public guardian

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27 October 2015

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Committee Secretary,

Re: Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings

I write in relation to the Committee's recent public hearing held in Brisbane on 16 October 2015, as part of the inquiry into violence, abuse and neglect against people with disability.

During my appearance at the Brisbane hearing, I undertook to provide certain information to assist the Committee with its investigations, which is now attached for the Committee's reference.

You are welcome to contact my office should the Committee have any further questions arising from the attached responses.

Yours sincerely,

Julia Duffy
A/Public Guardian
Office of the Public Guardian

public guardian

Response to questions on notice

Senate inquiry public hearing 16 October 2015

Public Guardian
October 2015

www.publicguardian.qld.gov.au

Introduction

On 16 October 2015, the Community Affairs References Committee (the Committee) conducted a public hearing in relation to the Senate inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability.

The Acting Public Guardian made submissions at the hearing and took questions on notice from the Committee regarding the following three matters—

1. statistics on the Office of the Public Guardian (OPG) fulltime equivalent staff
2. restrictive practices, and
3. service providers seeking to remove family member guardians due to excessive complaints.

The Acting Public Guardian's response regarding each of these matters is detailed below.

1. OPG fulltime equivalent staff

The OPG fulltime equivalent staff as at 30 June 2015 is set out in the following table—

Officer	Number
Executive Management	8
Community Visiting Program	158
Guardianship	62
Legal Team	15
Investigations	6
Corporate (including HR, Finance, IT, Communications, Policy and Reporting, and Administration	25
Total staff	**274**

2. Restrictive practices

The Committee has requested a summary of the restrictive practices statutory regime.

The statutory regime

The *Guardianship and Administration Act 2000* (GAA) and the *Disability Services Act 2006* (DSA) (collectively, the statutory regime) specify that restrictive practices may be used by a disability service provider for the purpose of reducing the risk of harm to the adult or others.

Restrictive practice means any of the following practices used to respond to the behaviour of an adult with an intellectual or cognitive disability that causes harm to the adult or others—

- containing or secluding the adult
- using chemical, mechanical or physical restraint on the adult, or
- restricting the adult's access to objects.[1]

[1] *Guardianship and Administration Act 2000*, s.80U; *Disability Services Act 2006*, ss.144, 145, 146 and 147.

Harm to a person means physical harm to the person, a serious risk of physical harm to the person, or damage to property involving a serious risk of physical harm to the person.[2]

The GAA and the DSA safeguard the adult's rights and interests by providing for the assessment, approval, regulation, monitoring and review of the use of restrictive practices by service providers. The statutory regime ensures that the service provider has regard for the human rights of the adult and uses the least restrictive way of preventing harm.[3] The Office of the Public Guardian, the Department of Communities, Child Safety and Disability Services (DCCSDS) and the Queensland Civil and Administrative Tribunal (QCAT) are primarily responsible for the administration of the restrictive practices framework.

The statutory regime provides a process for authorisation of actions that may otherwise constitute assault or other criminal offence against the adult. A service provider is not criminally or civilly liable if the service provider uses restrictive practices in accordance with the GAA and the DSA.[4]

The statutory regime applies only to adults with impaired capacity who—

- are 18 years or over
- have an intellectual or cognitive disability
- exhibit behaviour that either causes harm, or represents a serious risk of harm, to the adult or others, and
- are receiving services provided or funded by DCCSDS.[5]

Guardians are appointed by QCAT and are usually family members or close friends of the adult. QCAT may appoint the Public Guardian as a guardian of last resort in circumstances where there is no other appropriate person to appoint as the adult's guardian, or there is intra-family or guardian conflict.[6] To assist understanding and compliance with the statutory regime, DCCSDS has prepared a flowchart (Annexure A) and summary table (Annexure B).[7]

OPG has a specialised team of guardians to make decisions relating to restrictive practices which assures a consistent and expert approach to the protection of these adults' human rights.

Process for approving the use of restrictive practices

The authorisation process for the use of restrictive practices is dependent on the nominated restrictive practice and other circumstances.

Short term approval (up to six months) may be granted by—

- OPG – for seclusion or containment,[8] and
- DCCSDS – for restraint (chemical, mechanical or physical) or restricting access to objects,[9]

in circumstances where the service provider has identified an immediate and serious risk of harm to the adult or others and a guardian has not yet been appointed by QCAT.

[2] *Guardianship and Administration Act 2000*, s.80U; *Disability Services Act 2006*, s.144.
[3] *Guardianship and Administration Act 2000*, s.80U; *Disability Services Act 2006*, ss.139 and 141-144.
[4] *Disability Services Act 2006*, s.189 and 190.
[5] *Guardianship and Administration Act 2000*, s.80R; *Disability Services Act 2006*, ss.140 and 142. For impaired capacity requirement see *Guardianship and Administration Act 2000*, ss.80V, 80ZD and 80ZH; *Disability Services Act 2006*, s.178.
[6] *Guardianship and Administration Act 2000*, s.14.
[7] For further information on the restrictive practices statutory regime, please see the DCCSDS website on positive behaviour support: https://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support.
[8] *Guardianship and Administration Act 2000*, s.80ZH.
[9] *Disability Services Act 2006*, s.178.

Consent may be given by a QCAT-appointed guardian for restrictive practice matters for the use of containment or seclusion in respite or community access services, and chemical, mechanical or physical restraint or restricting access to objects across all service types.[10]

Consent may be given by an informal decision maker (a member of the adult's support network) for the use of restricting access to objects.[11]

Approval is given by QCAT for the use of containment or seclusion in accommodation support or community support services (and these practices in combination with other restrictive practices).[12] QCAT may grant approval for up to—

- 12 months for containment or seclusion,[13] and
- two years for other restrictive practices.

Approval of restrictive practices by the Public Guardian

The service provider must submit a Positive Behaviour Support Plan (plan) to the Public Guardian, together with a request for consent for the service provider to use certain restrictive practices on the adult.[14] The plan must outline strategies to address the harmful behaviour, reduce or eliminate the use of restrictive practices, and improve the adult's quality of life. DCCSDS has prepared a model plan to assist service providers with this requirement (Annexure C).

The plan must be informed by assessment and will include medical reports and additional information depending on the nominated restrictive practice, for example—

- chemical restraint – clarification of purpose form or letter issued in the preceding 12 months, or
- mechanical or physical restraint – pictorial diagrams of devices and/or staff training.

The plan is allocated to a senior guardian and assessed against the requirements of the DSA and the GAA. The senior guardian liaises with the service provider to revise and amend the plan if necessary to ensure compliance with the statutory regime. When the senior guardian is satisfied with the plan, it is escalated to management or the Public Guardian for approval as required.

Frequency of approval of the use of restrictive practices

The Public Guardian provides consent for the use of restrictive practices for approximately 300 clients per annum. In addition, the Public Guardian also provides a smaller number of some short term approvals. There are currently 11 short term approvals in place.

Monitoring of restrictive practices

Monitoring of the use of restrictive practices is conducted by—

- authorised officers appointed under the DSA,
- the OPG's Community Visitor Program utilising the inquiry/complaint function under the GAA, and
- third-party audits under the Human Services Quality Framework.

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[10] *Guardianship and Administration Act 2000*, ss.80ZE and 80ZF.
[11] *Guardianship and Administration Act 2000*, s.80ZS.
[12] *Guardianship and Administration Act 2000*, ss.80V and 80X.
[13] *Guardianship and Administration Act 2000*, s.80Y.
[14] *Guardianship and Administration Act 2000*, s.80U; *Disability Services Act 2006*, ss.144 and 150.

Review process

All approvals for the use of restrictive practices are time-limited and must be reviewed regularly.

Approvals for containment and seclusion

As noted above, OPG can provide short term approval for the use of containment and seclusion, for a maximum 6 month period. Otherwise, all applications for containment and seclusion are made to QCAT.

If OPG provides short term approval, at the end of the approval period, a service provider must then apply to QCAT to seek a new approval.

QCAT approvals for containment and seclusion can only be made for a maximum of 12 months. A service provider can apply for a further 12 month approval, at which point, QCAT would consider the request afresh, although information about the previous order would be before the Tribunal. The service provider would prepare a report for QCAT outlining the request and other supporting information.

Appointment of a guardian to authorise restrictive practices

QCAT can also appoint a guardian who has the authority to approve the use of restrictive practices, excluding containment and seclusion, for a period of up to 2 years. The guardian therefore, can authorise any restrictive practice other than containment or seclusion.

The Public Guardian is empowered to approve restrictive practices only when this is expressly provided for in a guardianship order made by QCAT.

The service provider must review the adult's plan every 12 months[15] and, within 30 days of the existing plan's expiration, submit to the Public Guardian—

- a revised plan, or
- a request for an extension of time (if required).

The Public Guardian cannot provide an extension of an existing plan without a formal request.

A person who is dissatisfied with the appointment of the Public Guardian can apply directly to QCAT for the appointment to be reviewed or revoked.[16] They can also seek advice, directions and recommendations from QCAT. QCAT may also give advice, directions or recommendations to the Public Guardian on its own initiative.

After 2 years, QCAT will automatically initiate a review of the guardianship appointment, which may be conducted on the papers or at a hearing. In the process of the review, information as to what was approved by the guardian would be before QCAT, to assist in deciding whether to continue the guardianship appointment.

For further information on QCAT processes please see information sheets and approved forms at http://www.qcat.qld.gov.au/matter-types/guardianship-for-adults-matters.

[15] *Disability Services Act 2006*, s.150.
[16] *Guardianship and Administration Act 2000*, s.81.

3. Service providers seeking to remove family member guardians

The Committee has enquired about instances where service providers have sought to have family members removed as guardians because the family has made excessive complaints about the service provided.

There are a number of reasons a service provider may seek to have family member guardianship revoked and the Public Guardian appointed, for example—

- the family is not willing to act as the adult's guardian,
- there is a reasonable belief that a family member guardian is not properly performing their functions or is subjecting the adult to abuse, neglect or exploitation,
- difficulty dealing with the adult's family in situations where multiple guardians have been appointed for different matters and their decisions conflict, and
- the family requesting the Public Guardian be appointed as the adult's guardian for restrictive practice matters only to ensure compliance with the statutory regime.

In some cases, it becomes apparent that a service provider initially sought the Public Guardian's appointment because of conflict between the service provider and the family, sometimes in response to a family member assertively advocating on the adult's behalf.

In other cases, QCAT may make a decision to remove a family member as the adult's guardian independently of any request from a service provider.

Appointment of the Public Guardian may occur as a guardian of last resort in circumstances where there is no other appropriate person to appoint as the adult's guardian, or there is intra-family or guardian conflict.

If the Public Guardian is appointed as an adult's guardian and the OPG becomes aware that the service provider is in conflict with the family—

- the OPG will negotiate with the service provider and the family to resolve the issues and manage the ongoing conflict, and
- if there is a more suitable person willing and able to appointed as guardian, OPG will liaise with that person and apply to QCAT for a review and revocation of the Public Guardian's appointment.

