Appendix I - Protocol for Managing the Eating of Inedible Objects

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Definition

Many of the children, young people, and adults we support will occasionally or regularly put inedible objects in their mouth and may swallow them.

It is important that we differentiate between those who have a formal diagnosis of Pica from a diagnostic professional, and those who eat inedible objects without diagnosis.

This protocol is applicable to any 'eating' of inedible objects whether formally diagnosed as Pica or not.

For the purposes of this document, we will refer to the 'eating' of inedible objects, encompassing mouthing, swallowing, and ingestion.

Further, for the purposes of this document we will refer to 'person we support' in reference to both children and adults.

What is Pica?

Pica is the craving and purposeful consumption of non-food substances or items with no nutritional value such as stones, dirt, metal, faeces. People we support may eat one specific inedible object, or lots of different ones. The people we support may have be diagnosed with Pica by an external medical professional. It is not the job of NAS staff to diagnose Pica and this protocol applies whether someone has been diagnosed with Pica or not.

For staff's understanding, the medical descriptions of Pica are summarised below.

The diagnostic criteria for Pica from the DSM-5 states that:

> *Pica is characterised by persistent eating of non-nutritive substances/items for at least 1 month; its occurrence is inappropriate to the individual's developmental level, and not part of a culturally or socially normative practice*.

The International Classification of Diseases 11th Revision states that:

> *Pica is characterised by the regular consumption of non-nutritive substances, such as non-food objects and materials (e.g., clay, soil, chalk, plaster, plastic, metal and paper) or raw food ingredients (e.g., large quantities of salt or corn flour) that is persistent or severe enough to require clinical attention in an individual who has reached a developmental age at which they would be expected to distinguish between edible and non-edible substances (approximately 2 years). That is, the behaviour causes damage to health, impairment in functioning, or significant risk due to the frequency, amount or nature of the substances or objects ingested*.

Duty of Care

Where eating or mouthing of inedible objects is known or emerging behaviour then it is important that this behaviour is recognised and raised with the relevant involved professionals both internally and externally, such as health and social care professionals and the PBS team.

A risk assessment should be completed with the input of all relevant professionals and a support plan. Risk assessments should consider any specific training requirements for staff supporting the individual, any specific environmental adaptations that the individual requires and any other control measure required to manage and mitigate the risks.

In an emergency situation, staff can only fall back on their professional experience, their training, their common-sense, the 'best interest' principle and their over-riding duty of care to wherever possible prevent harm to a vulnerable person. Provided staff act reasonably, proportionately and sensibly, their actions will be supported. Any such unplanned action must be carefully recorded on an incident form.

Review of all risk assessments and individual behaviour support plans (ISPs/PBPSs) must be undertaken within 24-72 hours of an unplanned response in order that a planned response/strategy can be implemented should the behaviour occur again in the future.

Assessments and Interventions

Assessment of eating of inedible objects behaviour is a continually developing area and factors that may cause and maintain it should be assessed. Professionals working with the individual may carry out a comprehensive functional behaviour assessment to ascertain, establish and/or better understand why they are eating inedible objects. The widespread use of functional behaviour assessments has contributed to the development of person-centred interventions based on the understanding of the function of behaviour.

Currently, there are no evidence-based treatments for Pica. Therefore, interventions focus on reducing the frequency of Pica behaviour through positive behavioural interventions, non-contingent reinforcement and environment enrichment strategies in a person-centred manner.

The eating of inedible objects is likely to involve a number of factors, therefore a combination of approaches across all settings is most likely to be needed. Any intervention should be collaborative (working closely with families, care givers and professionals) and individualised. A multi/transdisciplinary assessment involving health, social care, and education professionals (where appropriate) may be needed to develop and regularly review care plans. If a formal diagnosis of Pica is given, this ought to be included in their relevant plans with identified supportive behavioural strategies.

Medical Investigation

If an individual has eaten [**For the purposes of this document, we will refer to the 'eating' of inedible objects, encompassing mouthing, swallowing, and ingestion**] an inedible object that may cause harm, contact the GP, 111 or accident and emergency department for medical advice. If you are unsure whether an object may cause harm, seek medical advice to identify this. It is important that the risk of toxins and poisons is not forgotten.

