Achieving a Reduction in Restrictive Physical Interventions

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TODAY

- Who are Consensus
- The ‘Drivers’ for change and improvement in the UK
- Case Studies
- Developing our organisational response

Who are Consensus

- Provider of accommodation and support solutions for people with learning disabilities and complex support needs.
- National, for profit organisation established in 2005
- Support more than 540 people in a range of residential and supported living accommodation.
- 7 year programme of development. Our focus is on bespoke accommodation and support solutions for people with complex needs.
- Positive risk taking, willingness to challenge the ‘status quo’.
- Established the Positive Behaviour Intervention Team in 2007. All graduates of the Tizard centre.

The 'drivers' in the UK

Transforming Care – national response to Winterbourne view

Right care, right place; Corporate accountability; tightening regulation; Improving quality and safety.

The Model of Care

Ensuring Quality Services February 2014 - NHS England/LGA

Commissioning tool

Core Principles that should be present across Health education and Social care - PBS being the first of those principles

NHS England

The 'drivers' in the UK

Positive and Proactive Care:

reducing the need for restrictive interventions 2014

"Guidance for all those working in health and social care settings: commissioners of services, executive directors, frontline staff and all those who care for and support people" , along with a summary of key actions which include:

- 1) Leadership, assurance and accountability
- 2) Transparency

DH Department of Health

The 'drivers' in the UK

Positive and Safe Champions Network (DoH)

Norman Lamb – Minister of State for Care & Support

- Positive & Safe training for staff
- Accurate internal data
- Service commissioners must be informed by providers about restrictive interventions used for those for whom they have responsibility.

The 'drivers' in the UK

The Care Quality Commission (CQC) will;

- monitor and inspect against compliance with regulation on use of restraint. Ratings of providers are informed by this guidance.
- Review organisational progress against restrictive intervention reduction programmes.
- Scrutinise the quality of Positive Behaviour Support plans which includes the use of restrictive interventions.
- Expect staff to be prepared to explain to inspectors when and why they are using restrictive intervention.

The 'drivers' in the UK

NICE – Challenging Behaviour and Learning Disabilities - preventions and interventions for people with learning disabilities whose behaviour challenges – May 2015

- Include the person with learning disabilities and family in assessments , interventions and outcomes.
- Undertake functional assessments and implement positive behaviour support plans.
- Provide the least restrictive behavioural interventions.
- Reserve drugs as a treatment for severe aggression or self injury and only in combination with a behavioural, cognitive behavioural, or psychosocial intervention.

The 'drivers' in the UK

Community Care Act 2014 (implementation April 15)

- Personal budgets 'regardless of the setting you live in';
- Direct payments in residential care a possibility;
- Children and Families Act: children with special; educational need will have a single assessment, and educational , heath and Care Plan and the option of a personal budget;
- Integrated Personal commissioning (IPC) programme – a blend of health and social care funding for some people with the highest needs using personalised care and support planning and budgets;

Transforming Care – next steps

The authors:

- Association of Directors of Adult Social Services
- Care Quality Commission
- Department of Health
- Health Education England
- Local Government Association
- NHS England

Key principles

- Empowering people and families
- Getting the right care in the right place
- Driving up quality through regulation and inspection
- Workforce development

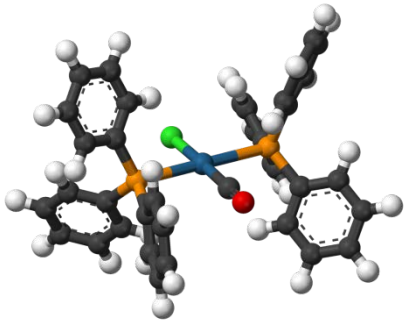
Within this a focus on :

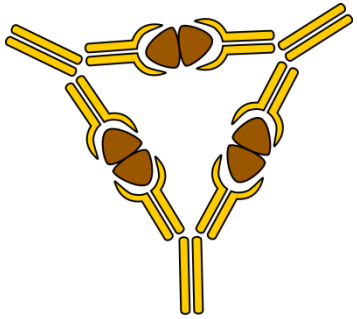
- A substantial reduction in the number of people placed in inpatient settings
- Reducing the length of stay
- Better quality of care for people in in-patient settings
- Better quality of life

Transforming Care

Case studies

Introduction





- Billy - 37 years old
  - ✓ Severe learning disability
  - ✓ Autism
  - ✓ Complex epilepsy (not diagnosed until admission to Consensus)
  - ✓ Complex sensory processing issues (proprioceptive hypersensitivity)
  - ✓ Steven's Johnson Syndrome – a rare condition arising from 'over-reaction' of the immune system to triggers such as a mild infection or a medicine leading to blistering and peeling of the skin and surfaces of the eyes, mouth and throat.
  - ✓ Neuroleptic Malignant Syndrome – a serious and unpredictable idiosyncratic drug reaction.