Figure 1: Full legislative scheme (general disability services)*

Steps 1 to 5

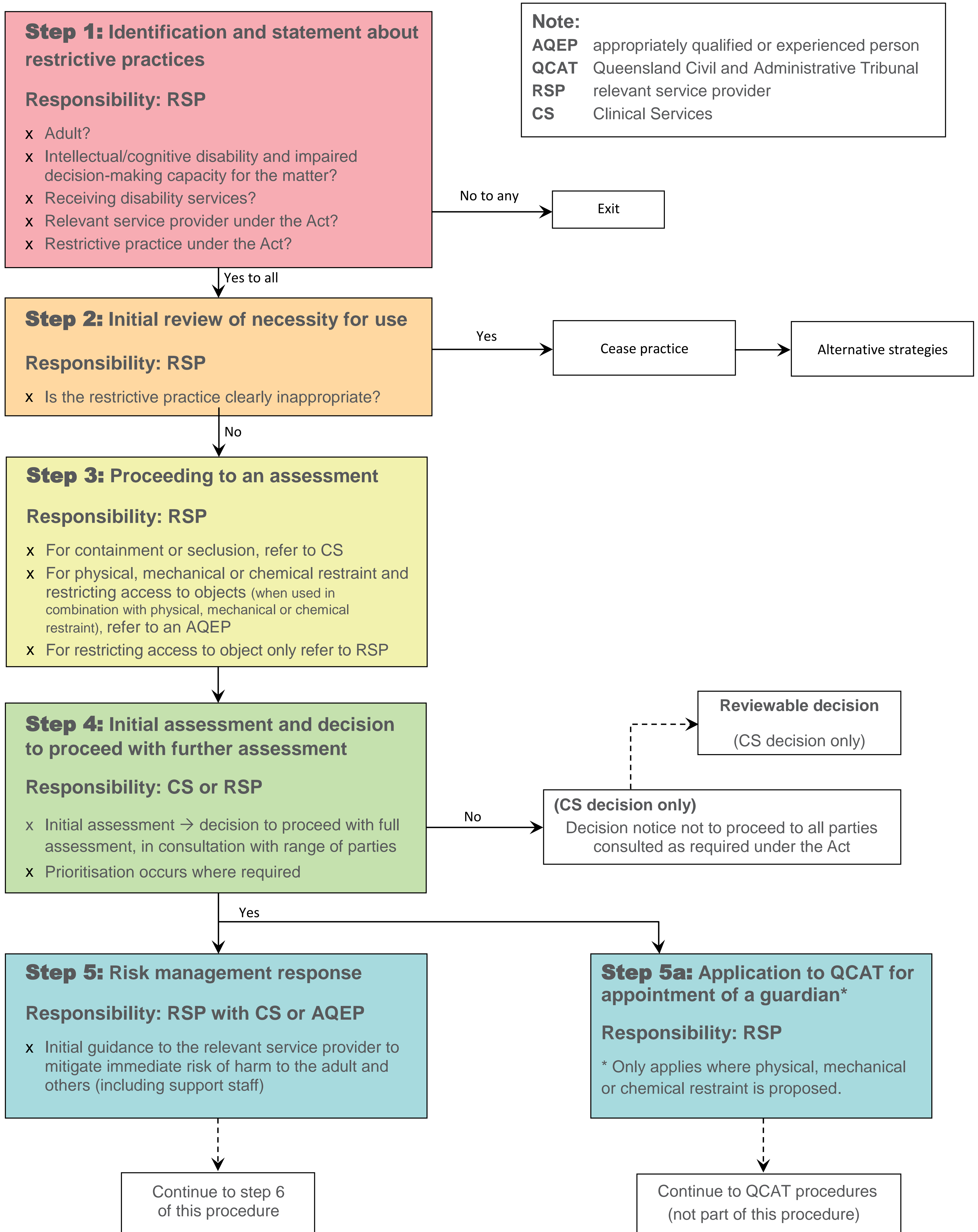
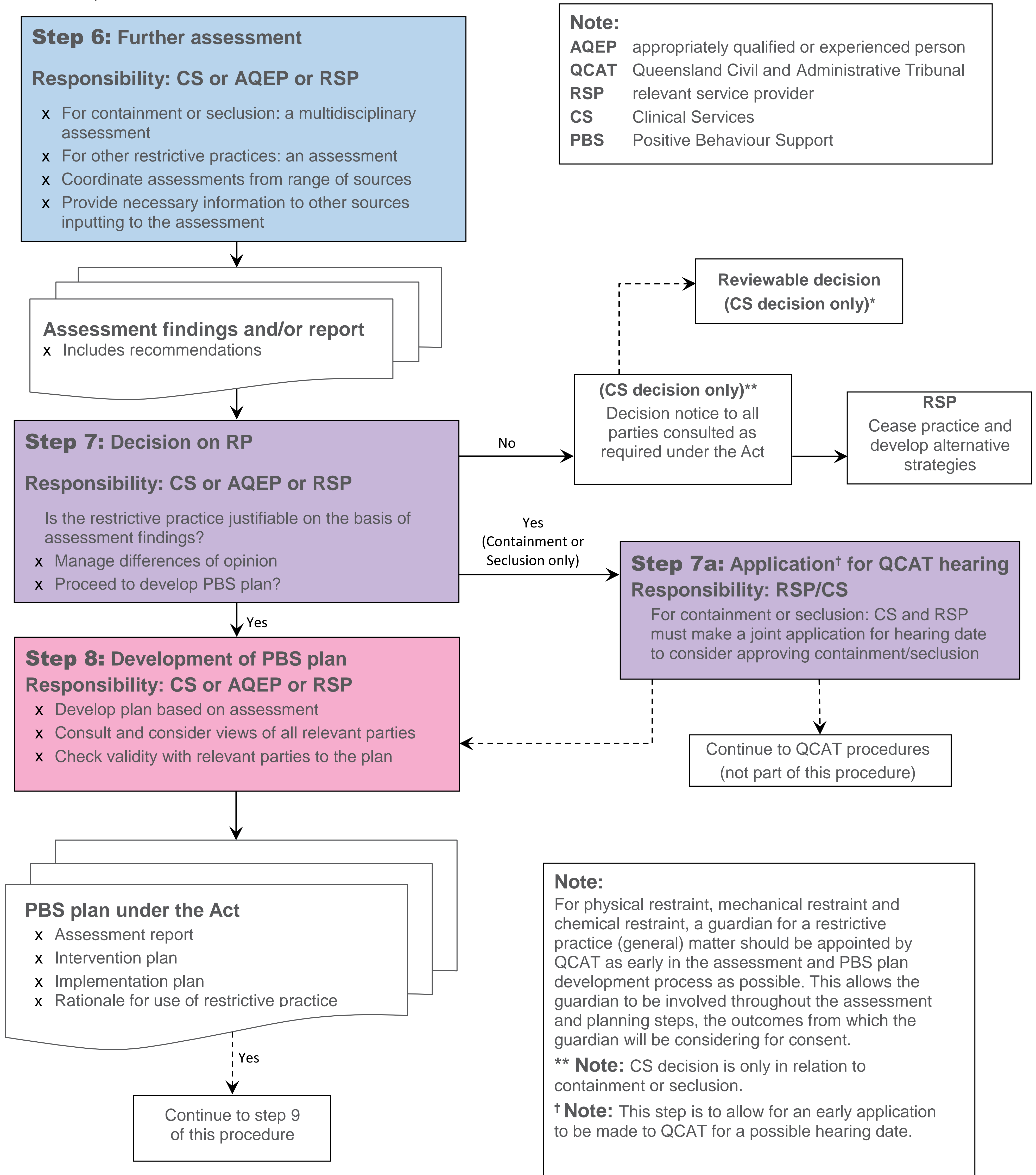


Figure 2: Full legislative scheme (general disability services) *

Steps 6 to 8



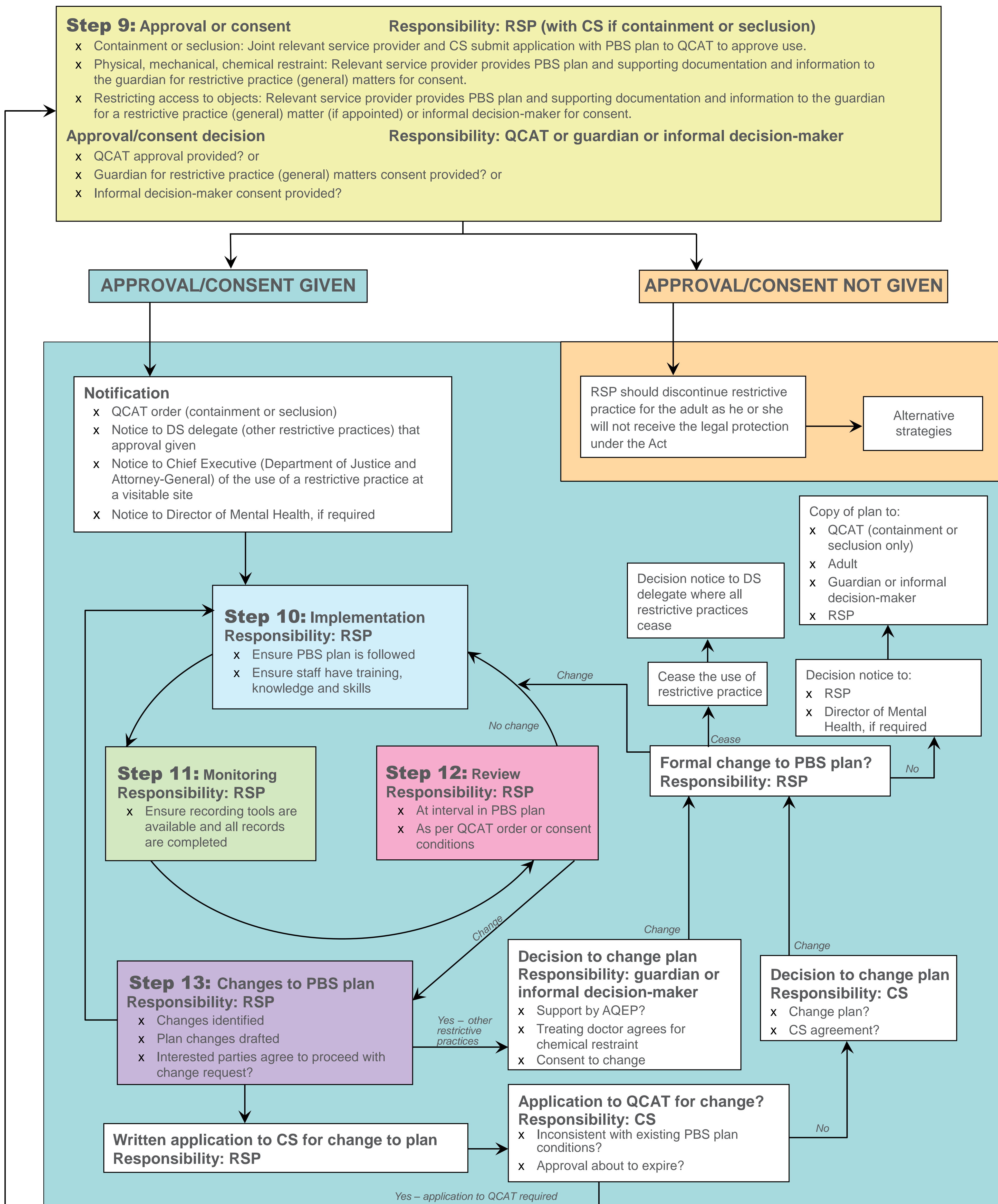
Note:
For physical restraint, mechanical restraint and chemical restraint, a guardian for a restrictive practice (general) matter should be appointed by QCAT as early in the assessment and PBS plan development process as possible. This allows the guardian to be involved throughout the assessment and planning steps, the outcomes from which the guardian will be considering for consent.

