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Distress Behaviour Support Policy

HP119 Homes Policies

September 2024

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1. Introduction
   1. All MHA colleagues and volunteers supporting people to live well in later life have a responsibility to ensure individual health, welfare and safety are supported appropriately along with others who may be affected by any distressed behaviour.
   2. When behaviours are caused by distress, or suffering, collaborative working needs to occur to implement behaviour support for a person, to enable them to live later life well.
   3. This policy and guidance, has a focus on finding causes and solutions, reducing and preventing distress behaviour and aims to increase colleagues’ skills and confidence when supporting individuals who need support, helping them to respond in an appropriate, safe, and consistent manner ensuring effective and caring support in difficult situations.
2. Scope and Purpose
   1. MHA recognises and promotes that all the individuals we support have the right to full protection of the law and to be supported, through all practicable means, to exercise their human rights, achieve positive outcomes and live meaningful lives. At all times and in all circumstances the people we support will be treated with respect, care, dignity, and protection from all forms of abuse or harm.
   2. If individuals distress behaviour poses a serious risk of harm to the individual or others the person’s rights still need to be supported. If any restrictive interventions are used these need to be:
   * legally and ethically justified,
   * absolutely necessary to prevent serious harm, and
   * be the least restrictive option.

Please refer to Reducing Restrictive Interventions policy.

* 1. The principles of the Mental capacity Act 2005 (England and Wales) and the Adults with Incapacity (Scotland) Act 2000 will be adhered to with regard to all decisions and interventions made on behalf of a person who may lack capacity.

* 1. This policy document should be read alongside relevant and associated MHA policies including Safeguarding, Mental Capacity, Equality and Diversity and included within any colleague induction and training programme.
  2. This policy applies to all MHA colleagues, including volunteers, working in an MHA care home, retirement living scheme or MHA community.

1. Definitions

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| Term | Definition |
| **Behaviour Support** | A person-centred framework of processes and strategies used to:  help preventing or reducing causes of distress,  proactively respond to and support a person expressing a need through their behaviour. |
| **5 step process** | 5-steps (identify, assess, analyse, plan, and review) which helps implement behaviour support. |
| **Distress Behaviour** | Any behaviour which is not the person’s usual behaviour, is a sign of distress and / or causes distress for the person or others. Distress arises from needs not being met such as hunger, pain, anxiety, loss or boredom. |
| **Usual behaviour** | This refers to behaviour that is usual for that person, not society or cultural norms. |
| **About Me and one page profile** | MHA documents that highlight a person’s likes, dislikes, past experiences and routines. All key information in enabling positive behaviour support to occur. |
| **ABC chart** | An observational tool that allows information about a particular behaviour to be recorded. The aim of using an ABC chart is to better understand what the behaviour is communicating. **Please note:** If your home uses RADAR the ABC charts are now covered by the ‘Behavioural Incident (Service User)’ record. |
| **DisDAT** | Disability Distress Assessment tool is used to help identify signs of distress in people who have limited communication. This can be a useful tool to use prior to the person coming into the home or scheme. |
| **Behaviour Support Plan** | Includes information about how a person behaves when they are content, their usual behaviour, strategies to help a person feel content and prevent distress, and how to respond if a person shows severe distress. It is based on a traffic light system –  GREEN, AMBER RED  This is because distress behaviour doesn’t usually come out of nowhere. There is usually a build up between when a person is not distressed (green), beginning to feel distressed (amber) to very distressed (red). |

**Difference between a person’s ‘usual’ behaviour and distress behaviour.**

What constitutes as distress behaviour compared to normal behaviour for a person will require a good understanding of each individual. Tools such as the DisDAT and the About Me document will assist with identifying if a person’s behaviour is a sign of distress.

1. Signs of Distress
   1. If the signs of distress are known and recognised, then it is easier to identify and reduce or remove the causes of distress.

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| **Signs** | **Examples** |
| **Verbal** | Shouting or screaming, swearing, or making comments which others may find inappropriate or offensive  Repeating words or phrases for example, asking to see a deceased relative, or asking to go home or to a place where they would have visited or lived in the past |
| **Emotional** | Following another person or colleague due to anxiety  Crying, being angry or anxious  Becoming withdrawn  Paranoia: For example, believing that their items have been stolen |
| **Physical** | Declining to eat or drink  Harming themselves or trying to harm others  Throwing objects  Repeated rocking motions or teeth grinding  Collecting items – may be due to feelings of loss or insecurity |

1. Causes of Distress
   1. There is always a reason for a person’s behaviour, it might be the only way a person can communicate, it can arise for different reasons which can be different for each individual.