- Billy has had in excess of 8 different home settings between ages of 14 and 37 years with numerous periodic admissions under section from the age of 14yrs

  ✓ private hospitals
  ✓ community homes
  ✓ Assessment & Treatment units

  (local and out of county placements)

  Consensus was approached to work with health and Social care to try to stop the merry-go-round of admissions and discharges.

Billy moved to a Consensus home in October 2014

- All behaviours observed were historically seen:
  - ✓ **Physical aggression (punching, grabbing, hair pulls, biting)**
  - ✓ **Damage to property**
  - ✓ **Self-injurious behaviour (head butting the floor, biting)**
  - ✓ **Urinating in & on clothing**
  - ✓ **Refusal to return to premises/car**
  - ✓ **Throwing items**

Month	No/ of Incidents	No/ that Required PRN	No/ that Required RPI
October 2014	17	1	5
November 2014	31	2	11
December 2014	29	4	20
January 2015	25	3	17

Restrictive Physical Interventions

- ✓ Escorts – 2/3 people
- ✓ Seated holds – 2/3 people
- ✓ Supine holds – 4/5 people (initiated by Billy dropping to the floor)

Often maintained as a result of sensory seeking deep pressure / contact

3 extended periods of Restrictive Physical Intervention

- October 2014 – 40 minutes with 10 minute interval disengagement attempts
- December 2014 – 7+ hours with 10 minute interval disengagement attempts and included the use of sensory weighted equipment
- January 2015 – 72 hours with 10 minute interval disengagement attempts

The challenge…

The last 2 both led to:

1) seclusion in his bedroom without a legal framework in place
2) The use of covert medication (MDT decision)

Admitted to Assessment & Treament under Section 2 (MHA)

because of the impact on other residents & progressed to compulsory detention under Section 3 (MHA)

whilst considering the least restrictive option

Partnership working

Local PCT - Consultant Psychiatrist, Community Nurse, Occupational Therapist, Speech & Language Therapist

Funding authority – Social Services Care Manager, Social Services Behaviour Specialist and consultation with Social Services Solicitor

Service Provider - Service Manager, Operational Manager, Positive Behaviour Intervention Team Lead and Behaviour Practitioner, Consultation with Consensus Solicitor

DOLS - Senior Practitioner

IMCA for Billy

Billy's mother - was included throughout but found attendance emotionally difficult

Options :

- ✓ Return to Consensus – on section 17 (temporary leave of absence) with a planned return to hospital. Remains under Mental Health – no DOLS required
- ✓ Discharge under section 117 to Consensus - court of protection order required for the locked door whilst waiting for (Community Treatment Order protocol) re-turned to an Assessment & Treatment Unit by police following a robust protocol.
- ✓ Single service – therapeutic isolation in his flat e.g. remove themselves reducing the need for restrictive physical intervention - requiring DOLS

Outcome

A bespoke, single occupancy service has been specifically designed with input from Occupational Therapists assessment.

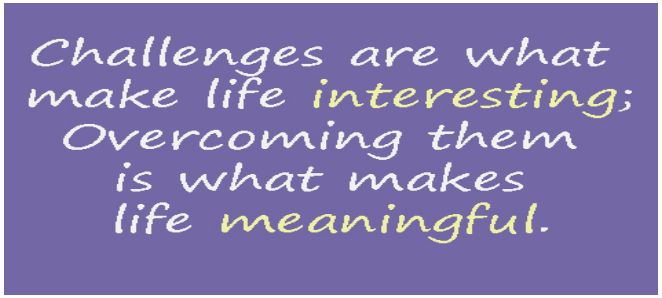
This will annexe the existing building providing:

- A safe, therapeutic isolation environment for when Billy would otherwise have required RPI and/or seclusion
- A self contained kitchen, lounge / diner, bedroom, bathroom where staff can continue to provide proactive support designed to reduce the occurrence of known behaviour's that challenge
- This includes use of weighted clothing and therapeutic equipment to reduce sensory seeking proprioception (touch) via RPI)
- Billy will continue to access the main building at times when his anxiety and mood state allows this without risk
- Positive Active support to build skills and confidence.