** **Note:** CS decision is only in relation to containment or seclusion.

† **Note:** This step is to allow for an early application to be made to QCAT for a possible hearing date.

Figure 3: Full legislative scheme requirements (general disability services)

Steps 9 to 13



Note: **AQEP** appropriately qualified or experienced person; **QCAT** Queensland Civil and Administrative Tribunal; **PBS** positive behaviour support; **RP** restrictive practice; **RSP** relevant service provider; **CS** Clinical Services; **DS** Department of Communities (Disability Services) (formerly Disability Services Queensland)

Note: the flowchart is not intended to be a comprehensive guide to the legislation, and if there is any inconsistency, the relevant legislation will prevail.

Restrictive practices requirements****

(Full legislative scheme post 1 July 2014)

Restrictive practice		Assessment	Plan	Approval / Consent	Plan implementation	Monitoring	Review
Containment or seclusion	General*	Multidisciplinary assessment (Clinical Services)	Positive behaviour support plan (Clinical Services)	Queensland Civil and Administrative Tribunal	Relevant service provider (support from Clinical Services)	Relevant service provider (support from Clinical Services)	Queensland Civil and Administrative Tribunal
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Short term approval**	—	—	Short term approval (public guardian)	Relevant service provider	Relevant service provider	—
Physical restraint or mechanical restraint	General*	Assessment (appropriately qualified or experienced person)	Positive behaviour support plan (relevant service provider)	Guardian for a restrictive practice (general) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (general) matter
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Relevant decision-maker (respite)	Relevant service provider	Relevant service provider	Relevant decision-maker (respite)
	Short term approval**	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—
Chemical restraint	General*	Assessment (appropriately qualified or experienced person)	Positive behaviour support plan (relevant service provider, with information from the treating doctor)	Guardian for a restrictive practice (general) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (general) matter
	Respite (fixed dose) only	—	—	Guardian for a restrictive practice (respite) matter – if appointed; or informal decision maker	***	***	***
	Community access services (fixed dose) only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider with information from the treating doctor)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Respite or community access service (PRN)	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider with information from the treating doctor)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Short term approval**	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—
Restricted access to objects	General*	Assessment (relevant service provider)	Positive behaviour support plan (relevant service provider)	Relevant decision-maker (general)	Relevant service provider	Relevant service provider	Relevant decision-maker (general)
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Relevant decision-maker (respite)	Relevant service provider	Relevant service provider	Relevant decision-maker (respite)
	Short term approval**	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—

* Where the adult in is receipt of a Disability Services funded accommodation support package and also has additional respite/community access services, the general rule applies.

** Short-term approvals are not available in all circumstances – please refer to the Operational Policy and Procedure Short-term approval for the use of restrictive practices in Disability Services (Full legislative scheme).

*** Plan implementation, monitoring and review not required for Chemical Restraint Respite (fixed dose) only.

**** This table is available by visiting http://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support/publications-and-resources

Image: Melpomenem/iStock/Thinkstock.

Preparing a positive behaviour support plan
— guidelines and model plan

0122_August 2014

Queensland Government

Introduction

The positive behaviour support plan is central to providing positive behaviour support to an individual adult by outlining:

- strategies that respond to the adult's needs and the causes of the challenging behaviour
- how the use of restrictive practices may be reduced or eliminated, and
- how the adult's quality of life may be improved.

The positive behaviour support plan is informed by an assessment of the adult and prepared by the disability service provider in consultation with the adult, their support network and stakeholders.

Disability service providers should ensure all clients with challenging behaviours have a positive behaviour support plan.

For clients who are supported by more than one service — and restrictive practices are used by each of those services — service providers must work together to develop and use the one plan.

A positive behaviour support plan must be developed before considering, or applying for approval or consent for, the use of restrictive practices.

Disability service providers are responsible for arranging assessments and preparing the positive behaviour support plan.

Following are guidelines and a model plan — which provides an example of how the plan may look. Please read the following before preparing a positive behaviour support plan for your client.

Guidelines

- Write the Positive Behaviour Support Plan (PBSP) in Arial font, size 11.
- Insert the page number in the lower right hand corner of each page. Use the format, Page 1 (not 'Page 1 of 20' or any other variation).
- Do not include the date or version number at the bottom of individual pages.
- Do include the date (which indicates the version number) in the authorisation signature block on the cover page.
- Use a blue font to highlight changes to a previous PBSP.
- All PBSPs must include and address the headings and sub-headings from the headings list (see pages iii-vi) that are relevant to the restrictive practices in use.
- The headings and sub-headings do not have to follow the same order as they appear in the following pages, but all material in the PBSP must fall within the listed headings and sub-headings relevant to the restrictive practices in use.
- If information is relevant to more than one heading or sub-heading, please refer the reader to the related, previous heading or sub-heading rather than duplicate the information.
- The exact wording of the headings and sub-headings in the list (in bold font) should be used unless otherwise indicated in the list (in italics).
- You may combine strategy headings when there is significant overlap but the same wording should still be used e.g. a strategies heading might read '*Strategies to be used by the service provider to meet the adult's needs and to support the development of skills*'.
- You may include community access arrangements as a sub-heading under the broader heading of '*Strategies to be used by the service provider to maximise opportunities through which the adult can improve their quality of life*'. Include details of the community access arrangements such as times, places, number of hours, etc.
- To avoid duplicating information, prepare the PBSP so sections of the plan can be photocopied and stand alone as instructions to be placed on office walls.
- Use attachments sparingly, if at all. Attachments are not for information that should be covered under the headings and sub-headings within the body of the PBSP. (Remember, the body of the PBSP must comply with the legislation in the absence of any attachments.)
- If attachments are required, clearly number the front page of each attachment and ensure the numbering is consistent with how the attachment is referenced within the body of the PBSP. Use the following format which uses the Arial font in size 20 and 12:

ATTACHMENTS

☐ ATTACHMENT 1: ______________________

☐ ATTACHMENT 2: ______________________

☐ ATTACHMENT 3: ______________________

Headings list

All PBSPs must include and address the following headings and sub-headings that are relevant to the restrictive practices in use.

Brief summary of the positive behaviour support plan
(No more than 3 pages and must include a summary of all strategies, community access and restrictive practices. Use terminology that is consistent with the wording of the headings used in the main body of the PBSP.)

Identifying information — person with a disability
(Name of person with a disability / gender / date of birth.)

Identifying information — plan author
(Name of plan author / contact details / qualification and registrations / position / training in positive behaviour support / training provider.)

Assessment information
(Type of assessment/s / assessor / date/s — one line per assessment as assessment detail is not required in the PBSP.)

Persons consulted and relationship to the adult
(E.g. adult, informal decision maker, guardian, administrator, family of adult, doctor/GP, service manager / house coordinator / direct support staff. If a forensic order is in place, the treating psychiatrist or senior practitioner must participate in development of the plan.)

Details of the person
(Detailing their likes, dislikes, hobbies, family, friends — name of heading of this section at author's discretion.)

Intervals at which the PBSP will be reviewed, including review of all strategies and all restrictive practices
(further sub-headings to be placed in this section at author's discretion about data gathering, observation tools, interim evaluations e.g. weekly / monthly, team meetings, stakeholder meetings, and any other sub-headings the author considers relevant.)

The strategies to be used by the service provider to meet the adult's needs

The strategies to be used by the service provider to support the adult's development of skills

The strategies to be used by the service provider to maximise opportunities through which the adult can improve their quality of life

The strategies to be used by the service provider to reduce the intensity, frequency and duration of the adult's behaviour that causes harm to the adult or others

The community access arrangements in place for the adult

The intensity, frequency and duration of the behaviour that has caused harm to the adult or others; the consequences of the behaviour; and the early warning signs and triggers for the behaviour, if known

Headings list (continued)

Containment

The positive strategies that must be attempted before using containment

The circumstances in which containment is to be used

A demonstration of why use of containment is the least restrictive way of ensuring the safety of the adult or others

The procedure for using containment, including observations and monitoring, that must happen while containment is being used

Any other measures that must happen while containment is being used that are necessary to ensure —

- **the adult's proper care and treatment; and**
- **the adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using the restrictive practice

Seclusion

The positive strategies that must be attempted before using seclusion

The circumstances in which seclusion is to be used

A demonstration of why use of seclusion is the least restrictive way of ensuring the safety of the adult or others

The procedure for using seclusion, including observations and monitoring, that must happen while the restrictive practice is being used

Any other measures that must happen while seclusion is being used that are necessary to ensure —

- **the adult's proper care and treatment; and**
- **the adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using seclusion

The maximum period for which seclusion may be used at any 1 time and the maximum frequency of the seclusion

Chemical restraint

The positive strategies that must be attempted before using chemical restraint

The name of the medication to be used and any available information about the medication, including, for example, information about possible side effects

The dose, route and frequency of administration, including, for medication to be administered as and when needed, the circumstances in which the medication may be administered, as prescribed by the adult's treating doctor

If the adult's medication has previously been reviewed by the adult's treating doctor — the date of the most recent medication review

The name of the adult's treating doctor

The circumstances in which the chemical restraint is to be used

A demonstration of why use of chemical restraint is the least restrictive way of ensuring the safety of the adult or others

The procedure for using chemical restraint, including observations and monitoring, that must happen while chemical restraint is being used

Any other measures that must happen while chemical restraint is being used that are necessary to ensure —

- **the adult's proper care and treatment; and**
- **the adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using chemical restraint

Mechanical restraint

The positive strategies that must be attempted before using a mechanical restraint

The maximum period for which the mechanical restraint may be used at any one time

The circumstances in which mechanical restraint is to be used

A demonstration of why use of mechanical restraint is the least restrictive way of ensuring the safety of the adult or others

The procedure for using mechanical restraint, including observations and monitoring, that must happen while the restrictive practice is being used

Any other measures that must happen while mechanical restraint is being used that are necessary to ensure —

- **The adult's proper care and treatment; and**
- **The adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using mechanical restraint

Headings list (continued)

Physical restraint

The positive strategies that must be attempted before using physical restraint

The maximum period for which the physical restraint may be used at any one time

The circumstances in which physical restraint is to be used

A demonstration of why use of physical restraint is the least restrictive way of ensuring the safety of the adult or others

The procedure for using physical restraint, including observations and monitoring, that must happen while physical restraint's being used

Any other measures that must happen while the restrictive practice is being used that are necessary to ensure —

- **the adult's proper care and treatment; and**
- **the adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using the restrictive practice

Restricted access to objects

The positive strategies that must be attempted before using restricted access to objects

The circumstances in which restricted access to objects is to be used

A demonstration of why use of the restrictive practice is the least restrictive way of ensuring the safety of the adult or others

The procedure for using restricted access to objects, including observations and monitoring, that must happen while the restricted access to objects is being used

Any other measures that must happen while restricted access to objects is being used that are necessary to ensure —

- **The adult's proper care and treatment; and**
- **The adult is safeguarded from abuse, neglect and exploitation**

A description of the anticipated positive and negative effects on the adult of using restricted access to objects

Model plan

POSITIVE BEHAVIOUR SUPPORT PLAN

for

TAYLOR GROVES

RELEVANT SERVICE PROVIDER/S AND RESTRICTIVE PRACTICE/S FOR WHICH APPROVAL IS SOUGHT BY EACH PROVIDER:

BestPrac Support Services

- Seclusion
- Chemical restraint
- Mechanical restraint

Additional service provider

- Additional restrictive practice 1
- Additional restrictive practice 2

AUTHORISATION
I, ______________________________, as authorised delegate of the Chief Executive for the power conferred under Section 158 of the *Disability Services Act 2006*, certify that this is a positive behaviour support plan (PBSP) that has been developed for______________________________. Signature: Name: Department of Communities, Child Safety and Disability Services Date:

Page 1

Adult's name here in CAPS, size 19 Arial font. The rest of the plan is in size 11 Arial font.

