

Norfolk Safeguarding Adults Board

Guidance for care
homes:

Moving away from a 'medication-first' approach to behaviours that challenge

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Introduction

Norfolk Safeguarding Adults Board (NSAB) published a Safeguarding Adult Review (SAR) in January 2020, which related to the support of two people with dementia in a care home. [Read the report \(SAR F&G\) on the NSAB website](#). There were a range of recommendations made to reflect the learning from the SAR. One of these, number 11, recommended “*Moving away from a ‘medication-first’ approach to challenging behaviour*”.

Specifically, that care providers should use detailed daily notes and good incident recording to develop **comprehensive, personalised management** plans; these should then be *robustly* followed by staff who have the appropriate skills in dementia / learning disability / mental health care (Recommendation 13). Positive behavioural support (PBS) is most well-known in learning disability (LD) services, but the principles apply across the board.

The SAR recognised that, **while training for care staff in Mental Capacity Act (MCA), dementia etc. is already a legal / contractual requirement**, it can be a challenge to assess how effective this is in practice, and to embed positive behavioural approaches when general pressures or specific crises arising in care settings can drive a more reactive response. This can then increase those behaviours which challenge others, increasing the risk of harm to themselves, others and the care staff.

This document aims to offer some practical support to all care staff, to assist the development and implementation of strategies that minimise harmful incidents, encourage acceptance of necessary care, reduce risk to staff and others, and, most importantly, improve the lived experience of the person themselves.

(*note that language use has developed since the report was written, and we have moved from “challenging behaviour” to “behaviour that challenges” as the preferred terminology requested by the [Norfolk Autism Partnership](#) and [Norfolk Learning Disability Partnership](#))

Points to support you in managing behaviour that challenges others

- **Have a really good history / background of the person**
Involve the person, family, friends – if they have been a resident for a long time, which staff know them best? What things did they really enjoy, or really dislike in the past, that might affect how they respond to things now? What routines did they have in the past that they might be trying to follow now? Really try and see the world from their side, how is their dementia changing how they see, think or feel about the things happening around and to them? For anyone who has additional support needs, including learning disability – make

sure you know what is meaningful to them. This knowledge helps to build relationships, emphasise a sense of safety and can help to calm a person if they are distressed.

- **Remember the basics – is there infection / pain / constipation, is the person frustrated / tired / over-stimulated by something?**

Basic care, ensuring someone has enough to drink each day, has eaten enough food, has taken the medication they are prescribed, has moved their bowels. If the person is unable to express what they are feeling or what they want because of cognitive / communication impairment, it is more likely they will try physical methods, which can include lashing out at others. Remember that most aggressive behaviours are driven to a large extent by fear, distress and/or confusion in the person presenting them. If we remember that all behaviour is communication of some kind – the person is trying to tell us something, and it is up to us to work out what that is.

- **Boredom**

This is often a key factor – there are links to a range of activity suggestion below; we all like to feel we are doing ‘something’, to have purpose to our day / time. Conditions like dementia or LD don’t change this, but it makes it harder for the person to say what they want to do, or think they are doing, or to initiate meaningful activity. For example, do you have ways the person can request items/activities which are not in their immediate environment? If their mobility is poor, the person can have difficulty in expressing their wishes about things outside the room.

- **What sort of behaviour?**

For example, the person is walking purposefully, and may believe they are going to a particular place, even though that may not in reality, be possible; are they seeking something or somebody? Are they wanting to exercise? Do they like being busy, looking for occupation? Do they need reassurance / comfort?

- **Record with respect in daily notes**

Describing the day-to-day care, support and social activity for a person in care should be impossible in one sentence; really think about the person, not just the tasks you have performed.

- **If an incident / event happens, record it fully – remember, detail / facts** Complete this **as soon as possible** so you don’t forget the detail, don’t end your shift without writing a clear account; this will also help others on the next shifts

- **Use ABC charts wherever possible:**

A is for Antecedent (“what happened *before*?”) – this helps to identify triggers: could be about mood or what they were doing, immediately before, or perhaps something had happened earlier in the day. Has there been an accumulation of events / factors? It may not be one clear trigger or event, but perhaps a build up of things over time.

B is for Behaviour (“what exactly happened at the time?”) - who was there, who else was affected, what did staff do to support the person?

C is for Consequence (“what happened next”) – what action was taken to follow up? How were they a little while later?

- **Use these notes to analyse what happened**

Think about what may have been behind the behavior: are there any patterns, less obvious triggers? All behaviour has a ‘trigger’ - something that sets off a reaction. We can assume it’s ‘them’ but often it can be us trying to get them to do something, someone or something else in their environment, perhaps something they see but we can’t.