Introduction

- John - 42 years old, he has a severe learning disability and autism
- Removed from family home aged 8
- 11 different home settings between ages of 8 and 37 years – each failed due to complex behaviour which challenged
- 9 hospital admissions under section
- In 2000 an investigation into serious abuse claims was neither able nor unable to prove accusations. It was alleged that John jumped from a first floor window to avoid abuse – both his ankles broken.
- He moved to a Consensus home in November 2010.
- John still acts out abuse scenes adopting pain compliance restraint postures while screaming to be released

Challenges

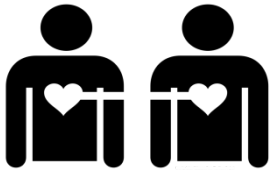


- John engages in repetitive & sequential behaviours (touching hair, furniture and playing with water)
- The intensity increases with anxiety which leads to physical aggression toward property (punching / kicking walls & furniture) and people (grabs, bites, hair pulls)
- John would find it very difficult to enjoy accessing the community and typically would do so on his terms, usually spontaneously on average once / twice a month (usually to a known toy shop)
- Previous interventions relied heavily on restricting his access to touch and water in a bid to eliminate the behaviours
- These restrictive practises increased John's anxiety which resulted in increased use of PRN medication and Restrictive Physical Intervention (RPI)

Achievements

- **Current PBS focuses on providing clear and consistent boundaries**
  - ✓ Allowing John to engage in positive touch
  - ✓ Have access to water play
  - ✓ Opportunities to increase quality of life

- **Over a 5-year period John has built some long term, consistent and trusting relationships**



- **John enjoys:**
  - ✓ weekly library trips and chooses DVD's to watch and is known positively by library staff and others users
  - ✓ Local shopping trips
  - ✓ Trips using the local trains (a 'passion' of his)
  - ✓ Most recently John attended his first out-patients review in many years, was present the whole 45-minutes and contributed ina meaningful way
  - ✓ More time independently engaging in things he enjoys (DVD's, photography)

Reducing Restrictive Practise

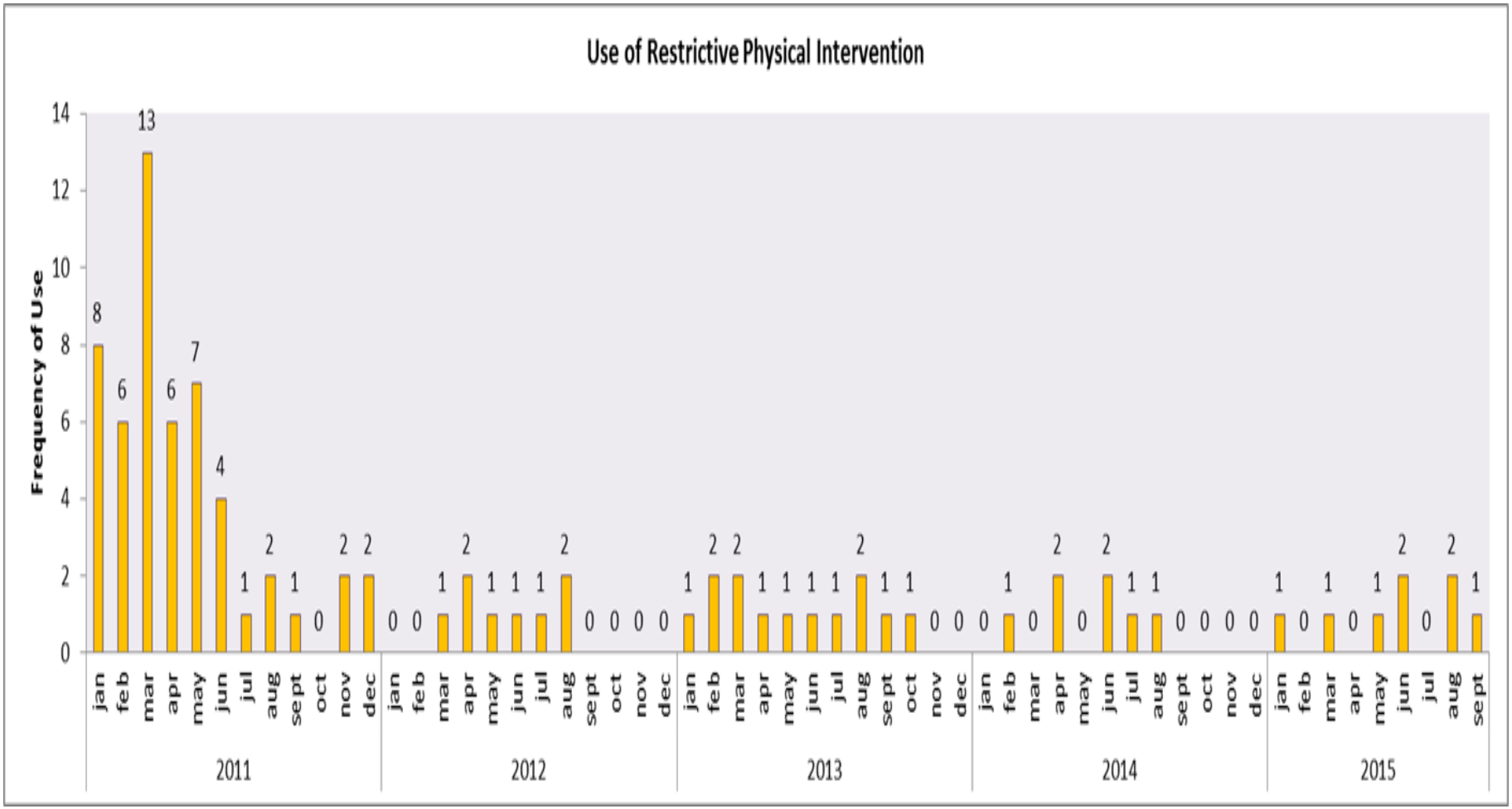
- 2015 saw John's consultant start to slowly reduce the use of long term medications, including Lithium. While this has resulted in a slight increase in PRN medication we are pleased with the progress he continues to make.