This model plan relates to one service provider to whom seclusion, chemical restraint and mechanical restraint is being used.

If more than one service provider is involved in development of a plan, list each service provider and the restrictive practice for which approval is sought by each provider. Delete this heading if not required.

The date referring to the version of the document should only be contained within the signature block.

Changes to a previous PBSP are to be highlighted in blue font

Model plan

It is preferable that the plan author can demonstrate specific training in positive behaviour support.

Identifying information – person with a disability		
Name of person with a disability	Taylor Groves	
Gender of person	☑ Male	☐ Female
Date of birth of person	20/07/1990	

Identifying information – plan author		
Name of plan author	Dee Yarrs	
Contact details	e: dee.yarrs@communities.qld.gov.au	p: 07 3333 3333
Qualifications and registrations	B.Psych.Sc Registered Psychologist, Australian Health Practitioner Regulation Agency	
Position	Behaviour Support Specialist	
Training in positive behaviour support	1. Functional Assessment and Positive Behaviour Intervention;	1. 2011
Training provider	1. Centre of Excellence for Clinical Innovation and Behaviour Support	
Intervals at which the PBSP will be reviewed, including review of all strategies and all restrictive practices	This plan is scheduled for review on the following dates Initial review one month from the date of this plan. Comprehensive reviews, at 3 months and 9 months from the date of this plan. Additional details of the ongoing evaluation of the strategies contained in this plan are contained in the "**Evaluation of the strategies to be implemented through this plan**"	

Each page is to be numbered using the format Page 1 not Page 1 of 20 or another variation. There should be no date or version number at the bottom of any individual page.

Persons consulted and relationship to the adult		
Adult	Taylor Groves	4 February 2014 12 March 2014
Family of Adult	Tim Groves (Brother) Jason Groves (Brother)	6, 21 February 2014 12, 19 March 2014
Guardian.	Peta Brown [Office of the Adult Guardian]	27 February, 2014
Neuropsychiatrist	Dr Sharon Kelp	17 January 2014 17 February 2014
Speech & Language Pathologist	Breanne Hats	28, 30 January 2014 13, 28 February 2014
Graduate Occupational Therapist	Melanie Day	17, 18, 19 February 2014
General Practitioner	Dr John Smythe	4 February 2014
Service Manager [BestPrac Support Services]	Felicity Camps	3 February 2014 12, 19 March
House Coordinator [BestPrac Support Services]	John Knox	3, 10, 17, 24 February 2014 6, 11, 18, 19 March 2014
Direct Support Staff [BestPrac Support Services]	Aaron Tims, Shane Dosk, Chris Spence, Angela Davis	5, 14, 20, 24 February 2014 12 March 2014

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E.g. adult, informal decision maker, guardian, administrator, family of adult, doctor/GP, service manager/ house coordinator/ direct support staff. **Note:** if a forensic order is in place, the psych or senior practitioner must participate in the development of the plan.

It is important that a medical review be undertaken to exclude medical factors contributing to Taylor's behaviour that causes harm to self or others.

A speech pathologist was consulted for this plan as Taylor's replacement behaviour is communication based, therefore making professional assessment integral for Taylor's success in achieving his learning goals.

Model plan

Detailing their likes, dislikes, hobbies, family, friends.

This information is important as it provides a more complete picture of Taylor than simply those matters relating to behaviour that causes harm to self or others. If the person has a person-centred plan it should be read in conjunction with this positive behaviour support plan.

Details of the adult
Taylor is an energetic and outdoor loving 23 year old. He is very proud of his back yard and once he gets to know a person, will invite them over to see his lawn and garden. Taylor has lived in supported accommodation since he was 21 years old. Taylor likes to get to know people before they come to his home. Taylor likes spending time with others that can keep up with him and like spending time outside. Taylor enjoys having a big glass of cold water with ice after his outside activities. Taylor lives with two other gentlemen who are significantly older than Taylor and who prefer to be inside rather than outside. Taylor does not seem to think being inside is much fun. Taylor's mother passed away when he was 21 and his father suffered a stroke shortly after the passing of his mother, at which time Taylor entered supported accommodation. Taylor has two older brothers [Tim and Jason] who take turns visiting Taylor once a month on a Saturday morning, sometimes taking Taylor [with staff support] to see his dad who is in a nursing home approximately two hours' drive away. It is uncertain if Taylor understands what has happened to his parents but he stopped signing for them after living in his home for a few months. Taylor looks forward to seeing his brothers each month and will spend extra time in the back yard to make sure it is very tidy for their visit. Taylor enjoys going out, some of his favourite places to visit is the local park which has a gym circuit, as well as basketball courts, soccer fields, the beach and bushwalking tracks. Taylor responds with support from his staff to members of the community with gestures, facial expressions and signs such as "good", "ok", "hello" and "bye". Taylor has relaxed body language and posture when out with small groups. Taylor is generally healthy, only experiencing minor colds once or twice a year. Taylor is not fussy when it comes to food and enjoys eating the healthy foods that staff prepare for him. Taylor also drinks plenty of water which further supports his health. As Taylor is constantly on the go, he has sufficient exercise daily to support his health and wellbeing. Taylor has damage to his frontal lobe that causes him to have short-term memory deficits.

Brief summary of this positive behaviour support plan

The following pages may be used as a check list for support staff
All staff to ensure they read, and are completely familiar with, the entire content of this positive behaviour support plan. Any questions should be immediately raised with Dee Yarrs.

Improving Taylor's quality of life will likely reduce his behaviour that causes harm to self or others. Specific strategies are in place to improve Taylor's quality of life. These include:

- Scheduling visits to Taylor's brother's houses and liaising with his brothers to organise times when they will come and visit him or take him out.
- A personal shopping program which is teaching Taylor to purchase small items from the local store, independently.
- Staff supporting Taylor to play soccer with the local club.
- Visiting the local park which has a gym circuit, as well as basketball courts, soccer fields, the beach and bushwalking tracks.
- Taylor particularly enjoys being outside in the sunshine.

It is important that Taylor has access to several of the following activities daily:

- Playing soccer, basketball, volleyball, catch and throw with a large ball, running on sand or grass with bare feet, push-ups and sit-ups, climbing ropes/playground equipment, caring for the lawn and garden, taking out the rubbish and car washing.

Communication:

- Taylor can use sign language.
- It is important that staff speak while they sign with Taylor, following his communication profile and 'All About Me' book.
- Remember to keep communication with Taylor short and clear, using speech whilst signing, maximum five word sentences.
- Taylor's short-term memory is supported well by regular speech and sign.

Taylor likes to know what is happening next:

- Taylor requires additional support around what is happening next, following
  - negative interactions with co tenants
  - if there have been changes to his schedule earlier in the day
  - if he is tired.
- It is important that prior to finishing one activity, Taylor is told what is happening next using speech and sign.
- Whilst Taylor is transitioning from one activity to the next, remind him what is happening next using speech and sign.
- Become familiar with Taylor's daily schedule to provide Taylor with stability in line with his schedule.
- Spend time using speech and signing with Taylor throughout the day about his daily schedule.

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This summary has been developed to provide a quick point of reference for direct support staff. All people, including direct support staff, must be familiar with the full positive behaviour support plan content, however the summary is here to guide staff if they are delayed in reading the full plan.

Try to keep this to 2 to 3 pages.

Model plan

Behaviour that causes harm to self or others was identified during the functional behaviour assessment.

Strategies here must [a] prompt to the replacement behaviour, and [b] manage the problem safely for all people in the area [Taylor, staff, other people in the vicinity].

Ensure organisational policy and procedures are followed here.

Behaviour that causes harm to self or others

The behaviour that causes harm to self or others that Taylor engages in are:

a. full body slam [running into walls and other solid objects, forcefully connecting with head, torso and limbs together] and hitting head on solid objects [walls]
b. hitting staff with his head [forward head-butt to staff head or shoulder area].

Due to these behaviours, Taylor wears protective headgear [mechanical restraint] during waking hours [maximum 18 hours at any one time]. Taylor is also prescribed Risperidone 3mg twice daily [chemical restraint] and as a last resort can be secluded (more information in the summary below). These restrictive practices are measures that are the least restrictive alternative for Taylor whilst he learns the replacement behaviour of signing "next" to staff so that they can tell him what is happening next in his day.

When Taylor is unsure of what is happening next he may show signs that indicate he is about to engage in the behaviour that causes harm to himself or others. These early behaviours are:

a. deep, low vocalisations [humming progresses to grunting] and pacing [3 fast steps back and forth]
b. runs towards staff, wide eyes and hands fisted at sides, stiff body.

If Taylor begins to engage in this behaviour immediately speak and sign to him what is happening next and encourage Taylor to use his 'next' sign.

If Taylor's behaviour escalates and he begins to use the behaviour that causes harm to self or others (full body slam and hitting head on staff):

1. ensure the safety of Taylor by speaking and signing what is happening next and that staff are there to help him, whilst moving any items on the floor out of Taylor's direct path
2. if Taylor continues to escalate, ensure the safety of all by telling other people in the room to leave immediately, keeping Taylor in your line of sight, position your back to the door and continue to speak and sign what is happening next and that staff are there to help him
3. if Taylor begins to attempt to hit staff with his head, commence seclusion by following the steps below:

   a. Redirect Taylor to the rear of the building and
      - lock the hallway limiting access to the front of the house while maintaining Taylor's access to the toilet and bathroom
      - Taylor is to be the only person in the rear of the building.

   b. If unable to redirect Taylor to the rear of the property:
      - all staff, co-tenants and others in the home are to proceed directly to the staff room and lock the door

   c. Staff are to ensure they remain in the closest position possible to the locked door, either the hall door or the staffroom door, and listening for cessation of banging sounds.

