COCHRANE TEMISKAMING RESOURCE CENTRE

POLICY MANUAL: PROFESSIONAL RESOURCE TEAM POLICY #5

TITLE **GENERAL SUPPORT STRATEGIES**	PAGE 1 OF 8
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ISSUED BY PROFESSIONAL RESOURCE TEAM	SIGNED BY EXECUTIVE DIRECTOR
FOR USE BY ALL DIRECT CARE STAFF	

With the introduction of the Quality Assurance Measures of the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008 (replacing the Developmental Services Act) guidelines for behavioural intervention services are provided along with an emphasis on empowering individuals with developmental disability regarding their rights and exercising choice. It defines support strategies as being therapeutic, educational, proactive and largely non-intrusive.

The guidelines in the present document reflect the philosophy and intent of recent legislation and also adhere to **legal, ethical and professional standards.**

Statement:

Individuals supported at CTRC have a Person Centered Plan that identifies the support strategies that will specifically address their individual needs. Psychological services will be involved in developing specific behaviour support strategies (behaviour support plan, behaviour assessment) when the frequency and/or severity of a challenging behavior warrants this intervention. These specific support plans will supersede the guidelines presented here when supporting clients with challenging behaviors. This policy works in conjunction with Non-violent Crisis Intervention training that all front-line staff at CTRC receive and the Support Strategies and Intrusive Measures policy # 14 (PRT) and 20 (residential services). **Please consult CTRC protocol for the administration of PRN medications (Pharmacy Related Policy #5, "PRN Medications (Specific)".**

Objectives:

1. To set out the Ministry's expectations for the use of consistent support strategies by service providers for people with challenging behaviors.

2. To give clear standard as to what strategies are acceptable and when they may be used.

3. To ensure CTRC develops and follows support strategies that adhere to legal, ethical and professional standards.

Procedure:

1. The Client Services Director will ensure these standards are widely publicized in Residential Services. The Residence Supervisor will follow-up with employees on an on-going basis regarding consistent applications of the standards.

2. This policy will form a part of the orientation package.

3. The Supervisor will determine when general training is required and/or specific training and make appropriate arrangements.

Promoting Co-operation:

In order to promote co-operation, an empathic attitude towards the individual receiving support is the key. Respect, understanding and acceptance encourages anyone to cooperate out of desire to please.

Caregivers need to be aware that there may be specific ways to promote an individual's co-operation or deal with an individual if he/she becomes agitated as a result of a request. This information can be found in the individual's Person Centered Plan.

Caregivers should always be available to interact and respond to an individual's requests, taking the time to listen. This will help to prevent agitation or any other behavior that the individual may display as a result of not being attended to or of feeling ignored.

When making a request, it is important to avoid warnings, threats and commands. These will generally evoke hostility or anger. You should formulate your request carefully, offering the individual a choice when possible. **Be sure your request is reasonable and clear.**

An individual may not always cooperate with staff's request. Unfortunately, we have a tendency to think that when an individual is "non-compliant" that we should not let him/her "win", that he/she will take advantage of us over and over again. **Avoid win/lose power struggles over issues!** Caregivers need to recognize when their request does not need to be responded to at the time. In such instances, reintroduce your request at a later time.

When an individual is busy, (i.e., watching television, making a puzzle), give the individual verbal cues, such as...in so many minutes...and introduce the request after that time has elapsed. When you need to reintroduce the request, you might try to refocus the individual's attention by engaging in a topic of conversation that you know will appeal to him/her and try to lead him/her to the designated area or task. When your request is resulting in the individual becoming agitated, re-evaluate the situation. **You cannot force cooperation**. You should immediately intervene to defuse the situation by listening to the individual and allowing him/her time and space to calm.

When an individual presents a challenging behavior that is not harmful to himself/herself or others, the behavior should be **IGNORED** (thus you are not inadvertently reinforcing the challenging behavior).

Examples of behaviors, which should be ignored:

- Whining
- Teasing
- Inappropriate and/or repetitive talk
- Swearing or abusive language
- Inappropriate questions
- Loud laughter
- Burps
- Nose picking
- Turning lights on/off
- Standing too close to caregivers
- Mild self-abusive behavior

Note: Volunteers will not work with individuals with challenging behaviour as described in 15(2) of the Quality Assurance Measures of the Services and Supports to promote the Social Inclusion of Person with Developmental Disabilities Act, 2008.

