Tees, Esk and Wear Valleys
NHS Foundation Trust

Blanket restrictions: Policy on the use of Global Restrictive Practices (Blanket Restrictions) in In-Patient Units

Ref: CLIN-0089-v2

Status: Ratified

Document type: Policy

Contents

1 Introduction

This policy describes the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within Tees, Esk and Wear Valleys NHS Foundation Trust. Whilst the drive for the Trust is to minimise the need for Blanket Restrictions, this policy describes the governance process when such restrictions are deemed necessary, justifiable and proportionate.

2 Why we need this policy

2.1 Purpose

The Trust is committed to ensuring that least restrictive practice is observed at all times. This is in line with Department of Health guidance: *Positive and Proactive Care: reducing the need for physical interventions (2014)* and the Mental Health Act Code of Practice (2015). It is also to ensure that the Trust is compliant with its regulated activities as monitored by the Care Quality Commission (the relevant regulations being regulation 13 and 17).

Blanket restrictions are actions on the ward that are applied routinely to all patients without individual risk assessments to justify such application, whether temporary or long term. Even when applied "justifiably", such measures must be necessary and proportionate to the identified risks.

2.2 Objectives

- Each ward area will operate procedures and protocols that match the needs of the patient group, to ensure therapeutic progress whilst minimising risks.
- Wherever possible, the least restrictive option principle shall be observed in order to maximise patient independence and experience.
- Where an individual needs a greater degree of restriction than would be usually observed in a particular ward, this is individually risk assessed, discussed with the patient, clearly documented and regularly reviewed.
- Where a ward area needs to operate a blanket restriction over and above that authorised across the Trust, this should be done for the shortest reasonable time and be monitored and reviewed through local governance arrangements. If the blanket restriction needs to be in operation for an indefinite period, this should be registered at LMGB.
- There must be a transparent and open culture of such Blanket Restrictions and a robust review, monitoring, escalating/ communicating and recording system (such as register, restrictive practice tool and grid) need to be in place.
- Wards, services and the Trust have a systemic approach to identify and challenge its practices that may amount to blanket restrictions, with a view to ensuring that care and treatment is provided according to the principle of using the least restrictive option and maximising independence

3 Scope

3.1 Who this guidance applies to

This policy applies to all clinical staff working within Trust in-patient areas.

4 Definitions

Term	Definition
Restrictive interventions	Defined as deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: • Take **immediate control** of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and • End or reduce significantly the danger to the person or others; and • Contain or limit the person's freedom for no longer that is necessary. Examples of restrictive interventions include: • Physical interventions • Rapid tranquillisation • Seclusion These are covered by the relevant Trust policies and procedures.
Restrictive practices	Those practices that limit an individual's movement, liberty and/or freedom to act independently in order to **maintain** the safety and security of service users, staff and the site. This policy provides guidance regarding Restrictive Practices. Examples of restrictive practice include: • Room searches and rubdown searches. • Access to courtyards, kitchens and calm rooms. • Monitoring of communications and visits. • Use or bringing on the ward of contraband items
Blanket restriction	**A blanket restriction** refers to the rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or classes of patients, or within a service, without individual risk assessments to justify their application.

5 Blanket restrictions

5.1 The need for blanket restrictions

Blanket restrictions are rules or policies that restrict a patient's liberty and other rights, which are routinely applied without individual risk assessments to justify their application. As a consequence, they can potentially violate Article 8 of the European Convention on Human Rights (ECHR) – the right to respect a person's private life.

The 2015 Mental Health Act Code of Practice allows for the use of blanket restrictions only in certain very specific circumstances e.g. in order to maintain the safety and security of the site, service users and staff.

Blanket restrictions must be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records.

Any blanket restriction should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an identified risk; they should be applied for no longer than can be shown to be necessary.

⚠ No form of blanket restriction should be implemented unless expressly authorised on the basis of this policy and subject to local accountability and governance arrangements (see paragraph 8.9 Mental Health Act Code of Practice).

The impact of a blanket restriction will be regularly reviewed through the Trust's governance processes.