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d. After nil banging sounds can be heard by staff for a period of 60 seconds:

- Staff to speak to Taylor through the locked door, asking if he is OK;
- When Taylor responds with his “yes” sound, staff are to ask Taylor “can I come in”;
- When Taylor responds with his “yes” sound staff to unlock and slowly open the door, identifying where Taylor is in the room;
- Staff are to stand close to the door way with a relaxed posture and body language and provide verbal support to Taylor, asking again if he is OK and if he would like a drink of water;
- When Taylor responds with his “yes” sound, a nod or sign for “good” staff to let Taylor know they will get him a glass of water and do so;
- When staff return to Taylor, they are to let Taylor know that everything is OK, that they are there to help him;
- When Taylor is exhibiting no behaviour that causes harm to self or others, has a relaxed posture and body language offer to help Taylor.
- Check his headgear to make sure it is securely fitted and not pinching any skin or pulling any hair.

Maximum duration / frequency of seclusion

- 15 minutes at any one time; or

Maximum frequency:

- Not more than twice per day or 60 times per month.

Reporting:

- Each use of seclusion is reported as soon as practical [verbally within 3 hours, formally within 24 hours] to the House Coordinator or On-call Coordinator;
- Record all use of seclusion on Taylor’s Restrictive Practice Reporting Form; and
- Complete a Behaviour Incident Report Form.

Debrief

Following the use of behaviour that causes harm to self or others, Taylor is often disorientated and may not remember why he is on the floor, against a wall or secluded. It is very important that staff let Taylor know they are there to help him.

- Ask Taylor if he is okay using speech and sign;
- Offer Taylor a drink of water.

When Taylor is de-escalated [relaxed posture and body language], let him know that when he is unsure of what is happening next, he can use his “next” sign to let staff know he needs help and they can help him. Staff to model using the “next” sign and invite Taylor to practice using his “next” sign with them.

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It is vital that Taylor be supported following use of behaviour that causes harm to self or others in a manner that will not trigger further behaviour. Debriefing should involve gentle reminders to Taylor to use the skills he has been learning to get what he wants or needs and that staff are there to help him whenever he is uncertain of what is happening next.

Model plan

A functional behaviour assessment identifies the purpose of a person's behaviour that causes harm to self or others. The positive behaviour support plan, can then target this purpose, ensuring the person can meet their needs without using behaviour that causes harm to self or others. There are multiple tools that may be used to conduct a functional behaviour assessment. In Taylor's case, Dee Yarrs (the plan author) selected the contextual assessment inventory, functional assessment interview, scatterplots and ABC note cards plus semi-structured interviews.

All behaviour serves a purpose, this is called a 'function'. The function will either be to access or avoid people, activities or sensations.

Detail of positive behaviour support

Assessment information

The following assessments were carried out to inform the development of this positive behaviour support plan:

Type of Assessment	Assessor	Date of Report
Comprehensive Health Assessment Program (CHAP)	Dr John Smythe	4/2/14
A Functional Behaviour Assessment	Dee Yarrs	30/3/14
Communication assessment	Breanne Hats	5/3/14
Mental health assessment	Dr Sharon Kelp	17/2/14
Occupational therapy assessment	Melanie Day	19/2/14

These reports of these assessments are kept in Taylor's file at the house. The overall assessment report for Taylor was written by Dee Yarrs and is also kept in Taylor's file.

Behaviours that cause harm to self or others

Taylor's behaviour that causes harm to self or others was identified through the Functional Behaviour Assessment as:

a. Full body slam [running into walls and other solid objects, forcefully connecting with head, torso and limbs together] and hitting head on solid objects [walls];
This behaviour also leads to the next behaviour that causes harm to self or others.
b. Hitting staff with head [forward head-butt to staff head or shoulder area].

It was identified that the following behaviours lead up to Taylor's behaviours that cause harm to self or others:

a. Deep, low vocalisations [humming progresses to grunting] and pacing [3 fast steps back and forth];
b. Runs towards staff, wide eyes and hands fisted at sides, stiff body.

The strategies to be used by the service provider to meet the adult's needs

The Functional Behaviour Assessment identified one function of Taylor's behaviour that causes harm to self or others:

1. Hitting head and full body slam into solid objects [behaviour to access staff support]
2. Hitting staff with head [behaviour to access staff support]

Taylor will make a deep humming/grunting noise and pace when he is unsure of what is happening next. Taylor does this to access staff support [the provision of information]. If staff do not respond to Taylor's deep humming/grunting and pacing within two minutes and provide information on what is happening next, Taylor's behaviour that causes harm to self or others will escalate and he will run towards and full body slam the closest large solid object and commence hitting head on that object. If staff do not respond to Taylor hitting his head and full body slam into solid objects within 30 seconds and provide information on what is happening next, Taylor will run towards staff, eyes wide, hands fisted at sides, stiff body and will hit staff in the head or shoulder area with his own head. This behaviour is more likely to occur if Taylor has had negative interaction with his co-tenant/s, and/or there are changes to his schedule earlier in the day, and/or he is tired.

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A functional behaviour assessment was conducted which identified one functional hypothesis which was very clear, therefore there was no need to test this hypothesis by conducting a functional analysis as part of the functional behaviour assessment. This hypothesis will be tested in practice and reviewed at the 3 month plan review.

The context/sequence of Taylor's behaviour is best understood in this format:

Setting event		Antecedent		Behaviour		Consequence
When Taylor has had; Negative interaction with co-tenant/s earlier in day *And/or* Schedule changes earlier in day *And/or Taylor is* Tired	⇨	*And he is;* Unsure of what is happening next	⇨	*He may;* start humming and then grunting and pacing, Run towards staff, eyes wide, hands fisted, stiff body *Before he;* Full body slams and hits his head on a solid object *or;* Hits staff with his head in their head or shoulder	⇨	*When he does this he gets to;* Access staff support

Function of behaviour: access staff support

Setting event [i.e. long-term triggers] strategies:

Taylor is more likely to respond using behaviour that causes harm to self or others when he is unsure of what is happening next, following negative interactions with co-tenant/s and or schedule changes earlier in the day and or is tired. Strategies that proactively support Taylor in these situations may reduce the likelihood of his use of behaviour that causes harm to self or others.

- Following negative interactions with co-tenants, staff are to ensure Taylor receives extra information [speech and sign] and additional reminders about activities for the day [once de-escalated and open to communication];
- Staff are to be well versed in Taylor's daily schedule and ensure they provide stability in line with this schedule;
  - Staff are to confirm well in advance that Taylor is able to engage in his daily activities as listed on his daily schedule, if staff identify any potential changes they are to have alternatives available for Taylor to choose from and communicate such to any staff coming on shift;
- Taylor would benefit from further investigation and possible clinical review into causes for any sleep disturbances when presenting as tired for more than two days in a row.
- Include all staff considerations and preparation of other options as topics for discussion, information sharing and updating at each staff meeting. To be signed off by the House Coordinator.

Antecedent [i.e. short-term triggers] strategies:

It has been identified that Taylor will engage in behaviour that causes harm to self or others if he is unsure what is happening next. Strategies that proactively support Taylor in these situations will reduce his need to use behaviour that causes harm to self or others.

- Taylor benefits from clear, concise and frequent communication [speech and sign] on what is happening next:
  - Staff are to ensure that prior [5 minutes] to completing a current activity with Taylor, they let Taylor know [speech and sign] what is happening next in his day;
  - Staff are to ensure that Taylor has opportunity to have some level of choice in relation to his next activity;
  - Staff are to continue to provide information to Taylor on what is happening next [speech and sign] whilst he transitions from one activity to another;
- Staff are to use speech and sign with Taylor about his daily schedule throughout the day;
  - Upon waking, immediately after breakfast and morning tea, half hour before and after lunch and afternoon tea, then hourly until dinner, half hour after dinner then hourly until Taylor chooses to prepare for bed.

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The setting event / ABC format shows the order of what happens as it happens in the setting. This is also useful later when addressing strategies.

Setting event is the long-term trigger.

Antecedent is the short-term trigger.

Behaviour includes precursor and challenging.

Consequence is the outcome the individual wants by using the behaviour that causes harm to self or others i.e. the function.

Antecedent interventions address the short-term triggers [Antecedents] that immediately trigger behaviour that causes harm to self or others.

A good plan informs us when, where and under what conditions you could predict the behaviour that causes harm to self or others to occur.

Model plan

These are the new skills we want to teach Taylor that will make his behaviour that causes harm to self or others inefficient, and give him an alternative to such behaviour.

Positive behaviour support plans [PBSP] should contain details of a behaviour that can replace the behaviour that causes harm to self or others. All replacement behaviour must serve the same function as the behaviour that causes harm to self or others. This plan describes a positive alternative that achieves the same result as the behaviour that causes harm to self or others. The replacement behaviour listed here is as easy, or easier to use, than the behaviour that causes harm to self or others.

These replacement behaviours to be taught to Taylor are the skills that he can use to get access to staff support. These are usually referred to as 'functionally equivalent replacement behaviours'.

The strategies to be used by the service provider to support the adult's development of skills

Teaching strategies

Replacement behaviour

Replace full body slam and hitting head behaviours with using a 'next' sign

- Staff are to teach Taylor to use the sign for "next" when he is unsure of what is happening next *[see Attachment 1]*;
- It is important that staff speak while they sign with Taylor, following his communication profile and "All About Me" book;
- Remember to keep communication with Taylor short and clear, using speech whilst signing, maximum five word sentences;
- Taylor's short-term memory is supported well by regular speech and sign.

Taylor has used sign language in the past, staff are to recommence using signs uniformly across all areas of Taylors life, speaking whilst signing:

Teaching Taylor the replacement behaviour

Taylor's support staff will provide teaching sessions where Taylor is given the opportunity to learn and practice his new skill [using "next" sign];

- After breakfast each day, staff are to discuss [speech and sign] the new skill with Taylor, reminding him they will practice during the day;
- Staff will also run through with Taylor what will be happening just prior to each teaching session, and check that he is okay to begin each training session [speech and sign];
- Teaching sessions are to take place after preferred activity, when Taylor is in a positive mood [smiling, relaxed posture, nil escalation for at least one hour before];
- Teaching sessions are to take place at least three times a day for three minutes;
- These sessions will begin on 15th May 2014 in Taylor's home where he will be prompted [speech and sign] to use his "next" sign at the end of each activity;
- Taylor's progress will be recorded on the Task Record Sheet.

Reinforcement of replacement behaviour

Every time Taylor uses the "next" sign, staff will immediately praise him for letting them know he needs help using speech and sign, and wants to know what is happening next. Staff to then immediately provide information using speech and sign - and wherever possible choices - on what is happening next to Taylor. Staff are to check if Taylor understands, using speech and sign, what is happening next.

Staff training

Training will be given to staff on 7th May 2014 by Dee Yarrs. Training will include:

- how staff can be best supported to implement this skills teaching [replacement behaviour]
- opportunities for staff to practice delivering the program
- feedback and performance feedback to staff by Dee Yarrs
- an opportunity for staff to provide feedback to Dee Yarrs regarding any likely issues in teaching Taylor this skill.