- As well as providing John with access to previously denied obsessions we have been able to reduce the amount of Restrictive Physical Intervention required.

This is especially significant for John who still 'acts out' his past abusive, pain control experiences

Abuse Response

Reduction in the use of restrictive physical intervention over time



Developing Our Organisation's Response to Restrictive Practices

Lead Behaviour Practitioner role

- Strategic lead for our Senior Management Team, up to date research, National guidance and data collection – RPI and PRN analysis and monthly summary
- Write and contribute to polices that give guidance to our employees with regard to supporting people who use our services.
- Embed a Positive Behaviour Support approach into the organisation – leading on Person Centred Approaches
- Provide competent and effective management support to my team

PBI Team role

North- Jan 2016

South

East Anglia

Sussex and Surrey

East Midlands

- Functional assessments of new referrals to Consensus
- Referrals from existing support services ,functional assessment and support to implement intervention strategies.
- Write PBS support plans
- Monitor the use of RPI and PRN

- Provide staff mentoring, training, and advice
- Provide out of hours on-call

Positive Behaviour Support Plan

- Background information and the behaviours of concern
- Antecedents/Behaviour Function/Early intervention
- Pro-active strategies (includes PCP preferences)
- Reactive strategies
- Monitoring and reducing all restrictions
- Post incident support
- Has the person we support been involved in writing this plan?
- Who else has been involved?

Reducing the need for Restrictive Physical Intervention

- Bild code of conduct - for organisations who deliver training on how to use Restrictive Physical intervention practices.
- Maybo/PBM partners – Training Needs Analysis
- My team - in-house trainers - service managers discuss: the context of the behaviour/s of concern, the outcomes of implementation of all proactive approaches and direct treatments and ensure

this

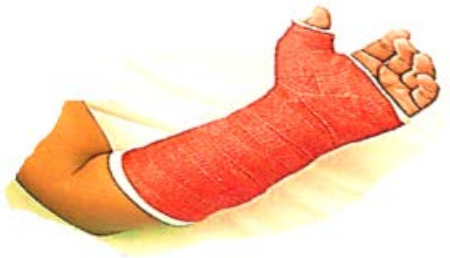
Is a last resort?

S0.....