5.2 Authorised Trust-wide blanket restrictions

Working within the policy of the Mental Health Act, Mental Capacity Act, including Liberty Protection Safeguards, and associated Codes of Practice, the Trust aims to balance human rights with the safety of its service users.

The Hospital Managers, through agreement at Executive Management Team and the Trust Board, have authorised the following blanket restrictions as being appropriate and proportionate to the safe provision of care within all in-patient services:

Blanket restriction	Rationale
No smoking on Trust premises	The rationale regarding smoking not being permitted on Trust property can be found in the Nicotine Management Policy. The policy supports the NICE "Smoking Cessation in Secondary Care" recommendation that all secondary care buildings and grounds are smoke free.
No smoking when on escorted leave	On escorted leave, service users are not allowed to smoke as there no evidence as to the safe distance to protect our staff from second hand smoke exposure (see the Nicotine Management Policy).
No alcohol on Trust premises	Alcohol is not allowed as: • It can undermine the person's treatment programme. • It can be a significant destabiliser for a person's mental

	health, negatively impacting on recovery • It can be a disinhibitor for aggressive and violent behaviour and/or self harm placing the service user and others at potential harm. • It can interact negatively and potentially dangerously with prescribed medication and other drugs. • It can be used to trade with or to coerce other people. • Once on a unit its onward distribution cannot be controlled.
No illicit drugs on Trust premises	Illicit substances are not allowed as: • Possession and distribution can constitute a criminal offence • It can undermine the person's treatment programme. • It can be a significant destabiliser for a person's mental health, negatively impacting on recovery • It can be a disinhibitor for aggressive and violent behaviour and/or self harm placing the service user and others at potential harm. • It can interact negatively and potentially dangerously with prescribed medication. • It can be used to trade with or to coerce other people. • Once on a unit its onward distribution cannot be controlled.
No New Psychoactive Substances (NPS or "legal highs") on Trust premises	NPSs are not allowed as: • They have unpredictable effects on physical and mental health. • They can be a significant destabiliser for a person's mental health, negatively impacting on recovery • They can be a disinhibitor for aggressive and violent behaviour and/or self harm placing the service user and others at potential harm. • They can interact negatively and potentially dangerously with prescribed medication. • They can be used to trade with or coerce other people. • Once on a unit its onward distribution cannot be controlled.
No illegal pornographic material on Trust premises	Pornographic material can be highly offensive to other service users. However the Trust respects the right for individuals to access mainstream pornography – this should be within a private area. When mentally unwell, behaviour can be disinhibited, and the use of sexually stimulating material may lead to sexualised acts that are offensive and may constitute an offence. Pornographic material may undermine specific treatment programmes e.g. for those admitted due to sexual and/or violent offences. Once on a unit its onward distribution cannot be controlled.

No weapons, including knives and firearms, onto Trust premises	The Trust has a duty to ensure the safety of staff and users of its services. No firearm, even if legally held, will be allowed on Trust premises. Regarding knives, it is recognised that some individuals may wish to hold a knife for religious reasons. This will be discussed with the service user and an individualised risk assessment agreed and updated on a regular basis.
All doors into clinical areas will be locked	A safe and protective environment for patients, staff and visitors within in-patient areas is of the utmost importance to the Trust. To support this, access to and exit from in-patient areas needs to be managed. All main access points to bed-based clinical areas will have a system so that access and exit is managed by clinical staff and on a request basis. This is covered within the Controlling Access to and Exit from Inpatient Areas policy. A patient's article 8 rights should be protected by ensuring any restriction on their contact with family and friends can be justified as being proportionate and in the interests of the health and safety of the patient or others.
Access to courtyards and outdoor spaces at night	In order to maintain a safe ward environment at night access to outside courtyard areas will be restricted. A ward will have the ability to open up outdoor courtyards at night on an individual or group basis depending upon the specific circumstances at the time, as long as they can be assured that staffing arrangements allow this to be done safely.

