Cheshire and Wirral Partnership
NHS Foundation Trust

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BLANKET RESTRICTIONS: GUIDANCE ON THE USE OF GLOBAL RESTRICTIVE PRACTICES (BLANKET RESTRICTIONS) IN INPATIENT UNITS

Lead executive	Director of Nursing, Therapies Patient Partnership
Authors details	Director of Nursing, Therapies and Patient Partnerships

Type of document	Guidance
Target audience	All inpatient staff
Document purpose	These guidelines describe the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use within inpatient areas within Cheshire and Wirral Partnership NHS Foundation Trust including the governance process that is required when such restrictions are deemed necessary, justifiable and proportionate.

Approving meeting	Clinical Practice and Standards Sub Committee	Date 20 May 2021
Implementation date	31 May 2021	

CWP documents to be read in conjunction with	
GR43	Low Secure Unit Operational Procedure
MH1	MHL Policy Suite
AM4	Psychiatric Intensive Care Unit (PICU) Security policy

Document change history	
What is different?	n/a
Appendices / electronic forms	Blanket restriction register
What is the impact of change?	n/a

Training requirements	Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Medical Director, Ward Managers, Bed Based Service Matrons
Corporate services	Clinical Practice and Standards Sub Committee
External agencies	NA

Financial resource implications	None

External references
1. Care Quality Commission – Brief Guide – Blanket Restriction on Inpatient Wards cqc blanket restrictions

2. Mental Health Act 1983 (MHA) and MHA Code of Practice (2015)
   https://www.legislation.gov.uk/ukpga/1983/20/contents
   https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

3. Mental Capacity Act 2005 (MCA) and MCA Code of Practice Mental Capacity Act
   https://www.legislation.gov.uk/ukpga/2005/9/contents
   https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

