Cumbria Partnership NHS Foundation Trust

Policy Title: Blanket Restrictions (CPFT)

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Policy On A Page

SUMMARY & AIM

This policy has been created to allow Cumbria Partnership NHS Foundation Trust (CPFT) to have a transparent and open view of the Blanket Restrictions in place, and to allow an effective review process for monitoring compliance.

All Staff within CPFT who deliver a caring role.

TARGET AUDIENCE:

Who is involved with this policy?

CPFT staff in particular in patient teams.

TRAINING:

Training will be provided in line with this policy implementation, and co-ordinated and recorded, this information on compliance will be available via dashboards.

KEY REQUIREMENTS

- Blanket restrictions are sometimes required in order to ensure safety within service areas operated by CPFT.
- Adherence to restrictions that apply to all patients in a particular setting.
- Adherence to Chapter 8 of (MHA CoP) concerning privacy, safety and dignity, including respect patients' rights
- No blanket restriction to be implemented unless expressly authorised by the Hospital Managers on the basis of the organisations policy and subject to local accountability and governance arrangements (Ch 8.9 MHA CoP)
- Any appended restriction will be deemed to meet the MHA CoP requirement for being expressly authorised by the Hospital Managers on the bases of Trust policy.
- To ensure that the Trust fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim of reducing them to a minimum.

CQC guidance and brief guidance on the use of blanket restrictions in mental health wards.

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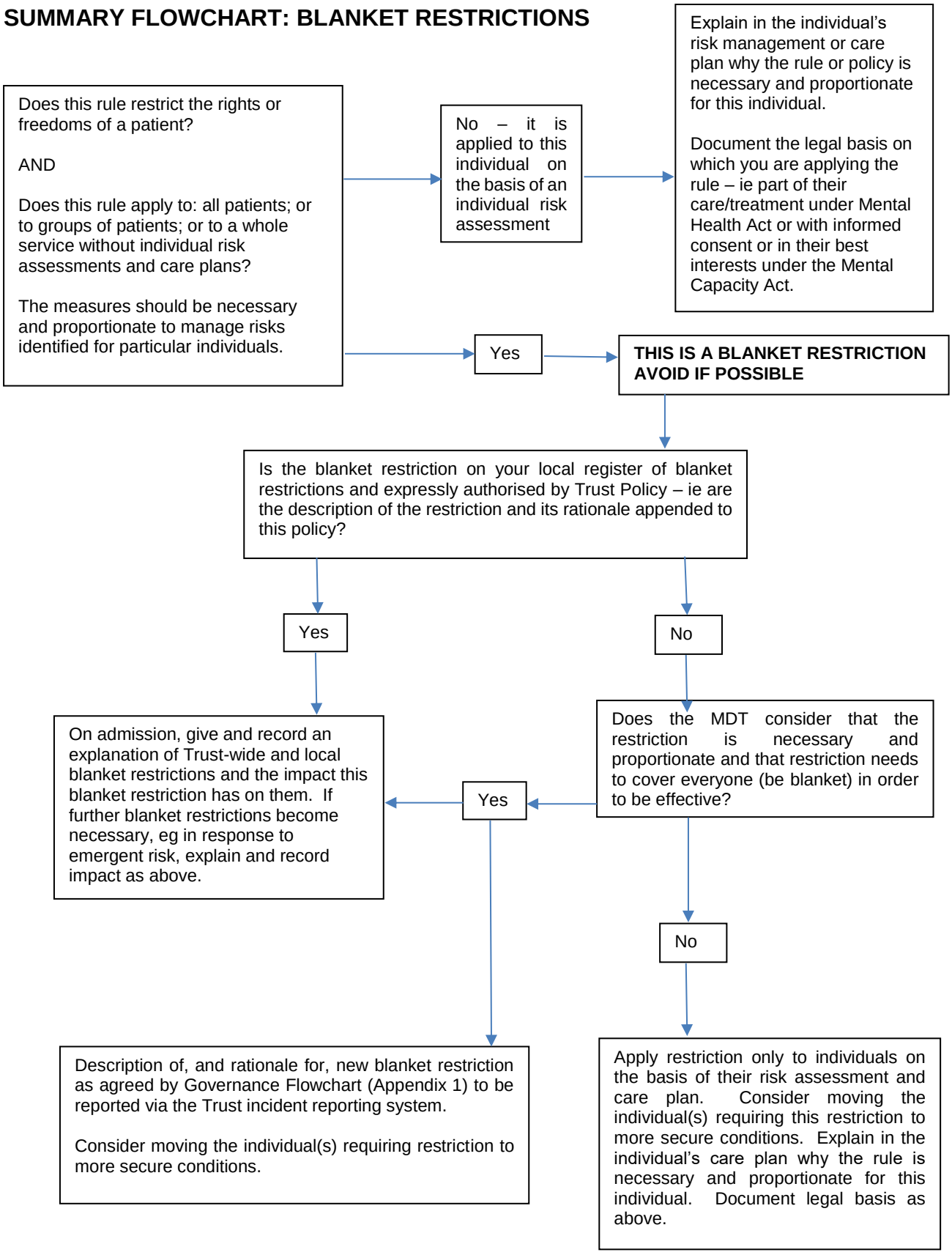
SUMMARY FLOWCHART: BLANKET RESTRICTIONS