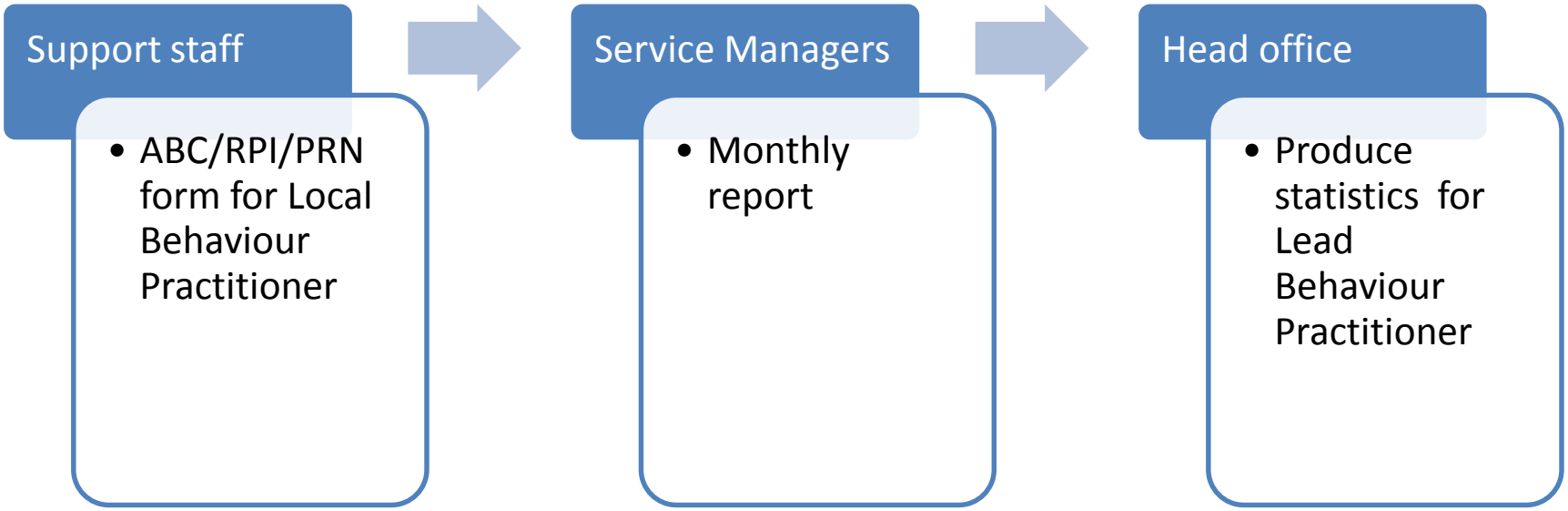

Senior leadership team PBS one day workshop
Service managers and team leaders
PBS 4 day
Support staff – PBS one day quarterly rolling programme

Other restrictions that are closely monitored

- Locked doors
- Lap straps
- Mechanical restraints
- PRN



Restrictive Physical Intervention and PRN Monitoring process



Restrictive Physical Intervention Date Analysis

Lead Behaviour Practitioner

Company Risk management Group

- Overall graph for all services in the company +/-
- Graph for individual services +/-
- Frequency, duration and evidence of regular attempts to dis-engage
- A trend graph for the individuals we support
- Report for Clinical Risk Group

- Ask questions to clarify and understand why restraint was necessary and

Continuous improvement Group

restraint.

Positive Behaviour Support

- PBS is not just about reducing or stopping behaviour
- ‘An approach that blends the rights of people with disabilities, with a practical science about how learning and behaviour change occur’ (Robert Horner 2000).
- Person Centred Approaches – Applied Behaviour Analysis and Quality of life outcomes.

DAVID

- Moved in late January 2014
- Children to Adult services
- Transition planning went well- new team got to spend time with him alongside his existing team
- After 1 week…. physical assaults towards staff
- 11 staff injures in the first month

Functional Assessment

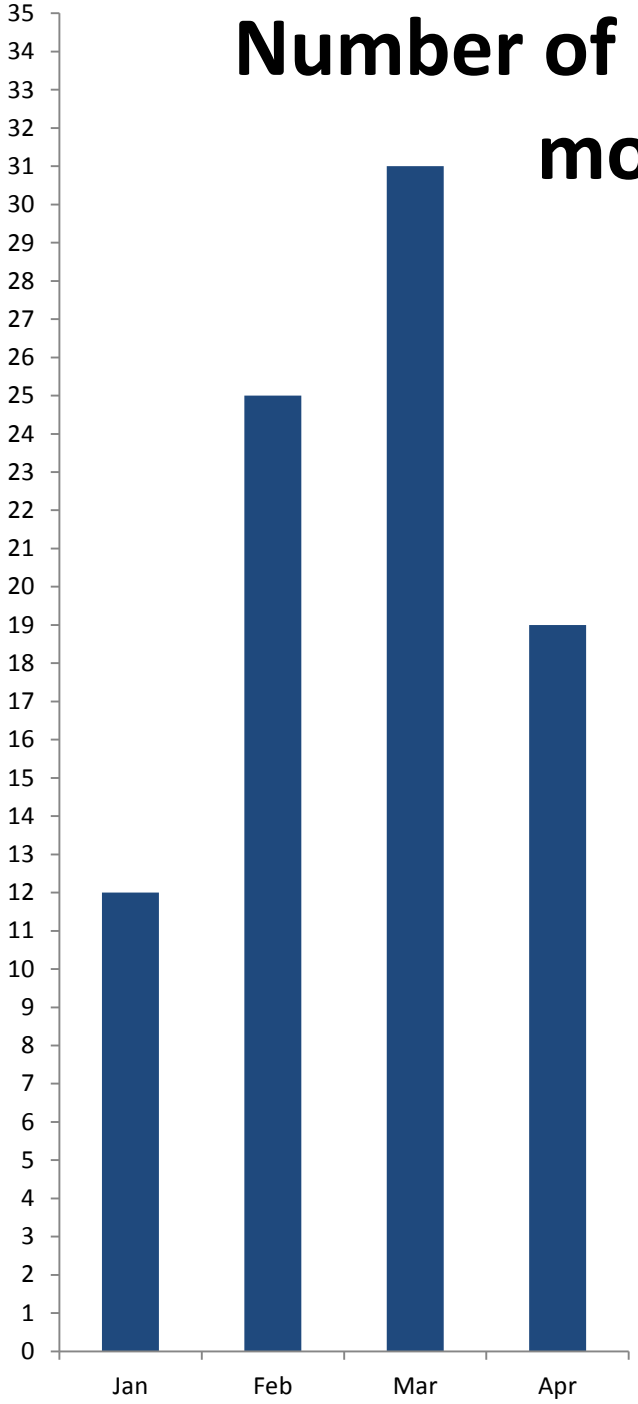
Proactive Strategies

Provided additional staff to help with support
Organised his day with highly preferred activities
Developing better communication supports

Reactive Strategies

The ‘last resort’ of restraint was becoming an every day occurrence

Number of RPI's in first 4 months



A Functional Assessment is not one single thing; it is a broad term used to describe a number of different methods that allow us to identify the reason a specific behaviour is occurring.