- Then use all this to **assess risk** – e.g. risk of harm, what type of harm, likelihood (how frequent is it happening?), impact on the person / staff / others. Record any identified risks in the person’s notes. This includes anything that might lead to the person coming to harm or causing harm to others. What might go wrong? What actions can you take to reduce the risk of something going wrong?

- **Consider the Mental Capacity Act (MCA)**

You may need to complete an MCA assessment in relation to the person’s care & support needs if there are concerns about the person’s ability to consent to the care they need. If the person is assessed to lack capacity, then a **best interest decision** will be needed, looking at the least restrictive option possible. You may have to consider Deprivation of Liberty Safeguards (DoLS) to authorise any Deprivation of their Liberty in their care plan, which still needs to be agreed as in the person’s best interests by the appropriate MDT. Although the local authority (LA) has a backlog, you have still made the application, and anything urgent will be given priority. Consider what measures are you having to take – e.g. 1:1 is a very restrictive measure.

- **Management Plan** - Work out a plan how to support the person in this specific area. This may change / adapt as you get more information; set it out clearly, and make sure all staff

(and family members where relevant) are fully aware of any plans or changes. How can you let everyone know?

- **Report**

Keep family members, key health and social care workers, Care Quality Commission, the LA safeguarding services informed. Do include any other incidents involving staff or 'minor' events for context when reporting a safeguarding issue to statutory agencies. This helps to build a better picture of what the person is doing and experiencing – it's about having all the pieces of the jigsaw.

- **Take positive action**

If you can understand why the behavior may be present, you can target your actions more effectively. Look to build the positive elements of a person's life (such as having an element of control, choice, participation, community presence) to reduce the pattern of behaviours. Keep the focus on adding these things rather than just the behaviour.

You might also think about using these positive opportunities to distract or divert the person, including using meaningful activity, the involvement of family and friends. Check that relevant medication is being taken; prompt fluids, or regular pain relief if required.

Sometimes 1:1 might be an idea – but remember this is a very restrictive measure and can upset or distress the person even more. If regular checks / monitoring is put in place, be really clear what this is intended to achieve.

- **Record and Review**

Record actions taken, and regularly review if your plan is working. Continue the process of logging and analysing any further incidents or reflect if your plan is working; encourage positive feedback to everyone if this is the case and see if any more restrictive measures can be relaxed.

What if risks of harm to themselves or others is increasing are increasing?

The key thing to remember is involve others – for example, consider primary health (like GP or community nursing), social care or more specialist support (such as occupational therapy, speech and language therapy). Keep any family up to date and aware of any issues.

- GP or the local authority can refer for consideration of NHS Continuing Healthcare, if the person is demonstrating very persistent high-risk behaviour putting them or others at risk (after any physical cause ruled out and medication / behaviour plans have not improved the situation)
- Refer to the local authority for a review of the placement

- Speak to your local contact from Norfolk County Council (NCC) / Integrated Quality team
- [Hertfordshire Partnership University NHS Foundation Trust](#) now provide specialist learning disability health services for people in Norfolk (used to be NCH&C)
- Norfolk & Suffolk Foundation Trust have a 24hr Helpline 0808 196 3494

Further support and information suggestions

Norfolk Positive Behaviour Support Service is commissioned by NCC and delivered by [Supporting Positively](#). This service is free to all providers and can support:

- Developing an organisational approach to PBS
- Embedding PBS training
- Developing PBS policies and procedures

Referrals accepted from:

- Social care providers within Norfolk and Waveney
- Health and social care staff within Norfolk and Waveney

Following referral ([Norfolk PBS Support Service- Referral form](#)):

- A member from Supporting Positively' s team will be in contact within one week
- An initial scoping call arranged to discuss input needed in more detail

The [Restraint Reduction Network](#) is a network of organisations and individuals committed to eliminating the unnecessary use of restrictive practices.

The [UK Positive Behaviour Support Alliance \(PBSA\)](#) is a partnership of organisations focused on improving the quality of life of people whose behaviour may challenge services, and those providing support. It is facilitated by Bild; the PBSA is a network of the Association for Positive Behaviour Support. They have also created this useful infographic [What does good PBS look like?](#)

Another member of the alliance is the [Challenging Behaviour Foundation](#) – they have developed an [information pack for family carers](#), which aims to provide information about PBS. It explains what it is, what it looks like in practice, provides questions to ask to check that PBS is being delivered well in the setting you are looking at and guidance on how family carers can find out more, including advice on training.

Norfolk & Suffolk Care Support (N&SCS) (a not-for-profit company created by care providers for care providers) norfolkandsuffolkcaresupport.co.uk/