6 Authorization and monitoring of restrictions on a specific unit

6.1 What should not form part of a blanket restriction

The expectation is that the following will NOT be subject to a blanket restriction (possible exceptions may apply to secure units – see section below):

- Access to (or banning) mobile phones (and chargers)
- Access to the internet
- Incoming and outgoing mail
- Visiting hours
- Access to money or the ability to make purchases
- Taking part in preferred activities

The Mental Health Act Code of Practice (2015) states that such restrictions "have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights".

6.2 Implementing a blanket restriction on a specified ward area

There may be occasions when it is necessary for the safe running of a unit that a blanket restriction be implemented. Examples of times where there may be a blanket restriction in place for a specific ward area or unit can include the following:

- Access to certain service-user areas, due to environmental risks that cannot be individually risk managed.
- Access to certain snacks and foods due to a service user having a severe food allergy.
- Access to takeaways limited to a certain frequency.

The expectation is that the need for such a blanket approach to manage the situation be fully explored before implemented, and include senior staff such as modern matrons and/or locality managers. If an alternative cannot be identified and the blanket restriction is still deemed necessary, ensure the following:

- All affected service user must be made aware of why the decision was made. Any impact the restriction may have on the service user should be documented in the electronic patient record.
- There is clear plan as to how the blanket restriction will be safely terminated, and the likely timescales involved.
- The decision should be escalated through normal line management arrangements at least to the level of the locality Head of Service for immediate approval. If in the judgement of the Head of Service this should be escalated further, an exception report can be made to the locality Director of Operations to report to EMT.
- The decision should in all cases be reviewed at the next QuAG. Monitoring and review mechanisms should be agreed and documented, in particular regarding progress towards the termination of the blanket restriction. QUAG will routinely report the use of blanket restrictions to Locality Management and Governance Boards who will in turn include their blanket restriction register in their respective reports to QuAC.
- QUAGs and/or LMGBs are to keep a register of blanket restrictions in place in order that the extent of any blanket restrictions are transparent and can be regularly reviewed as appropriate.

6.3 Secure Services

Recognised in the Code of Practice is that within Secure Services restrictions may form part of the broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security. Under such circumstances, blanket restrictions are permissible in order to manage high levels of risk to other patients, staff and members of the public.

The Secure In-patient Service operates an associated policy which specifically covers the range of potential blanket restrictions which may at any time operate in some or all of its in-patient units, as well as the governance arrangements around their use (Guidance on the use of Restrictive Practices within the Forensic Service).

See CQC guidance for blanket restrictions-
https://www.cqc.org.uk/sites/default/files/20170109_briefguide-blanket-restrictions.pdf

Even with this guidance it is very important to consider all aspects of Governance, involving patients and whether the blanket nature of restrictions is necessary and efforts to continually move away from such restrictions at the earliest and safest possible way must be made.

7 Governance arrangements

7.1 Management of the restrictive practice policy

Oversight and approval of the policy will be by the Trust Board, in accordance with the remit of that group and on behalf of the hospital managers.

Matters can be brought to the attention of the Executive Management Team on an exceptional basis should urgent consideration be required of a potential blanket restriction. The Executive Management Team meets weekly.

7.2 Local accountability

Responsible Clinicians are accountable for ensuring that patients are in the least restrictive environment and not subject to unnecessary restrictions.

Ward Managers are responsible for ensuring that blanket restrictions are only applied when required, are used for the minimal period of time they are needed for and are not in place to either punish patients or in response to inadequate staffing. In coming to such a determination, the Responsible Clinicians and Modern Matron for that ward area should be consulted. Wards should escalate the imposition of a blanket restriction through established routes e.g. huddles/supercells and Locality Quality Assurance Groups (QuAGs). It is good practice to keep a record of any blanket restriction (start date, end date, rationale, escalation route).

QuAGs have the authority to agree of otherwise a blanket restriction. If following review a blanket restriction is not agreed, the blanket restriction must be immediately terminated. If a blanket restriction is agreed, how the need for the ongoing restriction will be monitored will be agreed by the QuAG as will the plan to how the blanket restriction can be safely terminated. Blanket restrictions should be routinely reported from QuAGs to Locality Management and Governance Boards (LMGBs).