It is important that staff proactively identify the specific hazards relating to the item that has been eaten. For example, certain tree leaves may be toxic whilst others are not, so it is important to quickly identify the nature of the item to establish any additional toxicity. The ingestion of some items such as button batteries requires an immediate 999 call due to the risk of death.

If the eating of inedible objects is a new behaviour, it is important that this is flagged with appropriate professionals to ensure that testing for nutritional deficiencies and other physical causes and treatment can be explored as appropriate.

Eating inedible objects can be a way of someone communicating existing pain or discomfort. Medical problems such as pain (particularly toothache and earache), infection, and gastric discomfort caused by bacteria have particularly been linked to new behaviours that challenge.

Increased heart rates linked to physiological arousal have also been associated with self injurious behaviours. The measurement of physiological arousal using simple heart rate

monitors, usually attached to the wrist, is recommended especially for those who are high risk. For some individuals' internal elevation of arousal may be a risk indicator of episodes of moderate or severe self injurious behaviours

When the behaviour is known and medical causes have been ruled out, regular reviews with the relevant health professionals (including dentistry) to physically examine the person are advisable. The frequency and perceived normality of a behaviour for a person does not diminish the risk of each individual and cumulative incident of inedible objects being eaten.

Choking is a risk when inedible objects are ingested. All staff must be aware of how to respond when someone is choking and the key first aid principles of cough it out, slap it out, squeeze it out, and call 999.

Thorough record keeping is necessary to ensure that individual incidents of eating inedible objects are not dismissed as insignificant. **Repeated consumption of seemingly harmless non-edible material can cause significant health issues such as bowel obstruction or the build-up of toxins.** If there is any concern regarding bowel obstruction, immediate medical advice must be sought from the GP, 111, or hospital A&E.

Environmental Considerations

Priority ought to be placed on environmental checklists, audits and control measures that can be adapted to minimise risks. This must include assessment of every environment that is accessed by the person whilst within our care, such as buildings, outside spaces, as well as the wider community. It is recognised that the inedible objects within the wider community cannot be controlled in the same way as they can within our sites; but they must be recognised and appropriate steps taken to avoid exposure to this risk.

Additional ways to manage and minimise risks would include:

- Monitoring for dangerous items that may cause immediate risks of vomiting, choking, gut problems or poisoning. Seemingly normal every-day items can be toxic when ingested, such as some plants.
- Monitoring for items that may cause chronic ill-health such as infections and blockages to the digestive system.
- Restricting access to non-food related items and making modifications to indoor environment, outdoor environment, and walking routes.
- Having a fuse box with a Residual Current Device (RCD) breaker if wires may be chewed.
- Check all equipment, toys, etc for button batteries. Consider the removal of any items that use button batteries from the environment. The ingestion of button batteries requires an immediate 999 call.

Communication Considerations

Can a function of this behaviour be identified? Research has shown that this could be a behaviour which is related to a lack of social interaction and engagement with meaningful activities. Distraction by presenting highly desirable activities may decrease the frequency with which inedible objects are eaten.

Does the person have access to a meaningful communication system in the absence of expressive language? Best practice would be that an assessment of a persons' language and communication skills has taken place by a specialist Speech and Language Therapist which will inform carers of a person's communication levels. A communication passport or other appropriate tool should also be made available.

Can the person be taught the difference between edible and inedible objects? Would the use of social stories or visual supports assist the person to understand the inherent dangers of ingesting inedible objects?

A Speech and Language Therapist may help the person we support understand instructions and develop their ability to communicate choices and preferences, request attention or a favourite activity. Always consider the individual communication plan the person has in place, their level of understanding, and the level of their expressive communication.

Sensory Considerations

Offer alternative sensory input as appropriate and guided by a qualified Occupational Therapist. Replace the inappropriate item with a food similar in texture, such as rice paper, edible sand, liquorice cables, carrot stick, popcorn, twiglets. Different tastes and textures may need to be tried before a suitable alternative is found. A sensory box with items that resemble the appearance or texture of inedible items may be helpful. Initially the sensory box should always be available. The amount of time the sensory box is available for can then be reduced over time. Practice alternative self-soothing and calming activities. Refer to the individual positive behaviour support plan.

Sometimes stimulating senses other than taste and feel can help distract from eating inedible objects. One study showed that auditory stimulus (music) helped distract a child from Pica behaviours (reference 11).