- The Functional Assessment concluded that David had Tactile Hyposensitivity.
- A reduced response to feelings of touch and being touched, both internally and externally.
- Pain thresholds can be quite high and people will seek out high stimulating experiences to register any sensory feedback.
- Extremes in taste for salty /spicy dishes, enjoy the feel of highly textured surfaces and also seek out messy and boisterous activities.

This was exactly what David was doing- he was seeking ‘restraint’ to register this sensory stimulation.

Being ‘held’ was actually prolonged by David when staff attempted to let go and release, or when they tried to swap colleagues.

(In the previous service he was often seen being cuddled by the staff team)

Light bulb' moment for the team

- Refocusing their perception of the behaviour.

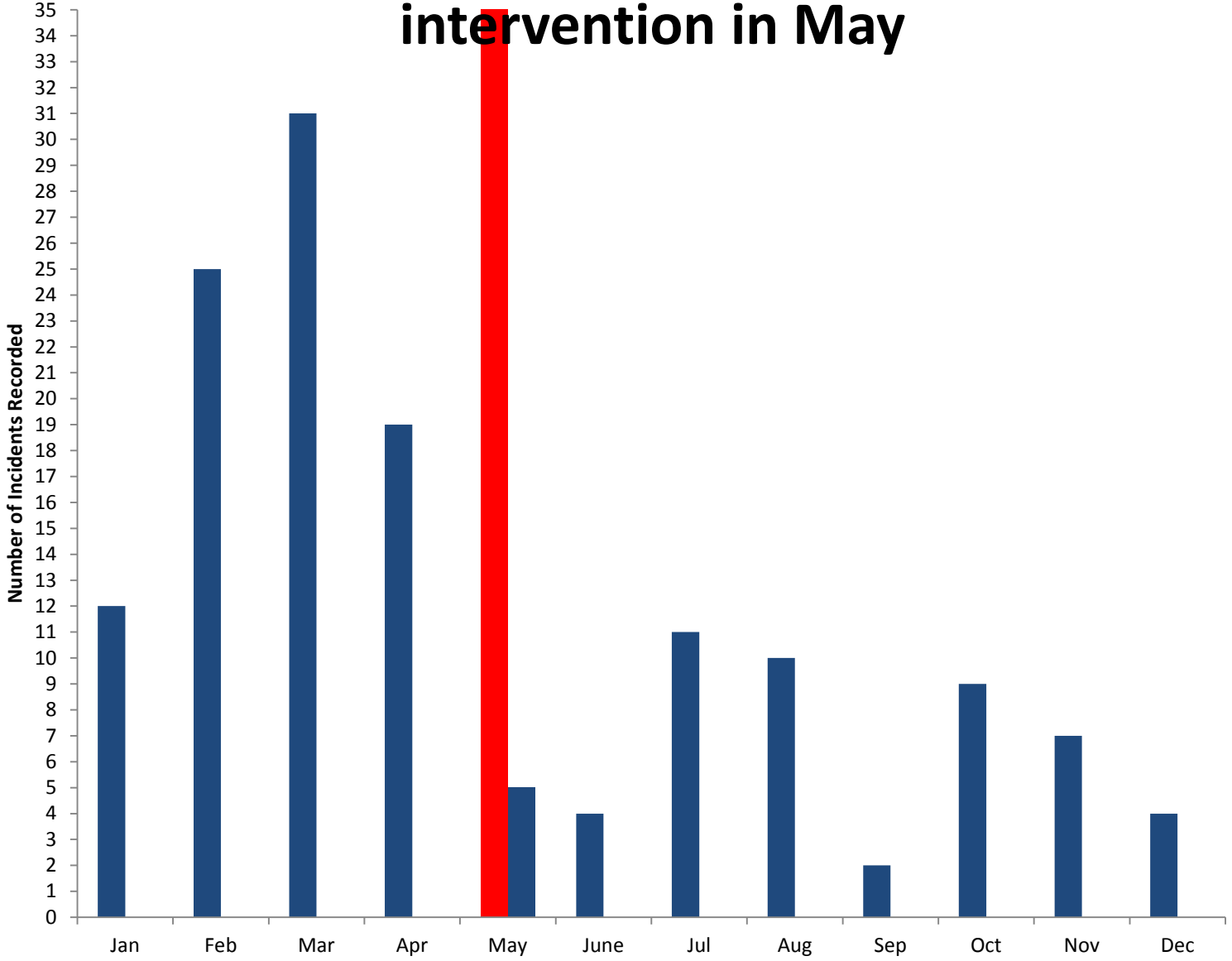
- No longer 'Aggressive' – functional in seeking sensory stimulation from being 'touched'.