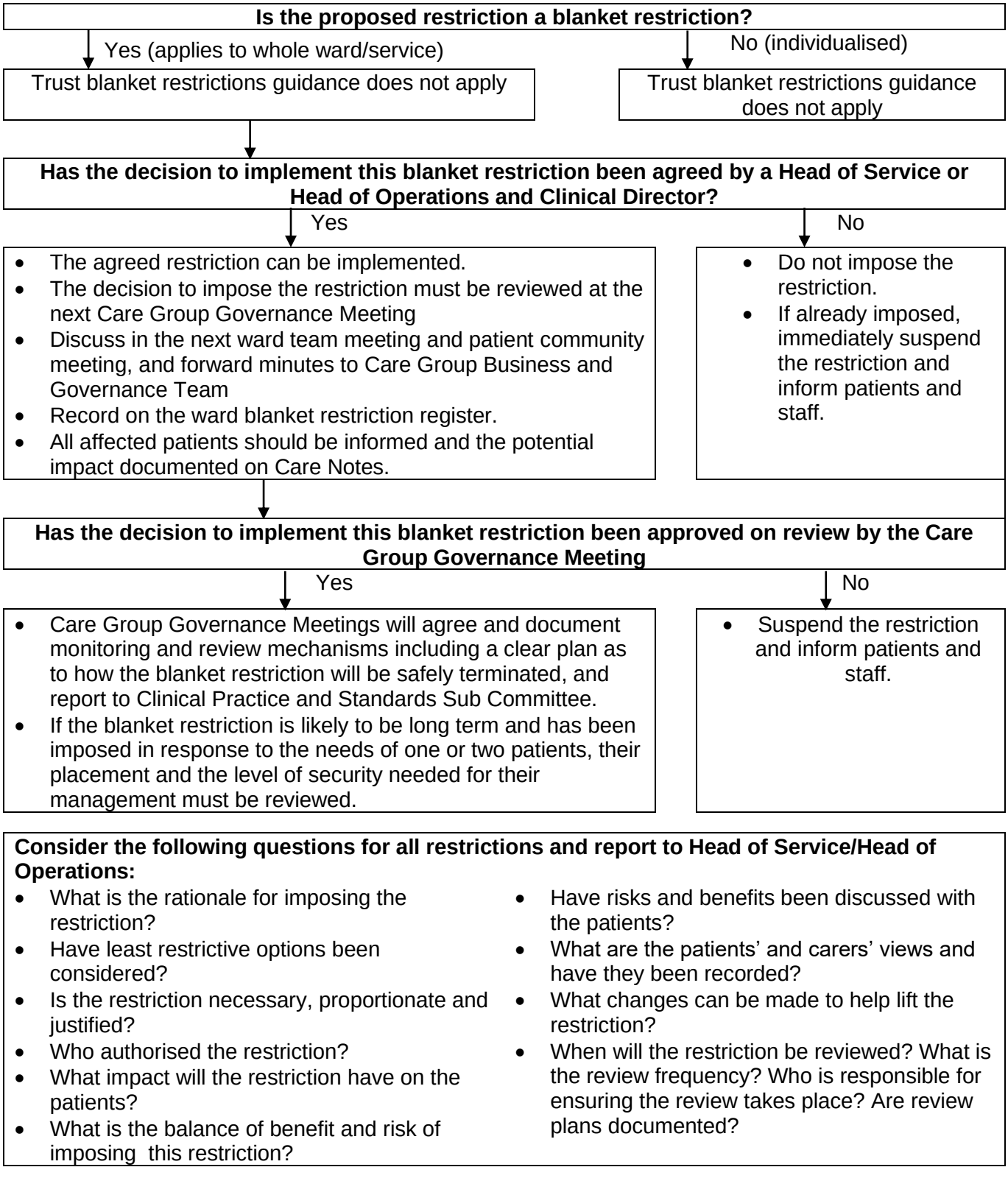
4. Deprivation of Liberty Safeguards (DoLS) and DoLS Code of Practice Cheshire West and Chester Council v P[2014] UKSC 19, [2014] AC 896
   https://www.scie.org.uk/mca/dols
   https://www.cheshirewestandchester.gov.uk/your-council/policies-and-performance/deprivation-of-liberty-safeguards.aspx

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No No No No	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart

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.



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

- 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?

1. Introduction

This guidance describes the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use within inpatient areas within Cheshire and Wirral Partnership NHS Foundation Trust. Whilst the drive for the Trust is to minimise the need for Blanket Restrictions, this guidance describes the governance process when such restrictions are deemed necessary, justifiable and proportionate.

2. Why we need this guidance

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 inpatient 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/unit, this is individually risk assessed, discussed with the patient, clearly documented and regularly reviewed.
- Where a ward/unit 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 approved at Clinical Practice and Standards Sub Committee (CPSSC).
- There must be a transparent and open culture of such Blanket Restrictions and a robust review, monitoring, escalating/ communicating and recording system need to be in place.
- Inpatient areas, Care Groups and the Trust have a systematic 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 inpatient 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 • Clinical restraint • Mechanical restraint • Seclusion • Segregation
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 patients, staff and the site. This policy provides guidance regarding Restrictive Practices. Examples of restrictive practice include: • Room searches and pat down searches • Restricted access to courtyards and kitchens • Monitoring of communications and visits • Prohibited use or bringing on the ward 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 groups 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, patients 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 patients.