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By responding this way, staff will ensure Taylor has his needs met without using behaviour that causes harm to self or others. This is critical to Taylor, to promote his use of the replacement behaviour in the future.

Goals and objectives for teaching the replacement behaviour]

By when?	Who?	Instead of what?	Function?	Will do	Function?	Conditions	How well?	Measurement
Within 3 months of plan implementation and teaching Taylor the new skill	Taylor	Vocalising, pacing, full body slam and hitting head - large solid objects and staff	To access information on what is happening next	Use the "next" sign with staff	To access information on what is happening next	As per all instruction pages 10,12,13,14	Taylor will use his new skill with 100% independence, on every occasion, when he wants to know what is happening next	As per below instruction and on following pages 12,13,14

Goal
By 15th August 2014 when Taylor is unsure of what is happening next; Taylor will use the sign for 'next' with staff. Taylor will use this replacement behaviour instead of full body slams and hitting head on large solid objects and staff.

Details
Taylor's Support Staff will indicate on the Task Record Sheet provided]; dates of teaching sessions, their initials and whether Taylor used the "next" sign when provided with varying levels of prompts. Taylor's success to be marked with a [✓] or a [✗] if not successful [i.e. required more prompting than the current level stated]. Support Staff are to fade their prompt levels when Taylor is successful [✓] three sessions in a row.

Generalisation:
- When Taylor is independently using this replacement behaviour in his home, the teaching and prompting process is to be replicated with Taylor in the community;
  - Dee Yarrs, with input from the entire support team, will develop further teaching sessions for Taylor in the community.
- Staff are to record when these new skills occur outside of the teaching sessions and whether Taylor used his skill, needed prompting, or used behaviour that caused harm to self or others. If behaviour that causes harm to self or others has occurred, support staff will also need to follow the Incident Reporting procedure.

Maintenance [refresher sessions]:
- Staff to provide maintenance teaching sessions. If Taylor is successfully using his new skill outside of teaching sessions then give a maintenance session once every six weeks. If Taylor is not using his new skill outside of teaching sessions, the teaching sessions need to be reviewed and Support staff need to contact the behaviour support team. Dee Yarrs will provide guidance to staff on these sessions.

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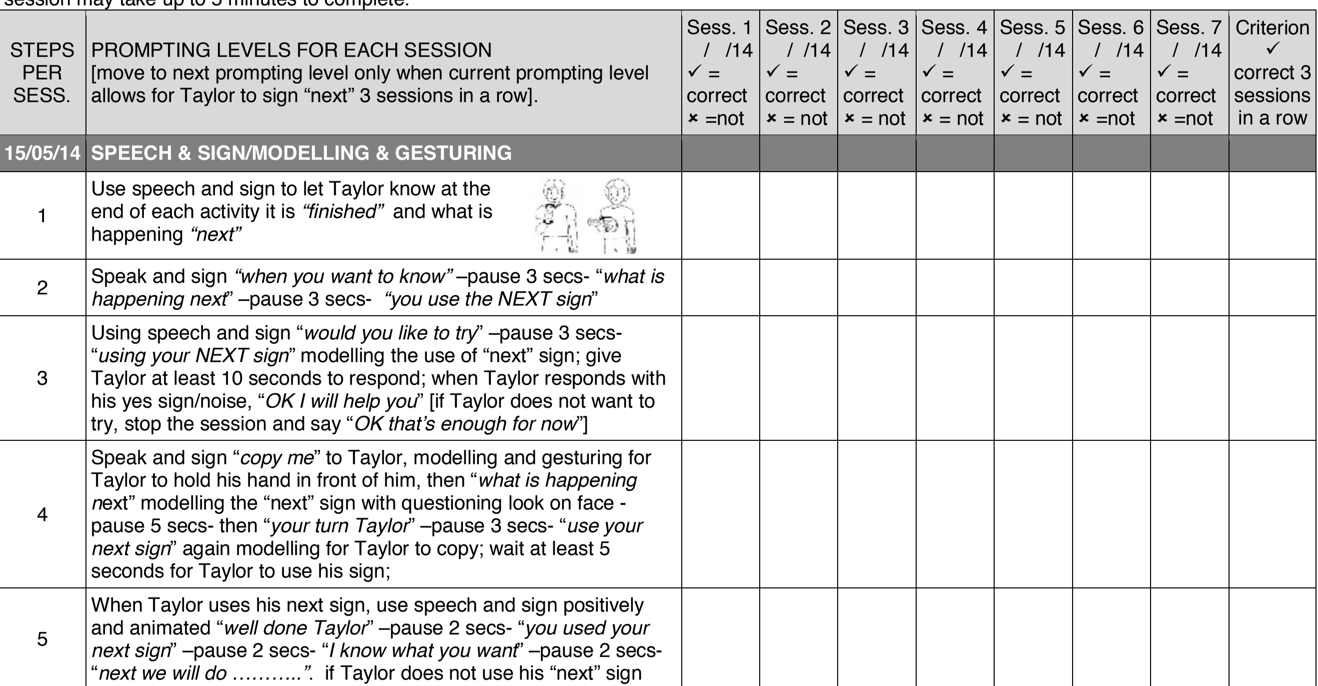
This training not only gives Taylor the opportunity to practice his new skill, across a new setting, but aides generalisation of his new skill to situations outside of the teaching sessions.

A considered approach to teaching Taylor the new skill is outlined here, with enough detail so all team members know what to do. The teaching strategy must carefully match Taylor's learning style and ability. Refer to the notes regarding Taylor's communication skills.

Reinforcement strategies are listed to support Taylor to learn the new skill. This plan specifies: when the reinforcer is given; under what conditions; how often; and how promptly it is provided. All of these details are important to ensuring reinforcer effectiveness and best practice to support Taylor to learn his new skill.

Note that the goal is not listed as the reduction or elimination of behaviour that causes harm to self or others. This will occur if Taylor learns the new replacement behaviour for his behaviour that causes harm to self or others. Similarly, if Taylor does not learn the replacement behaviour it is reasonable to expect that the behaviour that causes harm to self or others will continue. The focus then is on measuring specific skill development.



Task Record Sheet

Teaching Taylor to use his "next" sign with staff

At the beginning of each day, staff are to discuss using speech and sign the new skill with Taylor, reminding him they will practice during the day. Staff will also run through what will be happening just prior to each teaching session, and check with Taylor that he is okay to begin each training session. It is important that staff create a signing environment for Taylor by consistently communicating using speech and sign to Taylor. Each session may take up to 5 minutes to complete.

STEPS PER SESS.	PROMPTING LEVELS FOR EACH SESSION [move to next prompting level only when current prompting level allows for Taylor to sign "next" 3 sessions in a row].	Sess. 1 / /14 ✓ = correct × =not	Sess. 2 / /14 ✓ = correct × = not	Sess. 3 / /14 ✓ = correct × = not	Sess. 4 / /14 ✓ = correct × = not	Sess. 5 / /14 ✓ = correct × = not	Sess. 6 / /14 ✓ = correct × =not	Sess. 7 / /14 ✓ = correct × =not	Criterion ✓ correct 3 sessions in a row
15/05/14	**SPEECH & SIGN/MODELLING & GESTURING**								
1	Use speech and sign to let Taylor know at the end of each activity it is *"finished"* and what is happening *"next"*								
2	Speak and sign *"when you want to know"* –pause 3 secs- "*what is happening next*" –pause 3 secs- *"you use the NEXT sign*"								
3	Using speech and sign "*would you like to try*" –pause 3 secs- "*using your NEXT sign*" modelling the use of "next" sign; give Taylor at least 10 seconds to respond; when Taylor responds with his yes sign/noise, "*OK I will help you*" [if Taylor does not want to try, stop the session and say "*OK that's enough for now*"]								
4	Speak and sign "*copy me*" to Taylor, modelling and gesturing for Taylor to hold his hand in front of him, then "*what is happening next*" modelling the "next" sign with questioning look on face - pause 5 secs- then "*your turn Taylor*" –pause 3 secs- "*use your next sign*" again modelling for Taylor to copy; wait at least 5 seconds for Taylor to use his sign;								
5	When Taylor uses his next sign, use speech and sign positively and animated "*well done Taylor*" –pause 2 secs- "*you used your next sign*" –pause 2 secs- "*I know what you want*" –pause 2 secs- "*next we will do ………..*". if Taylor does not use his "next" sign								

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STEPS PER SESS.	PROMPTING LEVELS FOR EACH SESSION [move to next prompting level only when current prompting level allows for Taylor to sign "next" 3 sessions in a row].	Sess. 1 / /14 ✓ = correct × =not	Sess. 2 / /14 ✓ = correct × = not	Sess. 3 / /14 ✓ = correct × = not	Sess. 4 / /14 ✓ = correct × = not	Sess. 5 / /14 ✓ = correct × = not	Sess. 6 / /14 ✓ = correct × =not	Sess. 7 / /14 ✓ = correct × =not	Criterion ✓ correct 3 sessions in a row
	when prompted, go back to step 2.								
5/06/14	**SPEECH & SIGN/ GESTURE**								
1	Use speech and sign to let Taylor know at the end of each activity it is *"finished"* and what is happening *"next"*								
2	Using speech and sign *"when you want to know"* –pause 3 secs- "*what is happening next*" –pause 3 secs- *"you use the NEXT sign*"								
3	Using speech and sign "*would you like to try*" –pause 3 secs- "*using your NEXT sign*"; give Taylor at least 10 seconds to respond; when Taylor responds with his yes sign/noise, "*OK I will help you*" [if Taylor does not want to try stop the session and say "*OK that's enough for now*"]								
4	Gesture to Taylor to hold his hand in front of him, speak and sign "*what is happening n*ext" with questioning look on face -pause 5 secs- then "*your turn Taylor*" –pause 3 secs- "*use your next sign*"; wait at least 5 seconds for Taylor to use his sign, gesturing that he uses his hand in front of him to sign;								
5	When Taylor uses his next sign, use speech and sign positively and animated "*well done Taylor*" –pause 2 secs- "*you used your next sign*" –pause 2 secs- "*I know what you want*" –pause 2 secs- "*next we will do ………..*". if Taylor does not use his "next" sign when prompted, go back to step 2.								
26/6/14	**SPEECH & SIGN**								
1	Use speech and sign to let Taylor know at the end of each activity it is *"finished"*								
2	Use speech and sign *"do you want to know"* –pause 3 secs- "*what is happening next*" wait for Taylor to respond with his yes								

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STEPS PER SESS.	PROMPTING LEVELS FOR EACH SESSION [move to next prompting level only when current prompting level allows for Taylor to sign "next" 3 sessions in a row].	Sess. 1 / /14 ✓ = correct × =not	Sess. 2 / /14 ✓ = correct × = not	Sess. 3 / /14 ✓ = correct × = not	Sess. 4 / /14 ✓ = correct × = not	Sess. 5 / /14 ✓ = correct × = not	Sess. 6 / /14 ✓ = correct × =not	Sess. 7 / /14 ✓ = correct × =not	Criterion ✓ correct 3 sessions in a row
	sign/noise; [if Taylor does not want to try, stop the session and say "*OK that's enough for now*"]								
3	Using speech and sign *"let's practice our NEXT sign*" –pause 3 secs- "*what is happening next?*" with questioning look on face - pause 5 secs- then "*your turn Taylor*"								
4	When Taylor uses his next sign, use speech and sign positively and animated "*well done Taylor*" –pause 2 secs- "*you used your next sign*" –pause 2 secs- "*next we will do ………..*".								
26/7/14	**INDEPENDENCE**								
1	Use speech and sign to let Taylor know at the end of each activity it is *"finished"*								
2	Wait for Taylor to use his "next" sign								
3	When Taylor uses his next sign, use speech and sign positively and animated "*well done Taylor*" –pause 2 secs- - "*next we will do ……..*".								

