bild PBS Coaches Programme

OR

- be working within, employed by or accredited by a training organisation that is accredited within the BILD Physical Interventions Accreditation Scheme.

Sherwood Training

Trainers must be:

- Working within, employed by or accredited by a training organisation that is accredited within the BILD Physical Interventions Accreditation Scheme.
- Have completed the Bild PBS Coaches Programme
- Hold a Level 3 Award in Education and Training, or its equivalent

Training Records

All training must be recorded on the appropriate area/national training data base and reports made available for internal and external auditing.

Sherwood training

The trainer or training organisation must provide feedback on the performance of each course participant of Sherwood training in the following areas:

- Attitudes as reflected in the language and behaviour used during the course
- Knowledge of appropriate positive behaviour support strategies
- Knowledge of the principles underpinning the safe use of restrictive interventions
- Knowledge relating to the ethical and legal aspects in implementing the use of restrictive interventions
- Competence in each practical technique taught.

Participants who do not reach the required standards, and their managers, will receive feedback regarding:

- The areas in which they have failed to provide evidence
- The actions that can be taken to enable them to achieve competence in these areas
- The implications of their current level of competence when working with individuals who present challenging behaviour.

If this has implications for the person's current employment immediate action must be taken in line with Witham Prospect School Capability Procedures.

Individual Staff Competence Monitoring

In addition to formal face to face training, all staff working directly with the children and adults will complete the PBS Competence assessment on an annual basis prior to their annual appraisal. This can replace the last two supervision sessions in the lead up to their annual appraisal as the assessment gives opportunity to reflect and review current practice. This should be done on a 1:1 basis and staff should be given opportunity to raise any additional work issues and concerns during these sessions.