1. INTRODUCTION

This policy has been created to allow Cumbria Partnership NHS Foundation Trust (CPFT) to have a transparent and open view of the Blanket Restrictions in place, and to allow an effective review process for monitoring compliance.

2. PURPOSE

2.1 Blanket restrictions are sometimes needed in order to ensure safety within service areas operated by CPFT. However, such restrictions have the potential to have huge impacts on people's lives and can potentially violate Article 8 of the European Convention on Human Rights (ECHR), which requires public authorities to respect person's right to a private life. This policy is in place to ensure that CPFT fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim giving guidance on supporting people in an individualised way and minimising the need for blanket measures.

This is a Trust wide policy and applies to all areas in which the Trust supports people in wards and community settings.

2.2 Ch. 1.6 Mental Health Act Code of Practice (MHA CoP) states;
Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

2.3 In addition, Chapter 8 of (MHA CoP) is concerned with privacy, safety and dignity, including the duty of public authorities to respect patients' rights to a private life under Article 8 of the European Convention of Human Rights (ECHR). It pays particular attention to the practice of implementing blanket restrictions.

2.4 No form of blanket restriction should be implemented unless expressly authorised by the Hospital Managers on the basis of the organisations policy and subject to local accountability and governance arrangements (Ch 8.9 MHA CoP)

2.5 Blanket restrictions which have been approved by CPFT's Board will be appended to this policy; any such appended restriction will be deemed to meet the MHA CoP requirement for being expressly authorised by the Hospital Managers on the bases of Trust policy.

This policy describes how the Trust will meet the requirements of the MHA CoP with regard to blanket restrictions, when these are unavoidable.

2.6 The purpose of the policy is to ensure that the Trust fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim of reducing them to a minimum. The policy aims to support a culture where services are open and honest

about the blanket restrictions that they employ a proper process of consideration and documentation is applied to each such restriction.

3 DEFINITIONS

3.1 Blanket Restrictions

The term blanket restrictions refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application (Ch. 8.5, MHA CoP).

Blanket restrictions as defined in MHA CoP include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights (Ch 8.7 MHA CoP)

This definition is to be applied to all service areas within the Trust, not just hospital wards.

4 PROCEDURE

4.1 Principles of Practice

The specific processes that should be followed are set out below, and (in summary) in the flowchart **Appendix 1** of this policy. These are based on the following principles and legal frameworks.

General principles

- 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 service user should be considered and documented in the patients' record. (Ch 8.5 MHA CoP)

- Sometimes restrictions are needed or 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 that can be shown to be necessary. (Ch 8.6 MHA CoP)

4.2 Legal Frameworks

- For capable informal patients, their consent is required for their care and treatment i.e. restrictions blanket or otherwise would be authorized by a patients capacitous consent.

- For capable detained patients the legal authority to impose restrictions blanket or otherwise would come from either the patient themselves or the Mental Health Act 1983 (MHA).

- Where a patient lacks capacity and restrictions blanket or otherwise are necessary due to their mental disorder the legal authority would come from the MHA. For restrictions not related to mental disorder the legal authority would come from the Mental Capacity Act 2005 (MCA) in Best Interest.

- If blanket restrictions amount to a deprivation of liberty as defined by the 'acid test' set in the Cheshire West case (i.e. subject to continuous supervision and control and not free to leave) those subject to them must have their deprivation of liberty authorised by detention under the MHA (if they are in hospital), or by Deprivation of Liberty Safeguards (DoLS) under the MCA (if they are in hospital and eligible for DoLS or a registered care home) or an order made by the Court of Protection.

4.3 Process – prohibited items and searching

There is an agreed Trust wide list of items specific to each inpatient area not allowed within care areas (lighters/matches and fire hazard materials; illicit drugs/substances; alcohol; medication from home; rope; violent/racist materials). By local agreement, other items may be added to this list as part of a local register.