- David still has the need for firm pressure tactile activities- but with support on how to incorporate strategies that regulate his need to seek touch in a boisterous way, we reduced the need for restraining David.

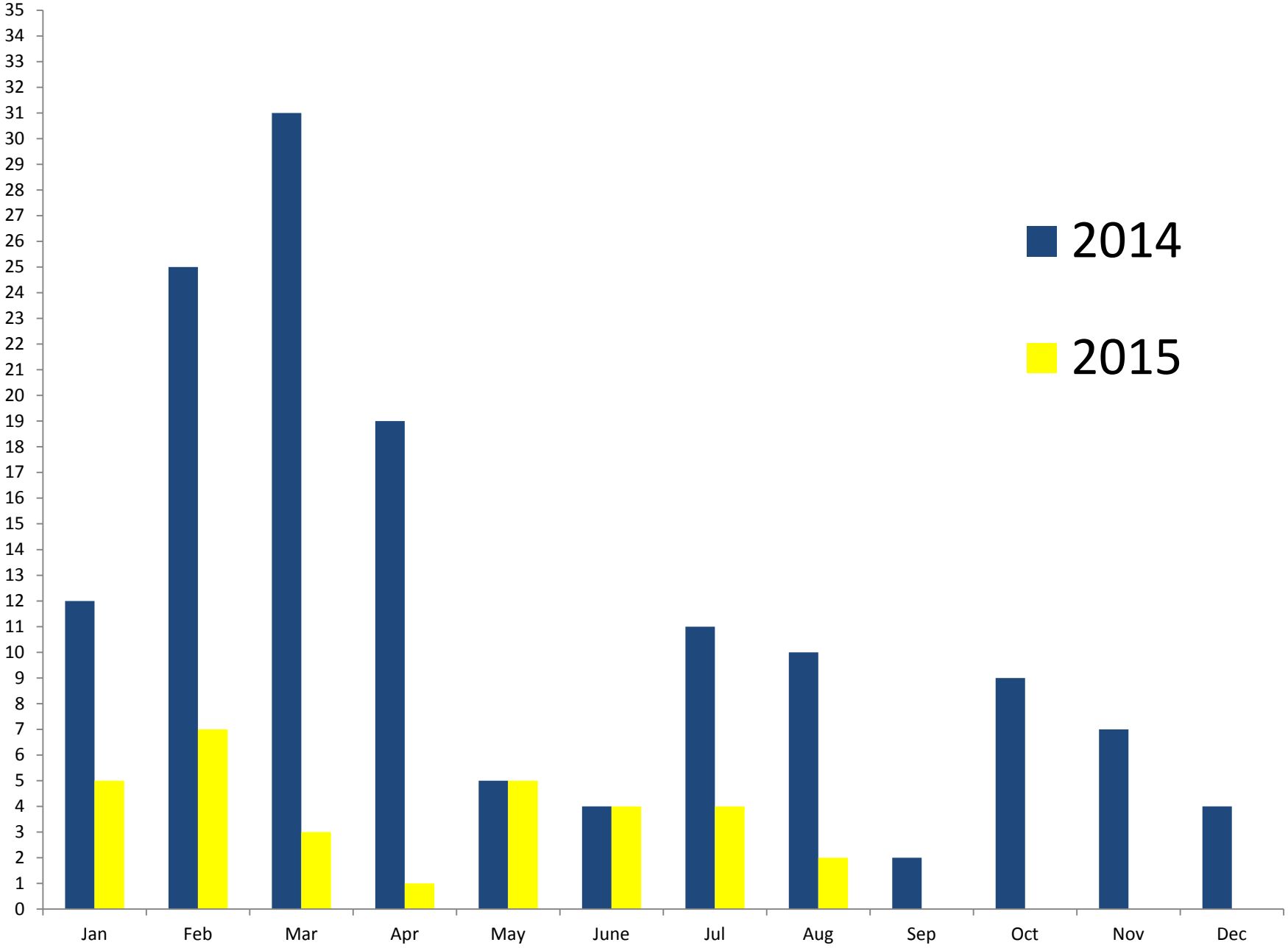
- Strategies to help David self –regulate the ‘cuddles’ and hugs and seek alternatives when he needs them, have been carefully planned around what we know David likes and will tolerate- such as :

- **Better communication for David i.e. “I want..” pictures.**
- **Deep pressure massage to shoulders.**
- **Messy activities- in particular cooking , gardening etc.**
- **Firm cushions tucked by his legs when watching TV.**
- **Back pack when out and about.**
- **Weighted blanket and lap mat**.