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| **Possible Cause** | **Examples** |
| **Health Condition** | * Chronic or acute health condition such as pain, the influence of medication, UTIs, constipation, arthritis, depression, and delirium. * Other health issues may increase distress such as dehydration, toothache or headaches * Dementia itself could be the cause of a person’s distress, short term memory, perceptions of the environment and changes to their personality. * Certain conditions can result in psychotic symptoms including hallucinations and delusions. |
| **Environment** | * The layout of a service may cause confusion especially if an individual has moved from their own home or a different environment. * Physical aspects of the environment such as noise, lighting, large spaces, too hot or too cold |
| **Other people** | Many instances of distressed behaviour will be linked to interactions with other people. |
| **Life story** | Events in the present can trigger memories to resurface and affect current behaviour. For example, receiving personal care could trigger memories about potential past abuse. |
| **Boredom and lack of appropriate stimulation** | Behaviour can be a way of expressing that people are bored and need something to do. As a person’s condition progresses, they may find it harder to take part in opportunities or find ways of occupying themselves |

1. Interventions

| Intervention | Definition |
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| **Music Therapy** | MHA’s Music Therapists are specially trained professionals who can provide therapeutic interventions to help alleviate distress behaviour. It is important to seek their advice and input when trying to understand a person’s distress behaviour. |
| **Medication** | Certain medication can have a key role in treating some of the underlying causes of distress such as infection, delirium and pain. Physical discomfort can be the main cause for distress and should be assessed as a potential cause. If an individual is not prescribed pain relief medication their GP or clinical practitioner must be contacted for a medication review.  The use of antipsychotic medication to manage distress has received significant attention because of concerns relating to adverse side effects, particularly in people living with dementia. Guidance (NICE 2018) recommends that antipsychotic medication should only be used for people with dementia who are either:   1. at risk of harming themselves or others or 2. experiencing agitation, hallucinations or delusions that are causing them **severe distress.** It is also important that all other strategies have been explored.   Antipsychotics should be kept under regular review and reduced and stopped where possible following advice from a medical professional |
| **Environment modification** | Creating or adapting an environment to compensate for a person’s difficulties can reduce a feeling of distress. For example, suitable signage can help with wayfinding. |
| **Green care** | Engaging with nature can have a range of mental and emotional benefits for people offering a feeling of normality, peace and wellbeing with an increased sense of freedom and a change of environment. |

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| Enhanced Observations (1:1) | Support plans for any enhanced observations or 1:1 support should be recorded separately using an appropriate support plan relevant to the risk assessment and identified needs.  The support plan should include:   * The reason(s) for commencing an enhanced level of observation * The level of observation required * The goal or expected outcome of the observations – clear and specific instructions * Activities to provide engagement and stimulation according to the individual’s preferences considering any potential risks * Delegated responsibility to change observation levels and under what circumstances   Which team members should support the observation based on skills, competency, and gender preferences of the individual  Frequency of review i.e., every 24hrs and by whom |

1. Behaviour Support - Standard Operating Procedures (SOP)

The following shows what information should be gathered in relation to behaviour before the person moves into an MHA care home or scheme and the ongoing monitoring and support required once the individual is in the home or scheme.

* 1. Before a person moves to an MHA service or Scheme

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| **Before a person moves into an MHA scheme or Care Home** |
| **Initial assessment.**  Consult with person and significant others to identify the person’s usual behaviour. Identify how a person might behave if they become distressed.  If the person has limited verbal communication, consider using the DisDAT tool to help identify how a person show signs of distress.  Are there any known causes of behaviour?  Are there any strategies that the family / friends use to reduce or remove the triggers?  **About Me:**  Seek out any other information that may help to understand behaviours and build a relationship with the person and their families / friends.  **Decide.** Can MHA meet the person’s needs? |

* 1. Shortly after a person has moved in

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| **Shortly after a person has moved into an MHA Home or Scheme.** |
| Has the person’s behaviour changed since moving in?  Consider if the person is showing signs of distress?  Are these related to the move?  Continue to gather information about the person to inform support.  Examine what tools / assessments are available to help identify causes of distress?  Identify if the positive behaviour support process needs to be put in place. |

Five Key Steps to Behaviour Support

Five key steps can be followed to provide behaviour support. These steps are shown in the diagram below. The Five Steps are referenced in more detail in the following sections.