4.4 If there is cause to search a detained patient or their belongings or surroundings, the search must be done in accordance with the Trust's Searching of Service Users Person, Room and Personal Belongings Policy. Consult the policy with regard to informal/voluntary patients. Authority to search much be sought; those permitted to authorise a search are included in the Trust's Searching of Service Users Person, Room and Personal Belongings Policy.

4.5 Any private property that is legal to possess, but is handed over by the patient for safe keeping, must be stored and the patient allowed to have access to it in accordance with (Ch 8.24 MHA CoP) and Trust Policy – Patient Valuable Property – SFI – PGN – 16 -03.

4.6 Please refer to the relevant policies for the management of property as above that is illegal to possess, such as illicit substances, (substance misuse and harmful substances on inpatient wards policy) and offensive weapons (Security policy). Seek advice from the Local Security Management Specialist / Safeguarding Leads with regard to other potentially illegal items.

4.7 Do not destroy or dispose of any property without specific permission from a relevant Network Manager / Quality and Safety Manager.

4.8 Exceptions permitted by the CQC in its 'Brief Guide for Inspectors'

4.9 The CQC Brief Guide for Inspection Teams – The Use of Blanket Restrictions in for Mental Health Wards - (check CQC website for latest guide) states that banning the following 'prohibited' or 'contraband' items should not be challenged as a Blanket Restriction. This is not an exhaustive list.

- Alcohol and drugs or substances not prescribed
- Items used as weapons (firearms, real or replica, knives, other sharps, bats)
- Fire hazard items (flammable liquids, matches, incense)
- Pornographic material
- Material that incites violence or racial/cultural, religious/gender hatred
- Plastic bags, metal clothes hangers
- Animals
- Equipment that can record moving or still images with the exception of mobile phones (i.e. Camera, web cameras).
- Smoke-free policies are deemed to be justifiable blanket restrictions

4.10 Additional Permitted Exceptions – Secure Settings

- Mobile phones
- Computers, Tablets, Games Devices with hard drives or sharing capabilities
- Items with voice recording capabilities
- Other items with enabled WiFi/Internet capabilities
- Items considered an escape aid
- Restrictions on access to money will be part of the security fabric of the ward
- Restrictions on take away food may be in place to ensure therapeutic activity of the ward is not undermined

4.11 The CQC Brief Guide also refers to searching:

- General Acute Wards: Random or routine searching permitted if there is specific cause
- Psychiatric Intensive Care Units (PICU): Random or routine searching backed by policy which includes clear rationale on the purpose of any search
- Low Secure Wards: Random searching likely, routine searching at times in response to specific issues

5 IDENTIFICATION AND DOCUMENTATION OF BLANKET RESTRICTIONS

(Flowchart included at Appendix 1 Blanket Restriction/Management Governance Escalation Process)

5.1 The impact on each patient of any blanket restriction must be recorded in their own clinical record.

5.2 Each care area will have a register detailing any Trust wide blanket restrictions in place in that location and will be available on the Trust Intranet – under the Blanket Restrictions section of Safer Care. The patient will be informed of these restrictions as part of the process of explaining their rights under the NHS and a record made that they have received this information.

5.3 Any Trust wide blanket restrictions will have an underpinning rationale and will have been considered and approved by the Trust Board.

5.4 Each area will maintain a register of any blanket restrictions over and above the Trust wide blanket restrictions available to patients and carers.

5.5 Blanket restrictions approved by CPFT's Board will be appended to the policy.

5.6 Each MDT must review its practices, existing blanket restrictions and any discontinuation plans on a regular basis at the appropriate meeting (at least 6 monthly) in order to identify and minimise the use of blanket restrictions. A record of these reviews is to be maintained in the minutes.

5.7 In the event that a practice is newly identified as a blanket restriction, an incident form must be completed and submitted to Network Governance via the team's exception report.

5.8 If it is **not immediately necessary** to apply the restriction in a blanket fashion, ensure that it is only applied to the patient/s whose presentation warrants the restriction.

5.9 If it is **immediately necessary** for risk management purposes to impose the restriction in a blanket fashion and this cannot be avoided after discussion with the Clinical Manager, this must be authorised by the Clinical Manager or the person formally deputising for the Clinical Manager.

5.10 The imposition of an immediately necessary blanket restriction must be reported by the completion of an incident form, highlighting the blanket restriction.

5.11 All patients should be informed that the restriction is in place and why) as far as possible, having due regard to any issue of confidentiality).