Risk Assessment

Risk assessments must consider the various factors discussed above, particularly environmental considerations. Risk assessments must consider every environment that the person we support accesses through the National Autistic Society, such as buildings, outdoor spaces, and the community.

Risk assessments should consider what staff supervision the person we support may need to keep them safe.

Risk assessments should be highly personalised and consider any cooccurring conditions that increase the person we support's risks associated with eating inedible objects, such as a history of choking or allergies.

Standard risk assessment good practice applies, such as collaboration with the person we support, family, and staff who know the person well to ensure as holistic and relevant an assessment as possible.

Risk assessments scoring high or above after mitigating steps should be escalated via the appropriate channels (i.e. for Adults Services, Risk Escalation Panel or for Schools, escalation to the Clinical Leads and Director of Education and Children's Services).

Record Keeping

All incidents involving Pica behaviour or the eating/ingesting/swallowing of inedible objects/items must be recorded in your service's incident reporting system, within 24 hours of the incident. General incident recording good practices are important, but it is also important that the narrative should focus on:

1. Exactly what happened (a factual account) including a precise description of the item and where it was found.
2. Whether the item was mouthed, chewed, or swallowed.
3. What methods staff tried to prevent the item being eaten (in line with an individual's support plan, where there had been time / ability to do so) and why this was not effective.
4. What behavioural or alternative response had been used and the reasoning for this action.
5. How long the episode lasted.
6. The outcome of the response used.
7. Any other outcomes of the item being eaten, such as choking or regurgitation.
8. The steps taken to ensure the health and wellbeing of the person we support (such as first aid, calling 111 or attending A&E).
9. The debrief provided to the person we support.
10. The steps taken to avoid a repeat of the same incident in the future, such as updating the risk assessment or increasing environmental checks.
11. Any injury to the individual supported or staff members as a result of an intervention must be fully recorded and medical assistance sought as required.
12. Any use of a planned/unplanned restrictive practices must be discussed with the manager of the service and the staff and individual fully debriefed.

Case Study Example – Recording Good Practice

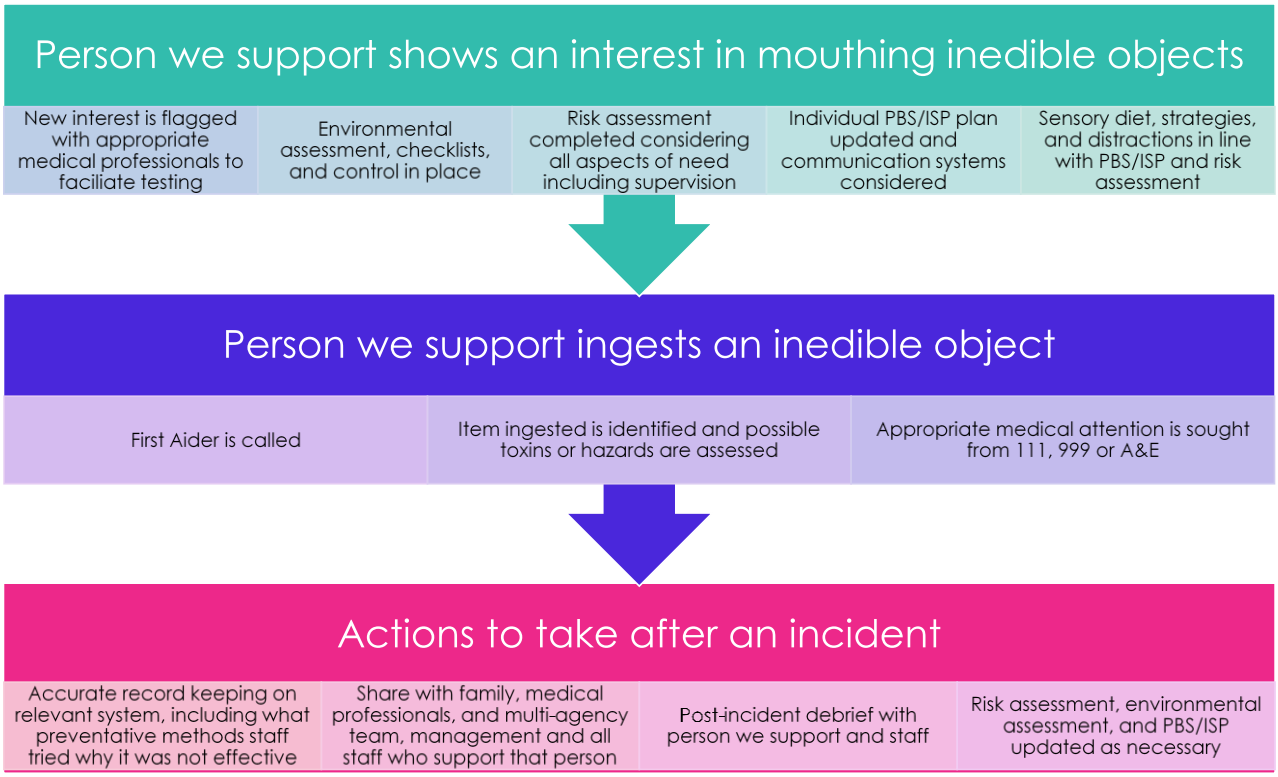
On Monday 10th April 2022 at 14:45, Jeremy was on a walk through Queen's Park with support workers Anna Jones and Colin Brown. Jeremy became interested in the daffodils that were in bloom. Anna attempted to distract Jeremy with the swings as this is an activity he enjoys. However, Jeremy remained interested in the daffodils and picked one which he quickly put in his mouth. Jeremy has eaten paper and fabrics before but not flowers. Colin prompted Jeremy to spit it back out which he did immediately. On inspecting the daffodil, it did not appear as though any had been swallowed. The daffodil was in Jeremy's mouth for approximately 20 seconds. Jeremy appeared well in himself and presented as calm. Colin asked Jeremy if he felt okay and Jeremy nodded. Anna explained to Jeremy that we needed to make sure he would be okay and so contacted manager Maria by telephone for advice whilst Jeremy returned home with Anna and Colin.