Directors of Operations will ensure that the Trust's Quality Assurance Committee will have sight of the use and impact of any exceptional blanket restrictions within their locality as part of the report provided through LMGB.

Any unauthorised blanket restriction identified by the CQC during inspections or monitoring visits should be addressed by the Provider Action Statement (PAS) and associated action plans and inform future such practices. CQC compliance action plans are monitored and overseen by the Trusts CQC Compliance Group.

Mental Health Act Reviewer Provider Action Plans should be considered at the Mental Health Legislation Steering Group and Restrictive Practice groups where they additionally exist (Secure Services for example).

8 References

Care Quality Commission – Brief Guide – Blanket Restriction on In-Patient Wards
Mental Health Act 1983 (MHA) and MHA Code of Practice (2015) Mental Capacity Act 2005 (MCA) and MCA Code of Practice
Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) and DoLS Code of Practice
Cheshire West and Chester Council v P[2014] UKSC 19, [2014] AC 896

APPENDIX 1: Relevant CQC Guidance

Evidence required by inspectors during an inspection

Inspectors will establish whether the service can give a clear account of why any blanket restriction is necessary and proportionate, and staff can demonstrate that:

- there is a systematic, regular review of any blanket restriction that is not an inherent part of the ward security;
- where the blanket restriction is an inherent part of the ward security, staff are permitted to consider relaxing it when it is inappropriate to the care of an individual patient and will not compromise the overall security of the service; and the ward takes a systemic approach to identify and challenge its practices that may amount to blanket restriction, with a view to ensuring that care and treatment is provided according to the principle of using the least restrictive option and maximising independence (COP, Ch. 1).

On wards where staff prohibit or restrict patients' access to items, and especially to items that would not normally be prohibited or restricted, the service should have a set of auditable standards for:

- How items are identified and what risk assessment is required
- What information about the restrictions and reasons is provided to patients and visitors
- How adherence is monitored (training, monitoring, managing breaches)
- Arrangements for audit and review

Reporting

1. In the '**assessing and managing risk to patients and staff**' section of the 'safe domain' inspectors will expect staff can state what blanket restrictions are in place, whether any are unwarranted, and/or whether there is a systematic, regular review of any blanket restriction that is not an inherent part of the ward security.
2. Under '**good governance'** in 'well-led' report on the quality of the provider's oversight of its blanket restrictions and the support provided to staff to actively review and manage these. No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of the organisation's policy and subject to local accountability and governance arrangements (Code of Practice 8.9).

Mental Health Act Code of Practice

The impact of a blanket restriction on each service user should be considered and documented in the patients' record (Ch 8.5 MHA CoP)

Sometimes restrictions are needed for risk management in relation to one or more service users, resulting in blanket restrictions which unnecessarily impact on others who do not need such restrictions. For the other individuals affected, consideration should be given to how they are affected by these restriction, whether these effects could be mitigated and the legal frameworks that are being used (see below). It may be appropriate to consider whether it is still appropriate for these individuals to share an environment.

Restrictions should never be introduced or applied in order to punish or humiliate but only ever as a proportionate and measured response to an identified and documented risk; they should be applied for no longer than can be shown to be necessary. (Ch 8.6 MHA CoP).

Blanket Restrictions

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Blanket restrictions are rules or policies that **restrict a patient's liberty and other rights**, and are routinely applied (usually for all patients in the ward/service) **without individual risk assessments** to justify their application.
No form of blanket restriction should be implemented unless **expressly authorised** and **subject to local accountability and governance** arrangements, as set out in the Trust blanket restrictions policy and summarised in the flowchart below.

Is the proposed restriction a *blanket restriction*?

Yes (applies to whole ward/service)

- Escalate to Head of Service level immediately.

No (individualised)

- Trust blanket restrictions policy does not apply .

Has the decision to implement this blanket restriction been agreed at Head of Service level or above?