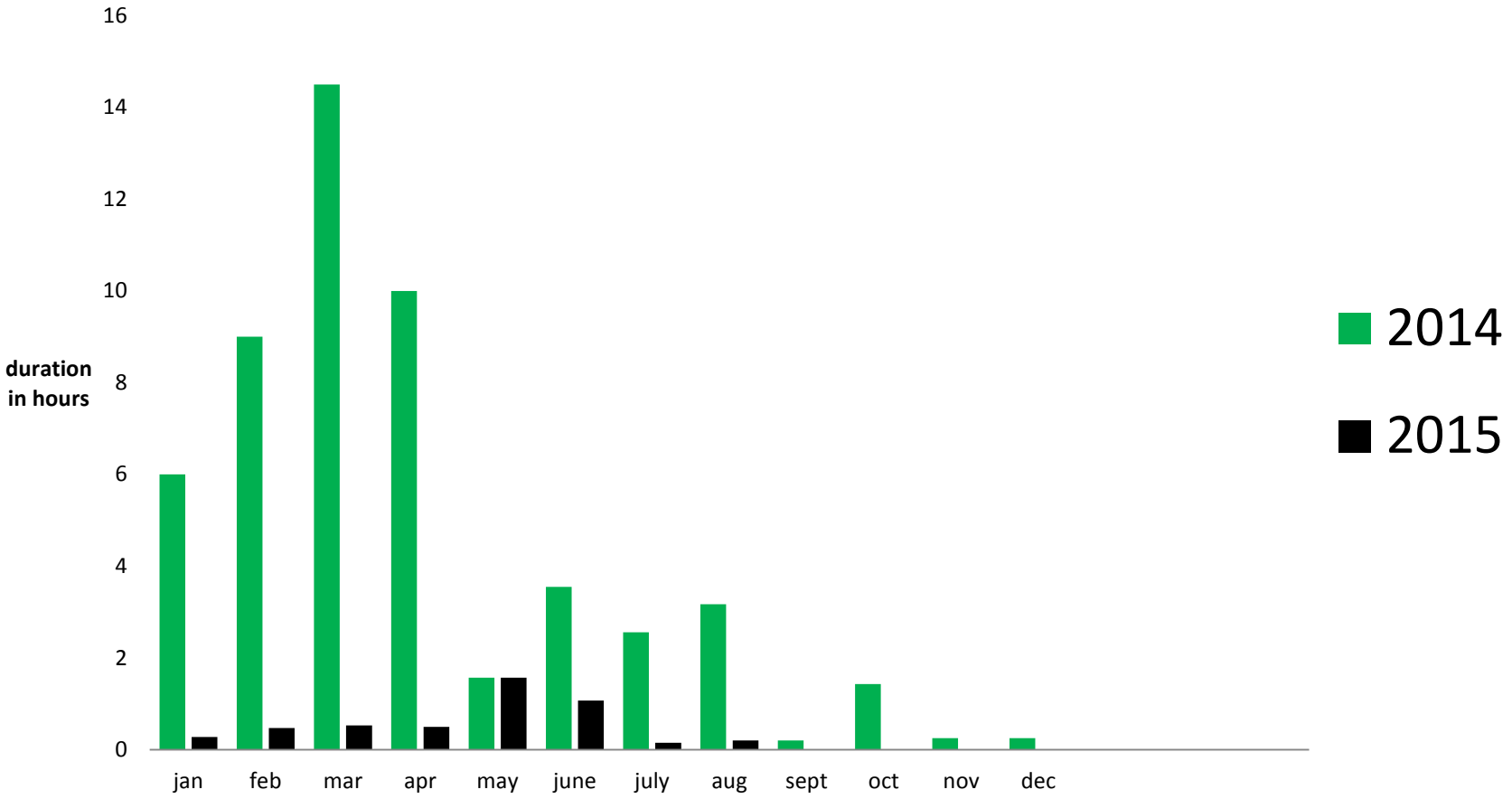
Showing decrease of RPI'S after intervention in May



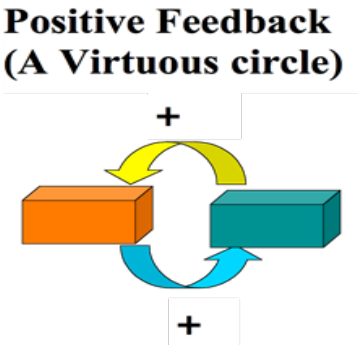
Number of RPI'S comparison



RPI - hours per month comparison 2014- 2015



Positive Life Goals setting, (Emerson & Fox, 2002) Outcomes:



David is having more frequent and more positive & appropriate social contact with others

He is learning an alternative way of meeting the same need which has previously been met by challenging behaviour

He is liked and respected more by others

An improvement in his environment; David is able to have a more enriched material environment