5.12 If this continues beyond a month this should be escalated.

5.13 If the need for the blanket restriction continues, it must go before Care Group in line with reporting procedures.

6 GOVERNANCE ARRANGEMENTS

6.1 In addition to the local arrangements described above, each Network should put in place processes for identifying and appropriately responding to blanket restrictions within its service areas.

6.2 Any blanket restriction identified by the CQC during inspections or monitoring visits will be addressed by the Provider Action Statement (PAS) and associated action plans.

6.3 CQC action plans are monitored and overseen by the Trust's CQC Quality Compliance Group.

6.4 Provider Action Statements are monitored via the respective Network and the Trusts Mental Health Steering Group.

7. COMMUNICATION

Details will be available on the Trusts intranet site

The policy will be made available to all staff via the Intranet and Trust website. A communication will be issued to all staff via the Communication Department immediately following publication.

8. IDENTIFICATION OF STAKEHOLDERS

- Communications & Finance
- Commissioning and Quality Assurance
- Workforce and Organisational Development
- Medical Directorate
- Staff Side
- Internal Audit

9. TRAINING AND SUPPORT

Training will be provided in line with this policy implementation, and co-ordinated and recorded, this information on compliance will be available via dashboards.

10. IMPLEMENTATION

The policy will be implemented with a robust communication strategy and implementation will be overseen by Quality & Safety Committee.

11. EQUALITY & DIVERSITY

In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner. (See Appendix A)

12. JUST CULTURE

The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

13. PATIENT INFORMATION LEAFLETS

Patient Information leaflets will be reviewed every 3 years with the exception of those documents which are reviewed on an annual basis. However, should there

be any changes in legislation or practice; all documents will be reviewed immediately irrespective of review date.

14 FRAUD, BRIBERY AND CORRUPTION

In accordance with the Trust's Counter Fraud, Bribery and Corruption Policy, all suspected cases of fraud and corruption should be reported immediately to the Trust's Local Counter Fraud Specialist or to the Executive Director of Finance.

15. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
Compliance with policy	Nursing care audits x 10 per month	Ward manager	Care group governance structure	Monthly

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the Care Group Governance committee
- Risks will be considered for inclusion in the appropriate risk registers

16. REFERENCES:

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

17. ASSOCIATED DOCUMENTATION:

- Searching of Service Users Person, Room and Personal Belongings Policy
- Safeguarding Policy
- Deprivation of Liberty Safeguards Policy

18. DUTIES, ACCOUNTABILITY AND RESPONSIBILITIES

18.1 The Chief Executive

The Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is

signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive through Executive Chief Operating Officer is responsible for keeping the policy updated and available to staff.

18.2 Board of Directors

CPFT Board of Directors is responsible to approving and monitoring blanket restrictions for use in specific service areas.

18.3 Care Group Associate Directors

The Care Group Associate Directors are responsible for ensuring that all Managers in their areas are aware of the policy and support its implementation.

18.4 Network Managers/Ward Managers/Teams

They are responsible for ensuring that the policy is fully implemented within the ward environment/the team/the department that they manage. They must ensure that the policy is readily available to all staff at all times. Managers must ensure that the recording and auditing is completed in line with this policy. Managers must respond appropriately to any concerns regarding the implementation of this policy within their service area.

18.5 Local Security Management Specialists / Safeguarding Leads

These subject experts are available to support clinical teams around operational issues that present with the implementation of this policy and around incident reporting and should be contacted for advice in their respective teams.

18.6 All staff

All staff members are responsible for ensuring that their practice is safe and is provided in accordance with current legislative frameworks. All staff members are required to ensure they (and anyone they line manage) abide by CPFT requirements as set out in this policy.

18.7 Approving Committee Responsibilities: Quality & Safety Committee

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

19. ABBREVIATIONS / DEFINITION OF TERMS USED

Keep lists in alphabetical order

ABBREVIATION	DEFINITION
CPFT	Cumbria Partnership Foundation Trust
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
ECHR	European Convention on Human Rights
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MHA CoP	Mental Health Act Code of Practice
PAS	Provider Action Statement
PICU	Psychiatric Intensive Care Units

DOCUMENT CONTROL

Equality Impact Assessment Date	N/A
Sub-Committee & Approval Date	Quality & Safety Committee 15/08/2019

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published
N/A			

Statement of changes made from version

Version	Date	Section & Description
0.1		• Creation of new policy
0.2	16/08/2019	• Formatting and additions to abbreviations table
0.3	16/08/2019	• Additions to Policy on a Page • Add to monitoring table • Additions to list of stakeholders

List of Stakeholders who have reviewed the document

Name	Job Title	Date
MH care group governance committee		June, July 2019
Quality and Safety Committee		June, August 2019