Maria identified online that '*All parts of the daffodil are toxic. When swallowed, it can cause nausea, vomiting, diarrhea, and abdominal pain. Eating the bulb can cause severe irritation of the mouth and stomach upset. These symptoms are usually not life threatening and resolve within a few hours*' (Information from https://www.poison.org/articles/daffodils). Therefore, Maria advised Anna to contact 111 for advice. 111 advised that as the daffodil had not been swallowed, Jeremy did not need to go to hospital on this occasion and should be monitored at home for any symptoms. Anna and Colin explained to Jeremy that he might feel some pain

in his stomach or mouth, or feel sick, and that if he did feel like this, he could point to what was hurting to tell them so. Jeremy nodded to confirm he had understood this and demonstrated pointing at his stomach.

Anna asked Jeremy if it was okay to tell his mum and dad, doctor, and other people about the daffodil and he nodded. Maria contacted Jeremy's parents, GP, and therapeutic team to advise them of this incident. Staff will update Jeremy's risk assessment and care plan to consider this new interest in eating flowers. Jeremy's care plan will be updated to consider this incident and adjust the walking route through the park in future.

Inedible Objects Flowchart



Actions Following an Incident of Eating Inedible Objects

An effective management approach and in line with the NAS policy on use of Positive Behaviour Support (SO-0029) ought to be aimed at preventative and proactive responses:

1. As discussed above, medical advice must be sought for any new behaviour in order to eliminate non-behavioural causes such as vitamin deficiencies or pain.
2. Any incident follow-up should include a debrief with the person we support, appropriate to their understanding and communication, to support them emotionally and to explore the incident from their perspective.
3. A review of all risk assessments pertaining to that individual must be undertaken to include the behaviour supported by the use of an unplanned restrictive practice.
4. Risk assessments must consider the various factors considered above, particularly environmental considerations. Risk assessments must consider every environment that the person we support accesses through the National Autistic Society, such as

buildings, outdoor spaces, and the community. Risk assessments scoring high or above after mitigating steps should be escalated via the appropriate channels (i.e. for Adults Services, High Risk Panel).