When the behavior is potentially harmful to self or others, or destructive in nature, RELOCATE OR REDIRECT the individual.

Sometimes it can be equally effective and much easier to relocate oneself than to relocate the individual. For example, when the individual is standing too close, it might be faster and more effective to walk a few feet away. If an individual is bothering another individual take the individual who is being "bugged" away from the other, and engage in a meaningful interaction with the "victim". Redirect or relocate other individuals that may be at risk.

Hugs and Other Affectionate Behaviors:

People with disabilities have the same desire and right to enjoy affection as do other members of our community. The individuals we support, however, may not have the same opportunities as other members of our community to express their desire and exert their rights. While you and I have brothers, sisters, children, husbands or wives…with whom to enjoy affection, many individuals we support have very little or no contact with family members, are not married and have no boyfriend or girlfriend, and have very few close friends. The closest and most trusting person is you, the person being paid to provide support.

Because of the nature of our work, we spend a lot of time at clients' homes which fosters close relationships and shares a lot of similarities with family life. It is almost inevitable that individuals receiving support come to treat us as a family member. However, we must remember that we are staff and not an individual's friend or family member, we have a different set of boundaries than those with whom they have real intimacy, and we should have only limited physical contact with the individuals we support. Contact such as close up hugs or resting a hand on an individual's thigh while talking are things staff should never do. Guidelines regarding affectionate behaviour would not be complete without a reminder of the importance of being aware of the laws pertaining to sexual exploitation. Our decision to respond in kind to an individual's affectionate behaviours could be challenged by someone misinterpreting our intentions, and in a worse case scenario, accusing us of sexual exploitation. Common sense, as usual, prevails, and it is advisable to avoid situations where your intentions could be misinterpreted.

Difficulty retiring, getting up at night:

When an individual is up for no specific reason and is not in any obvious distress, he/she should be directed back to bed. The caregiver should attempt to comfort the individual by leaving the light on for a few minutes, calming and reassuring. If the individual insists on staying up and is disturbing other residents, redirect him/her to another area. The individual should be directed back to bed after 15 to 20 minutes have passed. Verbal interactions should be limited. If the individual still resists or gets back up, allow them to stay up for half an hour and watch television, look at a book, etc., and then re-direct him/her back to bed.

Caregivers should document and investigate when there are on-going changes in individuals sleep patterns and causes are unknown.

Soiling/smearing (of urine/feces):

The majority of incidents when an individual has soiled will be incontinence. The Webster's dictionary defines "incontinency" *as unable to contain/restrain, incapable of controlling the excretory function.*

Caregivers must first determine if the incontinency is related to seizure activity, illness, poor muscle tone, or inability of the individual to access facilities. In such cases of incontinence, caregivers are to provide the individual with necessary care and assistance.

When incontinency occurs during the night, the individual should not be expected to assist the caregiver in cleaning. Verbal interaction should be limited to asking the individual to change his/her pajamas and to wait while the caregiver changes the bed. In all cases of incontinence, it is important to offer reassurance to the individual.

When it is determined that the soiling/smearing is a reaction or response to an event (e.g., being denied a request), or triggered by agitation of emotional outburst, there should be

NO LECTURES from caregivers. If the individual is willing and capable (physically, emotionally and cognitively), he/she should be directed in a calm voice to clean himself/herself and the soiled area. If an individual resists, limit his/her activity and movement to one area, until he/she is willing to cooperate or receive assistance. The caregiver should provide the least amount of attention possible and **avoid power struggles**. The caregiver will proceed to clean the soiled area without the individual's assistance.

Stripping:

When an individual refuses to keep clothes on, caregivers should first investigate possible reasons for the stripping (e.g., wet clothes, too tight, uncomfortable, etc.). If such is the case, provide more suitable clothes for the individual and assist with dressing as necessary. Verbal interaction should be limited to simple, basic instructions on dressing.

If an individual resists getting dressed, restrict his/her activity and movement to one area, until he/she is willing to get dressed or receive assistance. The request should be re-introduced within a reasonable period of time, 2-15 minutes, depending on the individual involved.

Whenever an individual is unaware of the importance of his/her privacy, it is the responsibility of caregivers to ensure this need is met.

Self-abuse:

If self-injurious behavior is frequent, severe and/or harmful, the individual should be on an appropriate treatment plan, therefore, these guidelines would not apply.