Yes

- The agreed restriction can be implemented.
- The decision to impose the restriction must be reviewed at the next QuAG.
- Discuss in the next ward level meetings and patient community meetings, and forward minutes to QuAG.
- Record on the ward blanket restriction register.
- All affected patients should be informed and the potential impact documented on PARIS.
- In Secure Services: Update the register, grid and tool for individuals, record impact on patient and agree review period.

No

- **Do not impose the restriction**.
- If already imposed, immediately suspend the restriction and inform patients and staff.

Has the decision to implement this blanket restriction been approved on review by QuAG?

Yes

- QuAG will agree and document monitoring and review mechanisms including a clear plan as to how the blanket restriction will be safely terminated, and report to LMGB.
- If the blanket restriction is likely to be long term and has been imposed in response to the needs of one or two patients, their placement and the level of security needed for their management must be reviewed.

No

- **Suspend the restriction** and inform patients and staff.

Consider the following questions for all restrictions and report to Head of Service:

- What is the rationale for imposing the restriction?
- Have least restrictive options been considered?
- Is the restriction necessary, proportionate and justified?
- Who authorised the restriction?
- What impact will the restriction have on the patients?
- What is the balance of benefit and risk of imposing this restriction?
- Have risks and benefits been discussed with the patients?
- What are the patients' and carers' views and have they been recorded?
- What changes can be made to help lift the restriction?
- When will the restriction be reviewed? What is the review frequency? Who is responsible for ensuring the review takes place? Are review plans documented?

References: TEWV Blanket Restrictions Policy; Mental Health Act 1983: Code of Practice 2015 (CQC).

9 Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Trust-wide					
Name of responsible person and job title	Dr Ahmad Khouja, Medical Director					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Ahmad Khouja, Medical Director Elizabeth Moody, Director of Nursing and Governance Jen Illingworth, Director of Governance Ruth Hill, Chief Operating Officer Santosh Kumar, Clinical Director, Secure Inpatient Services					
Policy (document/service) name	Framework on the use of Restrictive Practices within the Forensic Service					
Is the area being assessed a…	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			✓	Code of practice	
	Other – Please state					
Geographical area covered	Trust-wide in-patient areas					
Aims and objectives	Compliance with Code of Practice regarding restrictive practice / blanket restrictions					
Start date of Equality Analysis Screening (This is the date you are asked to write or	30.07.19					

review the document/service etc.)	
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	30.07.19

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay or Tracey Marston on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Detained patients within forensic services					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s Standardises process and removes variation in practice. Ensures managed within a governance framework.				
3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	✓ CQC and CoP	**No**	
Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)		
4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership				
Yes – Please describe the engagement and involvement that has taken place				
Have engaged with service users via the restrictive practice workstream.				
No – Please describe future plans that you may have to engage and involve people from different groups				

5. As part of this equality analysis have any training needs/service needs been identified?					
No	Please describe the identified training needs/service needs below				
A training need has been identified for;					
Trust staff	Yes/No	Service users	Yes/No	Contractors or other outside agencies	Yes/No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: **Dr A Khouja**				Date: **30.07.19**	
Your reporting (line) manager: Type name:				Date:	

10 Document control

Date of approval:	26 February 2020	
Next review date:	26 February 2023	
This document replaces:	Policy for managing blanket restrictions CLIN-0089-v1.1	
Lead:	Name	Title
	Dr Ahmad Khouja	Medical Director
Members of working party:	Name	Title
This document has been agreed and accepted by: (Director)	Name	Title
	Elizabeth Moody	Director of Nursing and Governance
This document was last reviewed by:	Name of committee/group	Date
	Patient safety group	20 January 2020
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	26 February 2020
An equality analysis was completed on this document on:	30 July 2019	

Change record

Version	Date	Amendment details	Status
1	07 Jun 2017	New policy	Withdrawn
1.1	04 Apr 2018	5.2 wording added re access to courtyards and outside spaces at night	Withdrawn
2	26 Feb 2020	Updated v 1.1 to provide additional guidance on escalation and monitoring processes. (Please note the publication of this version was delayed in error and was actually published on 17 February 2021 and not in Feb 2020.)	Published