5. A review of the individual behaviour support plan and changes made to support as required.
6. Staff should consider arranging a multi/trans-disciplinary meeting including the person we support, family members, staff who know the person well, and clinical specialists, to share knowledge and skills to explore creative ways of keeping the person safe. These could include successful distraction techniques, insights into motivations, and other strategies.
7. Where non-physical interventions are not sufficient to prevent clear imminent and immediate danger, Studio III / PBM consultancy service may approve and train staff in the use of a bespoke Restrictive Physical Intervention (RPIs). In such cases these should be documented within the ISPs/PBPSs and only used for the individual concerned. RPIs that have not been approved by the relevant training agency should not be included as part of a planned intervention. For the use of any RPI, the mental capacity of the person (if they are aged over 16 years and resident in England, Wales or Northern Ireland) must be considered. If they lack mental capacity to consent to the use of RPI, then a best interest's decision must be made authorising the use of the RPI before it can be included within the plan, and a record kept of this decision.
8. Any changes to training for a person we support should be based on the person we support's Risk Management and Restraint Reduction plan, and training needs assessment and agreed in line with policy and protocols (Restraint Reduction Network).
9. Staff should be trained in carrying out any changes to an individual support plan.
10. All staff coming into contact with the person we support need to be appropriately alerted to the risk of inedible objects being eaten.
11. All eating inedible objects risks should be noted on the school or service's clinical risk register.

References

1. Use of Restrictive Practice in NAS Schools and Services (Policy and Procedure)
2. Positive Behaviour Support in Schools and Services Policy
3. Mental Capacity (England & Wales) Act 2005
4. Adults with Incapacity (Scotland) Act 2000
5. Mental Capacity (Northern Ireland) Act 2016
6. Human Rights Act 1998
7. International Classification of Diseases 11th Revision
8. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013)
9. Positive and Proactive care: reducing the need for restrictive interventions (April 2014) Department of Health
10. Restraint Reduction Network
11. Rapp, John & Dozier, Claudia & Carr, James. (2001). Functional assessment and treatment of pica: A single-case experiment. Behavioral Interventions. 16. 111 - 125.
12. Poisons.org

Appendix I - Summary of Changes Made January 2024

New Page	Old Page (where different)	Section	Change
N/A		N/A	Formatting and spaces made consistent throughout to remove unnecessary spacing after section headings
1		Table	Fixed capitalisation of table headings
1		Table	Updated review date and version number
1		Contents	Contents page refreshed
1		Definition	Section re-ordered, some content split out into new subsequent section
2		What is Pica	New section
2		What is Pica	Addition of The International Classification of Diseases 11th Revision definition
2		What is Pica	Additional emphasis on diagnosis not being within NAS staff remit
2		Duty of Care	Deletion of repetition of 'is behaviour'
2		Duty of Care	Multidisciplinary section reworded to more generally refer to internal and external professionals
2		Duty of Care	Risk assessment split out into new paragraph
3	2	Duty of Care	24-72 hours reformatted to remove unnecessary spacing
3	2	Assessments and Interventions	Addition of word 'positive' before behavioural interventions
3		Assessments and Interventions	Addition of 'trans' to multi/transdisciplinary (transdisciplinary is language used in NAS schools)
3		Medical Investigation	Addition of reminder of document's definition of 'eating' to first sentence
3		Medical Investigation	Rewording of paragraph on medical causes for simplicity/understanding
3		Medical Investigation	Physiological arousal separated into new paragraph
4		Environmental Considerations	Addition of 'audits' and 'assessment of...'
4		Environmental Considerations	Indentation of bullet points adjusted
5	4	Communication Considerations	Addition of 'or other appropriate tool' after communication passport
5		Sensory Considerations	Reference number updated
5		Risk Assessment	Addition of 'for Adults Services' before High Risk Panel to contextualise for other directorates

5		Risk Assessment	Change of name of High Risk Panel to Risk Escalation Panel
5		Risk Assessment	Addition of example of 'for Schools, escalation to the Clinical Leads and Director of Education and Children's Services'
8		Actions Following an Incident of Eating Inedible Objects	Point 4 - Addition of 'for Adults Services' before High Risk Panel to contextualise for other directorates
8		Actions Following an Incident of Eating Inedible Objects	Point 6 - Addition of 'trans' to multi/transdisciplinary (transdisciplinary is language used in NAS schools)
8		Actions Following an Incident of Eating Inedible Objects	Point 7 – Rephrased to current Restraint Reduction Network language around imminent danger
8		References	References updated to include DSM-5 and ICD 11