Once Taylor is independently asking what is happening next using his sign, 3 sessions is a row, repeat the above sessions but with Taylor approaching staff without "finish" prompt from staff to find out what is happening next. Dee Yarrs will meet with Taylor's support team to discuss and then create the next Task Record Sheet for this level of independence

Communication amongst team members
1. The House Coordinator will prepare weekly cumulative graphs on Taylor's progress in learning the replacement behaviour within his home. The graphs will summarise data contained in the Task Record Sheets. 2. The graphs will be emailed to Taylor's family [Tim and Jason], the Service Manager, Dee Yarrs and Dr Kelp at least monthly. Recipients of this information will report back to each other via email. The graphs will also be presented at monthly team meetings to Support Staff. 3. Where indicated, Dee Yarrs will modify aspects of the teaching program, based on both the analysed data and observations of Taylor's Support Staff.

The strategies to be used by the service provider to maximise opportunities through which the adult can improve their quality of life

The primary means of improving Taylor's quality of life will be via the successful application of this plan's strategies and teaching the replacement behaviour. This will see a reduction in the use of behaviour that causes harm to self or others which will not only increase lifestyle and community engagement opportunities, but reduce the need for Taylor to be subject to restrictive practices. This work is at the core of this plan.

Other supports to improve Taylor's quality of life include:

1. Scheduling visits to Taylor's brother's houses and liaising with his brothers to organise times when they will come and visit him or take him out;
2. A personal shopping program which is teaching Taylor to purchase small items from the local store, independently;
3. Staff supporting Taylor to be involved with the local soccer club;
4. Visiting the local park which has a gym circuit, as well as basketball courts, soccer fields, the beach and bushwalking tracks.
5. Ensuring that Taylor has access to several of the following activities **daily**:
   Playing ball games, catch and throw with a large ball, running on sand or grass with bare feet, push-ups and sit-ups, climbing ropes/playground equipment, caring for the lawn and garden, taking out the rubbish and car washing.

The community access arrangements in place for the adult

Visiting the local park which has a gym circuit, as well as basketball courts, soccer fields, the beach and bushwalking tracks. **Taylor is to attend at least one of these outings of his choice every second day, for a minimum of two hours.**

Taylor is supported by staff to attend to household tasks in the community such as going shopping on a **weekly basis**.

Meeting new staff in a park or sports field. This occurs once per month on average, depending on the staff turnover at Taylor's home.

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Progress monitoring. This plan describes in detail the manner in which Taylor will learn the new replacement behaviour. For Taylor's supports to effectively monitor progress of this goal, a reciprocal communication approach must be adopted. Continuous two-way communication on goal progress is necessary to ensure that all stakeholders have input and remain actively involved.

Community access arrangements may be subsumed at the author's discretion as a sub-heading under the broader heading 'Strategies to be used by the service provider to maximise opportunities through which the adult can improve their quality of life'. Community access arrangements must be detailed; times, places, number of hours etc.

Model plan

The strategies to be used by the service provider to reduce the intensity, frequency and duration of the adult's behaviour that causes harm to the adult or others
The intensity, frequency and duration of Taylor's behaviour that causes harm to self or others will be reduced by both the application of this plan's strategies, including the teaching of the replacement behaviour. The effective implementation of the strategies will mean that it is less likely that Taylor will feel the need to use behaviour that causes harm to self or others. The effective teaching of the replacement behaviour will mean that Taylor can meet his needs without needing to resort to the behaviour that causes harm to self or others.

The intensity, frequency and duration of the behaviour; that has caused harm to the adult or others; the consequences of the behaviour; and the early warning signs and triggers for the behaviour, if known
The intensity of Taylor's behaviour is considered extreme. Taylors' hitting head behaviour to solid objects and or staff is of such intensity that he has suffered diffuse Traumatic Brain Injury [TBI] resulting in communication and cognitive impairment. The frequency of Taylor's hitting head behaviour is up to five times per day, seven days a week with duration of between five and ten seconds at a time. Taylor engages in the following behaviours before escalating to the behaviours that cause harm to self or others, these are the early warning signs; • Deep, low vocalisations [humming progresses to grunting] and pacing [3 fast steps back and forth]; • Runs towards staff, wide eyes and hands fisted at sides, stiff body. Setting Events and Triggers • Taylor experiencing negative interaction with co-tenant/s earlier in day; • If Taylor has had schedule changes earlier in day; • When Taylor is tired. • And, the short term trigger of Taylor unsure of what is happening next

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Seclusion:
The positive strategies that must be attempted before using seclusion
The continued use and need for the use of seclusion will be impacted directly by the application of strategies listed in this plan. It is anticipated that once Taylor is able to independently use the replacement behaviour (ie sign 'next') that reduction in seclusion will be clinically indicated. In the interim; 1. When Taylor is unsure of what is happening next he may show signs that indicate that he is about to engage in the behaviours that cause harm to himself or others. These early behaviours are; a. Deep, low vocalisations [humming progresses to grunting] and pacing [3 fast steps back and forth]; b. Runs towards staff, wide eyes and hands fisted at sides, stiff body; If Taylor begins to engage in this behaviour immediately use speech and sign to him what is happening next and encourage Taylor to use his "next" sign; 2. If Taylor's behaviour escalates and he begins to use the behaviours that cause harm to self or others (Full body slam and hitting head on staff) • Ensure the safety of Taylor by using speech and signing what is happening next and that staff are there to help him, whilst moving any items on the floor out of Taylor's direct path; • If Taylor continues to escalate, ensure the safety of all by telling other people in the room to leave immediately, keeping Taylor in your line of sight, position your back to the door and continue to use speech and sign what is happening next and that staff are there to help him;
The circumstances in which seclusion is to be used
Seclusion is only to be used when the safety of staff or others is at risk due to Taylor attempting to hit them with his head. 1. Taylor is only to be secluded within his own residential property, by removing all other persons from his space and restricting his free exit from the rear section of the building or 2. Preventing access to staff, co-tenants and others locked in the staff room.
A demonstration of why use of seclusion is the least restrictive way of ensuring the safety of the adult or others
The episodic use of seclusion will be used to reduce harm to staff from Taylor. The ongoing use of seclusion will not improve Taylor's quality of life or assist in the reduction of the overall impact of his behaviour that causes harm to self or others. However, its episodic use is necessary to prevent harm to staff while they implement the strategies in this plan and Taylor is learning the skill of signing "next" to ask staff what is happening next. The use of seclusion is the least restrictive alternative for Taylor at present whilst he learns his replacement behaviour.

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Model plan

The procedure for using seclusion, including observations and monitoring, that must happen while the restrictive practice is being used
The primary mechanism for ensuring the ongoing safety of Taylor and others is via the application of the positive strategies listed in this plan. If Taylor begins to attempt to hit staff or others with his head (forward head-butt to staff head or shoulder area) seclusion following the steps below; 1. Redirect Taylor to the rear of the building; a. Lock the hallway door maintaining Taylor's access to the toilet and bathroom, but limiting access to the front of the house b. Taylor is to be the only person in the rear of the building; 2. If unable to redirect Taylor to the rear of the property: a. all staff, co-tenants and others in the home are to proceed directly to the staff room and lock the door; 3. Staff are to ensure they remain in the closest position possible to the locked door, either the hall door or the staffroom door, and listening for cessation of banging sounds. 4. After nil banging sounds can be heard by staff for a period of 60 seconds: a. Staff to speak to Taylor through the locked door, asking if he is OK; b. When Taylor responds with his "yes" sound, staff are to ask Taylor "can I come in"; c. When Taylor responds with his "yes" sound staff to unlock and slowly open the door, identifying where Taylor is in the room; d. Staff are to stand close to the door way with a relaxed posture and body language and provide verbal support to Taylor, asking again if he is OK and if he would like a drink of water; e. When Taylor responds with his "yes" sound, a nod or sign for "good" staff to let Taylor know they will get him a glass of water and do so; f. When staff return to Taylor, they are to let Taylor know that everything is OK, that they are there to help him; g. When Taylor is exhibiting nil precursor or behaviour that causes harm to self or others, has a relaxed posture and body language offer to help Taylor. Check his headgear to make sure it is securely fitted and not pinching any skin or pulling any hair. Reporting: • Each use of seclusion is reported as soon as practical [verbally within 3 hours, formally within 24 hours] to the House Coordinator or On-call Coordinator. • Record all use of seclusion on Taylor's Restrictive Practice Reporting Form; and • Complete a Behaviour Incident Report Form.

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Any other measures that must happen while seclusion is being used that are necessary to ensure - The adult's proper care and treatment; and - The adult is safeguarded from abuse, neglect and exploitation
Taylor will be safeguarded from abuse, neglect and exploitation by accurate and efficient monitoring and evaluation, followed by rigorous and timely information sharing and feedback. The use of seclusion will be monitored and evaluated as follows: • Reported per use by Support Staff; weekly monitoring and monthly evaluation by the House Coordinator; monthly information provision to family [Tim and Jason], his Neuropsychiatrist, the Service Manager and the Behaviour Support Specialist by the House Coordinator.
A description of the anticipated positive and negative effects on the adult of using seclusion
The episodic use of seclusion is being used to prevent harm being caused by Taylor to others. The ongoing use of seclusion will not improve Taylor's quality of life or assist in the reduction of the overall impact of his behaviour that causes harm to self or others. The use of seclusion can increase a person's feelings of isolation and frustration.
The maximum period for which seclusion may be used at any 1 time and the maximum frequency of the seclusion
Taylor usually settles within 10 minutes of any incident of behaviour that causes harm to self or others. Seclusion may be used for a maximum of 15 minutes at the discretion of support staff. Seclusion will not occur more than twice per day, or 60 times per month.

Chemical restraint
The positive strategies that must be attempted before using chemical restraint
Taylor is prescribed fixed dose Risperidone. As a fixed dose, no strategies are attempted prior to each episode of administration. The continued use and need for the medication will be impacted directly by the application of strategies listed in this plan. It is anticipated that once Taylor is able to independently use the replacement behaviour (ie sign 'next') that reduction in chemical restraint will be clinically indicated.
The name of the medication to be used and any available information about the medication, including, for example, information about possible side effects
Risperidone Side effects staff must vigilantly observe for: • unsteadiness on feet when rising from sitting/lying • body temperature changes such as fever • rash, itching or hives on the skin • shortness of breath • swelling of the face, lips or tongue.