The Trust have authorised the following blanket restrictions as being appropriate and proportionate to the safe provision of care within all in-patient services in line with the CQC's Brief Guide on Blanket Restrictions within Inpatient 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, patients 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 patient 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 patient 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	**NPS's are not allowed as:** • They have unpredictable effects on physical and mental health. • 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 patient 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 illegal pornographic material on Trust premises	Pornographic material can be highly offensive to other patients. 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 patients. 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 patient 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 inpatient areas is of the utmost importance to the Trust. To support this, access to and exit from inpatient 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 outlined in the Securing or locking of access doors within inpatient areas policy CP36 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 outdoor spaces at night	In order to maintain a safe ward environment at night access to outside areas will be restricted. A ward will have the ability to open up outdoor spaces 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.
No fire hazard items (flammable liquids, matches, incense)	Fire is a potential hazard in all inpatient areas which are also high life risks and high fire risk areas. The consequences of fire in hospitals can be especially serious because of the difficulties and dangers associated with the emergency evacuation of patients, many of whom may be highly dependent. To enable a safe environment to be maintained for patients, staff and visitors all possible actions to reduce to risk of fires need to be taken which includes minimising the presence of fire hazard items across inpatient services.
No material that incites violence or racial, cultural, religious or gender hatred	The Trust is committed to providing an inclusive culture which treats all individuals with dignity and respect and to ensuring that individuals who access our inpatient serviced do not have a negative experience relating to their protected characteristic.

No plastic bags to be utilised or stored in areas that are accessible to patients	Plastic bags can cause high levels of harm as can potentially cause asphyxiation either intentionally or accidentally.

6. Authorisation and monitoring of restrictions for individual inpatient areas

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".

Restrictions in relation to any of the above should be based upon individual risk assessments and justifiable on grounds of best interests.

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 or unit can include the following:

- Access to certain patient areas, due to environmental risks that cannot be individually risk managed.
- Access to certain foods due to a patient having a severe food allergy.

The expectation is that the need for such a blanket approach to manage the situation be fully explored before being implemented, and include senior staff such as matrons, Heads of Clinical services and Responsible Clinicians. If an alternative cannot be identified and the blanket restriction is still deemed necessary, ensure the following:

- All affected patients must be made aware of why the decision was made. Any impact the restriction may have on individual patients should be documented in their 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 Head of Service for immediate approval. If in the judgement of the Head of Service/Head of Operations/Clinical Director this should be escalated further, an exception report can be made to the Care Group Associate Director of Operations to report to the Executive Team.
- The decision should in all cases be reviewed at the next Care Group Governance Meeting. Monitoring and review mechanisms should be agreed and documented, in particular regarding progress towards the termination of the blanket restriction. Care Groups will routinely report the use of blanket restrictions to the Clinical Practice and Standards Sub Committee and include their blanket restriction register (Appendix 1) in their respective reports.
- A register of blanket restrictions (Appendix 1) will be in place to ensure that the extent of any blanket restrictions are transparent and can be regularly reviewed as appropriate.

6.3. Secure Services

It is recognised in the Mental Health Act Code of Practice 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 Low Secure inpatient Service operates an associated policy (Low Secure Unit Operational Procedure GR43) which specifically covers the range of potential blanket restrictions which may at any time operate in some or all of its inpatient units, as well as the governance arrangements around their use.

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 policy

Oversight and approval of the policy will be by the Trust Board.

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 Matron/Head of Clinical Service for that ward area should be consulted. Wards should escalate the imposition of a blanket restriction through established routes e.g. Care Group Governance Forums. It is good practice to keep a record of any blanket restriction (see Appendix 1 for Blanket Restriction Register template)

Care Group Governance forums have the authority to agree 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, the ongoing monitoring of the restriction will be Governance forums as will the plan to safely terminate the blanket restriction. Blanket restrictions should be routinely reported to the Clinical Practice and Standards Subcommittee. **Associate Directors of Operations** will ensure that the Trust's Quality Committee will have oversight of the use and impact of any exceptional blanket restrictions.

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 Quality Committee.

Mental Health Act Review Provider Action Plans should be considered at the Quality Committee by exception.

Appendix 1 - Blanket Restriction Register

Care Group:							
Description of Blanket Restriction applied and rationale	**Ward/ Unit where restriction applied**	**Date of implementation**	**Approved by (HOC/HOO/CD)**	**Date of review at care group governance meeting**	**Approved Yes/No**	**Date of review**	**Date of termination of restriction**