Step One – Identify

* If a person’s behaviour is a sign of distress.
* If any strategies are outlined in the person’s care plan.

A risk assessment should be completed if there is any risk to themselves or others which will inform a separate support plan depending on the area of need i.e., health or mental health.

Step Two – Assess

* + 1. The second step of the behaviour support process focuses on understanding the possible causes for the behaviour through assessment and observations. This can come through use of the ‘Behavioural Incident (Service User)’ record, or an ABC chart if you scheme does not have RADAR or uses Nourish. This needs to be completed if:
  + It is believed the behaviour witnessed is a sign of distress or other people are distressed by the behaviour.
  + If a person’s behaviour has changed i.e., it is not their usual behaviour.
  + If requested by an outside organisation (such as the community mental health team) for a period of assessment / monitoring (including timed intervals and sampling of behaviour)
  + Each time a person shows the (distress) behaviour until enough information has been collected to identify person centred strategies to reduce the person’s distress.
    1. The more information you have gather the easier it will be to analyse and plan strategies.
    2. Other assessment can occur to identify potential causes of distress. For example, the Abbey Pain scale can be used to see if the person’s distress is caused by pain.

Step Three – Analyse

* + 1. Analyse the information gathered thinking about:
  + Does the person show signs of distress at similar times during the day?
  + What does this tell you?
  + What are the main triggers?
  + What changes could you make to the environment or team approach?
  + Is additional support needed such as the community mental health team or from the person’s GP?

Step Four – Plan How to Support the Person

* + 1. The next step is planning proactive strategies to help prevent or reduce the person’s distress behaviour. These strategies can include de-escalation techniques, prevention, or reduction of triggers. This information needs to be recorded in SP7 (mental health) and SP1 (capacity and communication) to establish how a person communicates distress. It may be decided that a person needs a Behavioural Support Plan (BSP). A BSP should be completed if:
  + The person is behaving in a way that indicates severe distress for them or others.
  + Current strategies described in a person’s support plan are not reducing the distress.
  + There is a clear and immediate risk of harm linked to the distress behaviour(s).
  + Restrictive practices may have to be put in place to keep the person or others safe.

Step Five – review

* + 1. It is necessary to monitor and review how the process is working on a regular basis. Returning to step 1 will help with this analysis. The strategies will need to be examined and updated if they are no longer reducing distress.

1. Roles and Responsibilities

| Role | Responsibilities |
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| **Organisation** | As an organisation MHA have the responsibility to:   * The people we support who may express distress behaviour to have a quality assessment of needs, planning of their support and best treatment / intervention possible to reduce this distress. * Ensure our environments are not causing distress behaviour for the people we support and create reasonable adjustments. * Ensure MHA colleagues have the necessary training to ensure they are skilled in behaviour support, de-escalation techniques, avoidance of or minimization of restrictive interventions. * Promote the involvement of people in the support they receive, and significant others are involved. |
| **Managers of MHA services** | Managers have a responsibility to provide guidance and direction for all colleagues using the skills of the team effectively, acting as a positive role model for improvement and innovation.  Where an individual’s distress levels increase and there may be a risk to themselves or others, for whatever reason, managers should support the completion of an additional risk assessment to determine the impact and form a basis for creating a person-centred support plan. |
| **Quality Improvement Managers** | Quality Improvement managers will be responsible for checking all incidents that are automatically notified to them via email. With these incidents, ensure that information is included in good detail and that appropriate records are attached in a timely way e.g., regulatory body notifications, photos  A monthly random sample of 10 incidents will be taken from each home that is in the area that is assigned to the QI Manager; where a home has two floors, take 5 from each floor. The quality of reporting will be monitored, taking note of factual detail in descriptions and note whether they were followed through in the workflow by the manager in the time frames set (or that a note has been made of why timescale was changed and re-set by the manager)  Where there are issues relating to reporting and responding to incidents noticed on spot checks, to escalate concerns to the AM and RD as appropriate  A monthly data report will be produced for Area Managers incorporating trends relating to more commonly occurring incidents such as falls, medicine management errors, pressure injuries developed in house, unexplained tissue injury and behavioural incidents (service users), and noting any trends relating to overdue events |
| **MHA Colleagues** | All MHA colleagues must be aware of their duty of care to take reasonable action to safeguard the people we support, report any concerns, and maintain records in respect of the requirements of this policy. |

