

Case study 1: Meera

Meera is a 16 year old girl living in a residential home with 3 other young people. Meera has a learning disability as well as autism and she also has limited communication skills.

The people who support Meera became concerned as she started to have prolonged episodes of distress two or three times a week. The episodes often start about half an hour after she returns home from school.

The regular routine in the home is that on return from school or college the young people who live in the home are offered a drink and snack and encouraged to relax after having a day of structured activities.

When distressed, Meera will move around the house quickly, sometimes screaming at the same time. If anyone tries to approach her she may hit herself quite hard in the face and grab the clothing of anyone who comes too near. Sometime she will attempt to bite other people.

As Meera's distress increases she may rip at her clothes and throw them off, often leaving herself almost naked.

Staff are worried about Meera hurting both herself and other people as well as being concerned about her nakedness. They are also worried that they cannot move the other young people out of her way quickly enough when she is running around.

Meera had a health check last month to ensure the distress wasn't caused by pain and the staff are keeping good records of the incidents to see if any triggers can be identified. A number of different proactive and de-escalation strategies have been tried to prevent Meera from becoming distressed and help her to calm when she is distressed.

The agreed reactive strategy in her behaviour support plan directs staff to physically intervene if anyone's safety is compromised. All staff receive training in how to do this as safely as possible. Two staff hold Meera by the arms and escort her into a downstairs room with closed blinds which protect her privacy. Meera will not let anyone stay in the room with her so staff release her and retreat quickly to wait outside the door.

Sometimes Meera opens the door and tries to come out. To prevent this happening, the staff on duty sometimes hold the door handle when they can hear that she is near the other side of the door. This part is not in Meera's agreed behaviour support plan.

Meera usually calms down after about 15 minutes of being on her own in the room. After this time staff can approach her, offer her drink and assist her to get dressed.

The amount of time the door handle is held for is always recorded on the incident form, but some staff are worried that they are restricting Meera's liberty illegally.

Preventing Meera from leaving a room when she wished to, meets the accepted definition of seclusion which is not permissible in children's homes that are not registered as secure children homes (*Children Homes Regulations, 2015*)

Recently, an Ofsted inspector has queried the use of seclusion as an unplanned strategy.

The service wanted to know whether they could justify the use of seclusion as part of their duty of care, and whether it was the least restrictive option.

They asked a PBS specialist to review Meera's case.

The specialist carried out a behavioural assessment. This involved gathering information from all parties involved in Meera's care. The specialist also spent time observing Meera in the residential home and set up special recording systems to get specific information to help her understand the reason for Meera's behaviour.

The assessment indicated that Meera's behaviour had a sensory function and that it seemed likely that she was trying to regulate her sensory input.

This is something she finds more difficult to do when she is tired or during periods of non-structured activity.

The service followed the specialist's advice and reviewed Meera's behaviour support plan. Meera's family and the professionals involved in supporting her have all agreed with her new behaviour support plan and have agreed to review it in 3 months' time.

Meera's routine has now been changed so it has more structure and she knows what to expect on return from school. An occupational therapist conducted a sensory assessment and devised a treatment plan to help Meera's sensory regulation. The staff have had some training in supporting Meera's sensory diet and are working on this proactively – before she becomes distressed.

When she comes home from school she spends time on one to one basis with a favoured member of staff. They do gentle activities together that she enjoys and is good at and also tries some sensory activities that have been suggested by the occupational therapist. She is particularly fond of completing jigsaws and some computer games.

Meera has a weighted jacket which she sometimes will choose to put on.

When she becomes upset, a blanket and the jacket are offered to her.

While Meera gets used to her new routine, a programme of fun after school activities has been offered to the other young people so they are less likely to be in the way if she does become upset. This has helped to reduce staff stress levels and also means that staff are less likely to need a restrictive response.

As well as implementing a number of proactive strategies, the service have also reviewed their reactive strategies to see whether they are always using the least restrictive response and have devised a checklist of things for staff to consider during any distressed episode.

Staff are more confident that if they think it is necessary to use a restrictive practice that they have considered all the other options available at that time.

Conclusion

The specialist could not agree that using seclusion was the least restrictive practice as by gaining a good understanding of the reasons for Meera's distress, this meant they could identify less restrictive methods to support her.

As a result of addressing her sensory needs directly, both through a proactive programme and as a reactive response, records are showing that any restrictions used are now used less frequently and for shorter duration.

(continues)

Principles

If a restrictive measure is used as an emergency response for safety reasons, other proactive strategies must be in place to ensure that the use of such restrictions are reduced over time.

The emergency response should always be the least restrictive needed at the time to keep the person and others safe.

October 2015

Centre for the Advancement of PBS

BILD, Birmingham Research Park, 97 Vincent Drive, Edgbaston, Birmingham B15 2SQ | 0121 415 6960 | capbs@bild.org.uk | www.bild.org.uk/capbs