Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

Ref: CLIN-0089-v1.1

Status: Ratified

Document type: Policy

Contents

1 Introduction....3
2 Why we need this policy....3
2.1 Purpose....3
2.2 Objectives....3
3 Scope....3
3.1 Who this guidance applies to....3
4 Definitions....4
5 Blanket restrictions....4
5.1 The need for blanket restrictions....4
5.2 Authorised Trust-wide blanket restrictions....5
6 Authorisation and monitoring of restrictions on a specific unit....7
6.1 What should not form part of a blanket restriction....7
6.2 Implementing a blanket restriction on a specified ward area....8
6.3 Secure Services....8
6.4 Individualised approaches to risk-based care planning....8
7 Governance arrangements....9
7.1 Management of the restrictive practice policy....9
7.2 Local accountability....9
8 References....9
9 Equality Analysis Screening Form....10
10 Document control....14

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.

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.

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 usually observed in a particular ward, this is risk assessed, discussed with the patient, clearly documented and 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.

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 other persons 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 (MOVA - management of violence and aggression) • 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 the site, service users and staff. 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.
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. The 2015

Mental Health Act Code of Practice allows for the use of blanket restrictions only in certain very specific circumstances.

Blanket restrictions should 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.

Within secure services, blanket restrictions can form part of the broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public (paragraph 8.8 Mental Health Act Code of Practice). This is governed through a separate document: Policy on the use of Restrictive Practices within the Forensic Service.

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 policy.

5.2 Authorised Trust-wide blanket restrictions

Working within the policy of the Mental Health Act, Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS), 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 behavior 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 behavior 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 behavior 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, behavior 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 ay 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 Authorisation 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 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.
- The decision should be escalated through normal line management arrangements at least to the level of the locality Head of Service. 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. QUAG will report the use of blanket restrictions to Locality Management and Governance Boards.
- QUAGs and/or LMGBs may wish to consider keeping 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 Forensic 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 (Policy on the use of Restrictive Practices within the Forensic Service).

6.4 Individualised approaches to risk-based care planning

A service user would normally have access all the activities and opportunities associated with that unit. However, for clinical and/or risk-based reasons, it may be appropriate for an

individual service user not to have to access to one or more of those activities. This decision must be based upon a multi-disciplinary risk assessment, with a clear rationale why it is not appropriate at the current time, and when restrictions will be reviewed.

The service user must be made fully aware of why the decision was made, as well as how and when it is to be reviewed. This discussion will be documented on the Electronic Patient Record, as well as the impact the restriction may have on the service user.

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

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 QUAGs.

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 bimonthly report provided through Locality Management and Governance Boards.

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

8 References

Mental Health Act 1983: Code of Practice 2015.

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.	Forensic					
Name of responsible person and job title	Dr Ahmad Khouja, Deputy Medical Director					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Forensic SDG					
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	Forensic Locality - Ridgeway Secure Services					
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	17.11.16					

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)	17.11.16

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

<table>
<tr><td colspan="6">5. As part of this equality analysis have any training needs/service needs been identified?</td></tr>
<tr><td>No</td><td colspan="5">Please describe the identified training needs/service needs below</td></tr>
<tr><td colspan="6">A training need has been identified for;</td></tr>
<tr><td>Trust staff</td><td>Yes/No</td><td>Service users</td><td>Yes/No</td><td>Contractors or other outside agencies</td><td>Yes/No</td></tr>
<tr><td colspan="6">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</td></tr>
<tr><td colspan="5">The completed EA has been signed off by:
You the Policy owner/manager:
Type name: Dr A Khouja</td><td>Date:
17.11.16</td></tr>
<tr><td colspan="5">Your reporting (line) manager:
Type name:</td><td>Date:</td></tr>
</table>

10 Document control

Date of approval:	07 June 2017	
Next review date:	07 December 2020	
This document replaces:	N/A	
Lead:	Name	Title
	Dr Ahmad Khouja	Deputy Medical Director
Members of working party:	Name	Title
This document has been agreed and accepted by: (Director)	Name	Title
	Brent Kilmurray	Chief Operating Officer
This document was last reviewed by:	Name of committee/group	Date
	Patient safety group	15 May 2017
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	07 June 2017 Minor amendment ratified 04 Apr 2018
An equality analysis was completed on this document on:	17 November 2016	

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	Published
1.1	02 June 2020	Review date extended from 07 June 2020 to new date of 07 December 2020	Published