1. Training and Monitoring
   1. All colleagues working in care homes must complete levels 1 and 2 of MHAs understanding and responding to distress behaviours training. This training helps to recognise signs and triggers of distress and how to de-escalate situations using different non-restrictive interventions. This training must be refreshed every two years.
   2. All colleagues with a leadership role (e.g., managers, seniors, nurses, and deputy managers) in particular those working in Homes registered for dementia / dementia nursing care must complete training Levels 3 and 4 of the understanding and responding to distress behaviours training. This training examines de-escalation skills, exit strategies, positioning and defensive skills and skills to release from grips.
   3. This training is facilitated by an approved MHA provider, certified by BILD Association of Certified Training and compliant with the Restraint Reduction Network Training Standards.
   4. Training data will be provided from MHA’s people development system (Learning Zone) and will be reviewed and monitored by senior managers.
2. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Compliance is assessed through direct observation, monitoring and supervision of our colleagues, regular audit of support plans, review of documentation, incident reports and internal service audits.
   3. Each colleague’s line manager must ensure that all teams are aware of their roles, responsibilities, and limitations regarding the support of people presenting with distress behaviour.
   4. This Policy will be available to the people we support and their representatives in alternate formats, as required.
   5. Any review of this policy will include consultation with people we support, our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.
   6. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)
3. Impact Assessments (Inc. EDI)

TBC

1. Resources and References
   1. Legislation
   * [The Care Act 2014 Gov.UK](https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets)
   * [The Health and Social Care Act 2008 Regulated Activities 2014](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents)
   * [Social Service and Wellbeing (Wales) Act 2014](https://socialcare.wales/resources-guidance/information-and-learning-hub/sswbact/overview)
   * [Health and Social Care Standards (Scotland) 2022](https://hub.careinspectorate.com/national-policy-and-legislation/health-and-social-care-standards/)
   * [Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents)
   * [Adults with Incapacity (Scotland) Act 2000 Principles](https://www.gov.scot/publications/adults-with-incapacity-act-principles/)
   1. Guidance
   * [Rights, Risks and Limits to Freedom Guidance (Scotland) 2021](https://www.mwcscot.org.uk/sites/default/files/2021-03/RightsRisksAndLimitsToFreedom_March2021.pdf)
   * The Gloucestershire 5 step approach – behaviours that challenge in dementia [5 Step Approach Guidance and Resource Pack](https://www.gloucestershire.gov.uk/media/5761/5_step_approach_booklet-64562.pdf)
   * NICE: Dementia – assessment and support for people living with dementia <https://www.nice.org.uk/guidance/ng97>
   * Alzheimer’s Society [About Dementia](https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/symptoms/managing-behaviour-changes)
   1. MHA documents
   * [DisDAT Assessment Tool](https://intranet.mha.org.uk/Interact/Pages/Content/Document.aspx?id=2310&utm_source=interact&utm_medium=quick_search&utm_term=hp119)
   * [DisDAT passport](https://intranet.mha.org.uk/Interact/Pages/Content/Document.aspx?id=2311&utm_source=interact&utm_medium=quick_search&utm_term=HP119)
   * Consent Policy
   * Mental capacity and Deprivation of Liberty safeguards Policy
   * Adult safeguarding Policy
2. Version Control

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| Version | Version Date | Revision Description / Summary of Changes | Author | Next Review Date |
| 1 | April 2023 | Policy reviewed and amended | Dementia Lead  Head of Standards & Policy | April 2024 |
| 2 | September 2024 | Compliance Review  Branding updated  Additional reference to MHA Policies – section 12 | Head of Standards & Policy | April 2025 |