Self-stimulating behaviors or mild forms of self-abusive behaviors should be ignored.

Examples of behaviors to be ignored:

- Body rocking which does not usually lead to more harmful behavior
- Biting of hands which does not injure or break skin

When mild self-abusive behaviors lead to more severe or harmful behaviors, redirect verbally and/or relocate the individual.

Examples of these behaviors:

- When body rocking leads to head banging or escalates to violent body rocking where there is potential harm to the individual

Taking and/or destroying objects:

Many individuals with developmental disability have difficulty understanding the concepts of "belonging to one" versus "belonging to others". Those who are capable of asking permission to borrow other's belongings might still not realize that asking permission distinguishes borrowing from stealing. It is important for caregivers to know whether the individual took the object with the intent to borrow or to keep.

When an indivdual takes an object, which does not belong to him/her, or breaks or destroys it, and it is determined there was NO INTENT to steal or destroy the object, there should not be any negative consequences. When this occurs, use a simple "no" as verbal interaction could be reinforcing. The victim needs to be comforted and reassured that the issue will be resolved.

When it is determined that the intent was to keep the object, he/she is to return it, if possible, and apologize for their action. The individual is to be counseled as to the inappropriateness of his/her behavior.

Disruptive/Out of Control Behavior:

Crisis intervention is used to refer to procedures used to interrupt or control an otherwise dangerous or unmanageable situation.

Crisis intervention procedures are: not support strategies
Short term
Possibly intrusive

All crisis intervention procedures used will be documented in the individual's file.

CTRC has adopted the "Non-violent Crisis Intervention" model as the acceptable crisis intervention procedure. All caregivers will receive ongoing training in its application.

The following has been taken in part from the Non-violent Crisis Intervention participant workbook.

In any crisis development situation, there are four distinct and identifiable behavior levels. The purpose of defining each level is to attempt to meet each level with the appropriate staff response, verbal and non-verbal, to defuse or de-escalate the crisis development. The following behavior patterns can be seen in most people who are escalating toward a potential violent episode.

1. **Anxiety level**-noticeable increase or change in a person's typical behavior, e.g., pacing, rate of speech.

   Staff Attitude/Response-Supportive

This approach requires the caregiver to be empathic and actively listen to what is bothering the individual. This is when most potentially explosive situations are defused.

2. **Defensive level**-begins to lose rational thinking and may become challenging and verbally abusive.

Staff Attitude/Response-Directive
This approach entails setting limits for the individual. Limits need to be clear, simple, brief, reasonable, enforceable and non-threatening.

3. **Acting out person**-loss of control, which usually involves physical aggression.

Staff Attitude/Response-Non-violent physical crisis intervention- often at this point, the caregiver must physically control the individual's behavior until he/she can regain control on his own. Non-violent physical control restraint should be used only as a last resort. You have now reached the point where all verbal means of managing the situation have been exhausted. The person is no longer responding to reason, and he/she may present a danger to himself/herself, caregiver or other people in the area. If physical control is required, only the non-violent physical control restrains shown in CPI training should be utilized.

4. **Tension reduction**-decrease in physical and emotional energy.

Staff Attitude/Response-Therapeutic rapport
The caregiver needs to re-establish therapeutic rapport and communication. This is one of the best times to attempt to talk with the individual. Surprisingly enough, many times the person is actively seeking communication.

Non-Verbal Communication

At all of these levels, caregivers must keep in mind the importance of non-verbal communication and its impact.

Proxemics (personal space): your proximity can be perceived as a threat. Give as much space as possible. The critical distance for most people is about 1-1/2 to 3 feet.

Kinesics (body posture and motion): use a supportive stance which is non-challenging and provides an escape route. Keep your hands out in plain view, at your sides if possible.

Paraverbal Communication: This involves three elements: the tone, volume and cadence of voice (rate of speech). Caregivers must be consciously aware of how they are speaking to the individual as much as the words they use.

For more detailed information, refer to the most recent Nonviolent Crisis Intervention Workbook.

Note: When a challenging behaviour seems unresponsive to the general support strategies outlined in this policy and continues to progress in severity (e.g., disruptiveness, destructiveness and repetitiveness), then consideration should be given to making a referral to Psychological Services for further and more specialized assistance. Staff should discuss these concerns with their supervisor.