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The dose, route and frequency of administration, including, for medication to be administered as and when needed, the circumstances in which the medication may be administered, as prescribed by the adults treating doctor
3mg morning orally 3mg evening orally
If the adult's medication has previously been reviewed by the adult's treating doctor – the date of the most recent medication review
15 March 2014
The name of the adult's treating doctor
Dr Kelp, Neuropsychiatrist Dr Smythe, General Practitioner
The circumstances in which the chemical restraint is to be used
Taylor is prescribed fixed dose Risperidone 6mg [3mg b.d.] by his Neuropsychiatrist Dr Kelp. Taylors Risperidone aids in reducing the intensity of serious incidents, whilst the proactive measures in this plan are being implemented.
A demonstration of why use of chemical restraint is the least restrictive way of ensuring the safety of the adult or others
The routine use of Risperidone is being undertaken to reduce the intensity of Taylor's incidents of behaviour that causes harm to self or others, during the implementation of the behavioural strategies listed in this plan. By reducing the intensity of Taylor's behaviour it also aids in avoiding the use of highly intrusive forms of restriction such as physical restraint. In combination with the strategies outlined in this plan, the use of chemical restraint Risperidone is the least restrictive alternative to support Taylor.
The procedure for using chemical restraint, including observations and monitoring, that must happen while chemical restraint is being used
The Risperidone is pre-packed by the pharmacist in a Webster Pack and is checked and signed for by staff when collected. The administration of Risperidone is immediately recorded on Taylor's medication chart, signed by staff member administering and countersigned by next staff member on shift [confirming medication has been removed from the Webster Pack]. Any issues arising regarding side effects or missed medication will necessitate the following immediate actions: • Contact the General Practitioner; or o Poisons Information Centre 13 11 26; then • Contact the House Coordinator or On-call Coordinator; then • Complete and fax an Error in Medication form to the Service Manager.

Any other measures that must happen while chemical restraint is being used that are necessary to ensure – the adult's proper care and treatment; and – the adult is safeguarded from abuse, neglect and exploitation
Taylor will be safeguarded from abuse, neglect and exploitation by accurate and efficient monitoring and evaluation, followed by rigorous and timely information sharing and feedback. Taylor's medication will be monitored and evaluated as follows: • Daily monitoring by Support Staff; monthly monitoring by Dr Smythe; quarterly evaluation by Dr Kelp; quarterly information provision to family [Tim and Jason], Service Manager and Dee Yarrs by the House Coordinator. Taylor is monitored closely for any side effects by his support staff and is provided with a nutritious and varied diet and drinks plenty of water. No other medications are introduced to Taylor without prior approval from his Neuropsychiatrist Dr Kelp and General Practitioner Dr Smythe. Taylor has monthly general health checks with his General Practitioner Dr Smythe as additional monitoring for side effects.
A description of the anticipated positive and negative effects on the adult of using chemical restraint
Chemical restraint is to be used in order to reduce the intensity of serious incidents, whilst the proactive measures in this plan are being implemented. Medications such as Risperidone can have serious side effects which will be monitored daily by Taylors support staff daily and monthly by Dr Smythe. Following advice from Taylor's Neuropsychiatrist quarterly by Dr Kelp, it is understood that the positive effects of use of Risperidone for Taylor is reduced mood affect contributing to his self-injurious and harm to others behaviour.

Mechanical restraint
The positive strategies that must be attempted before using a mechanical restraint
Taylor routinely wears his headgear for 18 hours per day. As such, there are no positive strategies which precede each episode of him placing it on each morning. The continued use and need for the mechanical restraint will be impacted directly by the strategies listed in this plan. It is anticipated that once Taylor is able to independently use the replacement behaviour (ie sign 'next') there will be a reduction in his head hitting behaviours and that the use of the mechanical restraint can be reviewed for reduction in use.
The maximum period for which the mechanical restraint may be used at any one time
18 hours continuous with removal for showering and retiring to bed.
The circumstances in which mechanical restraint is to be used
Consistent with the recommendation of Dr Kelp, Neuropsychiatrist, Taylor is to wear his protective headgear during waking hours.

Model plan

A demonstration of why use of mechanical restraint is the least restrictive way of ensuring the safety of the adult or others

Taylors' hitting head behaviour to solid objects and or staff is of such intensity that he has suffered diffuse Traumatic Brain Injury [TBI] with ongoing contusions, hematomas, lacerations and nerve damage resulting in communication and cognitive impairment.

Due to the significant frequency, intensity and duration of Taylors behaviour that causes harm to self or others, and following professional advice from Dr Kelp, Neuropsychiatrist, Taylor wears protective headgear during waking hours. This is an interim measure which is vital to keep Taylor safe and reduce possible injury whilst he learns the replacement behaviour.

The procedure for using mechanical restraint, including observations and monitoring, that must happen while the restrictive practice is being used

Upon rising, Taylor is to be invited to assist staff to put his headgear on, staff are to ensure it is securely fitted with no hair caught in the back laces and both chin straps secured without pinching any skin. Upon retiring or having a shower, staff are to invite Taylor to help them take his headgear off.

Following hitting head behaviour, when safe to do so and Taylor is happy for you to approach, staff to inspect Taylor's headgear to ensure it is securely fitted and not pulling any hair or pinching any skin.

Taylor's protective headgear is to be cleaned with sanitising wipes and inspected nightly after Taylor goes to bed for any signs of wear and tear to the padding, internal and external soft surfaces, back laces and double chin strap. Any identified concerns are to be recorded on Taylor's headgear maintenance form and the House Coordinator or On-call Coordinator to be contacted immediately.

Any other measures that must happen while mechanical restraint is being used that are necessary to ensure –
- **The adult's proper care and treatment; and**
- **The adult is safeguarded from abuse, neglect and exploitation**

Taylor will be safeguarded from abuse, neglect and exploitation by accurate and efficient monitoring and evaluation, followed by rigorous and timely information sharing and feedback.

Taylor's Restrictive Practices will be monitored and evaluated as follows:

- Reported per incident, daily monitoring by Support Staff; monthly monitoring by the House Coordinator; monthly information provision to family [Tim and Jason], the Service Manager and the Behaviour Support Specialist by the House Coordinator, annual reviews by his Neuropsychiatrist.

A description of the anticipated positive and negative effects on the adult of using mechanical restraint

Positive effects include impact reduction to Taylor's head/skull/brain. Taylor has chosen the colour of his latest headgear and for it to have a double chin strap and appears reasonably happy to wear his headgear daily [minimal or nil refusal to wear].

Additionally, Taylor's headgear will protect him whilst he is learning his replacement behaviour. It is anticipated that when Taylor has successfully mastered his replacement behaviour and ceases using his behaviour that causes harm to self or others, this restraint may be removed.

Wearing the headgear in public results in some attention to Taylor which may cause him some embarrassment.

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Action list		
Action	**Person responsible**	**Scheduled date of completion**
Training entire support team in plan implementation	Dee Yarrs	7/05/14
Deliver the skills teaching program use “next” sign		
1. Teach speech & sign/modelling	Support Staff	5/06/14
2. Teach speech & sign/gesture	Support Staff	25/06/14
3. Teach speech & sign	Support Staff	25/07/14
4. Monitor independence	Support Staff	15/08/14
5. Review and prepare Generalisation	all	15/08/14
Record progress of goal achievements on weekly graphs, feedback to support staff, plan author and clinical neuropsychiatrist monthly	House Coordinator	Ongoing
Task Record Sheets completed daily and forwarded to House Coordinator each Monday	Support Staff	Ongoing
Summary of Task Record Sheets forwarded to plan author	House Coordinator	30th each month
Monthly contact with family to discuss positive behaviour support strategies and goal achievement	House Coordinator	30th each month
Contact House/On Call Coordinator immediately following incidents of behaviour that causes harm to self or others	Support Staff	Ongoing
Complete Behaviour Incident Report forms and ABC Note cards following incidents of behaviour that causes harm to self or others	Support Staff	Ongoing
Record any use of behaviour that causes harm to self or others on Scatterplot	Support Staff	Ongoing
Record and report each use of seclusion to House Coordinator	Support Staff	Ongoing
Record and report any observed side effects of Risperidone	Support Staff	Ongoing
Report any observed side effects of Risperidone to Dr Smythe and Dr Kelp	House Coordinator	Ongoing
Daily inspection of protective headgear, recording and reporting any identified concerns to House Coordinator	Support Staff	Ongoing
Monthly information provision to family, Dr Kelp, Service manager and Dee Yarrs on use of seclusion	House Coordinator	30th each month
Quarterly information provision to family, Service manager and Dee Yarrs on chemical restraint	House Coordinator	Last week each quarter
Quarterly information provision to family, Dr Kelp, Service manager and Dee Yarrs on mechanical restraint	House Coordinator	Last week each quarter
Attend monthly team meetings to discuss Taylor’s achievements facilitated by the House Coordinator	Support Staff	Ongoing
Add *‘preparation of other options’* as a topic to team meeting agendas	House Coordinator	Ongoing
Attend review meetings facilitated by the plan author at 1, 3 and 9 months post implementation	Service manager House Coordinator Support Staff	30/05/14 30/07/14 30/01/15
All staff to read and ‘sign-off’ that they have read the plan.	All staff	start

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To ensure Taylor receives appropriate support, actions need to be completed in a timely manner and form part of the monitoring and evaluation process.

Model plan

Specify the ways that data will be gathered so there can be a review of the strategies on an ongoing basis. Consider observation tools, interim evaluations e.g. weekly/monthly, team meetings, stakeholder meetings. Further sub-headings to be placed in this section at the author's discretion and what the author considers relevant for this section.

Evaluation of the strategies to be implemented through this plan

Recording episodes of behaviour that cause harm

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

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

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

Evaluating skill development

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

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

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

Evaluation of this plan

Support Staff and the House Coordinator will attend regular meetings to review Taylor's achievements. Taylor's PBSP is to be reviewed initially at one month of implementation by his entire support team including Support Staff, House Coordinator and Service Manager, facilitated by Dee Yarrs. After three months of implementation there will be a comprehensive review undertaken of the plan, including all Support Staff, House Coordinator, Service Manager, and family, facilitated by Dee Yarrs. Taylor's PBSP will again be comprehensively reviewed at 9 months, including Support Staff, House Coordinator and Service Manager, facilitated by Dee Yarrs.

ATTACHMENTS

Attachment 1: Signing instructions for 'next'

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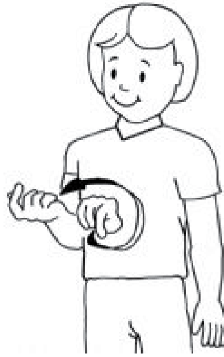
Use attachments sparingly, if at all. Attachments are not for information that should be covered within the headings and sub-headings within the body of the plan.

If attachments are required, clearly number the front page of each attachment and ensure the numbering is consistent with how each attachment is referenced within the body of the plan.

Attachment *1*: Signing instructions for 'next'



NEXT
Performance: With pointer finger extended from fist in a hook, start with finger pointing downwards. Rotate wrist so that pointer finger ends pointing up.

http://www.signplanet.net/SubTools/SubSignSingle.asp?SignID=546
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Preparing a positive behaviour support plan — guidelines and model plan

Queensland Government