Blanket Restrictions Policy

This policy supports staff to provide care to patients in the least restrictive way. However, it is recognised that there may be times when in the interests of patient safety, a decision may be made that has direct impact on patients' ability to carry out an activity or move around freely. Where such decision takes place and are applied to everyone who uses the service or part of a service, these are referred to as blanket restrictions and this policy supports staff decision making and the recording blanket restrictions.

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Policy On A Page

SUMMARY & AIM

Thie aim of this policy is to provide guidance to employees acting on behalf of, or with delegated responsibility from, the Trust. This policy details how the Trust complies with the Mental Health Act Code of Practice (1983) and its regulated activities monitored by the Care Quality Commission (CQC) when using restrictive practices.

It sets out the process within the Trust to authorise, monitor and review restrictive practices in this case blanket restrictions and aims to keep the use to a minimum.

KEY REQUIREMENTS

The Trust is committed to providing care to patients in the least restrictive way. However, it is recognised that there may be times when in the interests of patient safety, a decision may be made that has direct impact on patients' ability to carry out an activity or move around freely.

Where such decision takes place and are applied to everyone who uses the service or part of a service, these are referred to as blanket restrictions.

Within the Trust there are two distinct types of blanket restrictions:

- Those in place across the whole Trust to meet national guidance or legislation.
- Those implemented by individual wards/ services on a short-term basis to maintain patient safety.

Any blanket restriction should be based on risk assessment, involve communication with patients and the staff team, be for the shortest time possible, be reviewed and logged on the Trust database held by the Compliance Team.

TARGET AUDIENCE:

This policy applies to all clinical staff in the Directorate of Mental Health and Families, Young People and Children/Learning Disability and Autism Directorate.

TRAINING

This policy has no specific training, but staff should read the policy and be able to describe a blanket restriction and that it should be proportionate and

necessary, in place for the shortest time possible and must be logged on the Trust record of blanket restrictions.

1.0 Quick look summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
1		Original Policy
2	28/03/25	Policy moved to new template and ward restriction record added
3	26/04/25	Comments considered and amendments made to types of restrictions. Final Draft.
4	04/06/25, 12/07/25 and 18/08/25	Amendments made regarding drinks and poster.
5 and 5.1	22/09/25	V5.1, following poster sign off, log review and review by Policy Group
5.2	24/03/26	Final version - New electronic log added and directorate amendments by HoN - with changes to reporting.

For Further Information Contact: Least Restrictive Practice Practitioner Robert.kerr5@nhs.net or Michelle Churchard-Smith, Deputy Director of Nursing and Quality Michelle.Curchard@nhs.net

1.2 Key individuals involved in developing and consulting on the document:

- Paul Howley, Matron Beacon Unit
- Michelle Churchard-Smith, Deputy Director of Nursing and Quality
- Rob Kerr, Least Restrictive Practice Practitioner
- Least Restrictive Practice Group
- Saskya Falope, Head of Nursing Directorate of Mental Health
- Zayad Saumtally, Head of Nursing Families, Young People and Children/ Learning Disability and Autism Directorate

Consultation:

- Medical Director

- Nursing Director
- Compliance Team
- Clinical Directors for all Directorates
- Heads of Nursing for all Directorates
- Clinical Governance Leads, CHS, MH and FYPC/LD
- Safeguarding Lead
- Health Safety & Security Advisor
- Ward Sisters/ Charge Nurse
- Expert Policy Group

1.3 Governance

Level 2 or 3 approving delivery group – Least Restrictive Practice Group

Level 1 Committee to ratify policy – Safety Forum

Monitoring of blanket restrictions will occur monthly in directorate quality and safety meetings and quarterly at the Least Restrictive Practice Group. A central log of all blanket restrictions will be held by the Compliance Team.

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 (Amendment) Regulations 2023 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010 (Amendment) Regulations 2023. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.

- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

Blanket Restriction: The Mental Health Act Code of Practice (1983, p:64) defines '…the term "blanket restrictions" refers to rules or polices 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.'

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision.
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0 Purpose and Introduction

The Trust is committed to providing care to patients in the least restrictive way. This is in accordance with the Mental Health Act Code of Practice (2015), the Mental Health Units Use of Force Act (2018) and the good practice recommendations from the Restraint Reduction Network Training Standards and the Health and Social Care Act Regulations (2014) 13 and 17. However, it is recognised that there may be times when in the interests of patient safety, a decision may be made that has direct impact on patients' ability to carry out an activity or move around freely.

Where such decision takes place and are applied to everyone who uses the service or part of a service, these are referred to as blanket restrictions. Blanket restrictions should never be used to punish or manage patients for the benefit of others.

The Mental Health Act Code of Practice (1983, p:64) defines '…the term "blanket restrictions" refers to rules or polices 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.'

Blanket restrictions for example, may include restricting a patients access to certain areas within a care setting, limiting, or banning access to telephones or money, the internet, games or having set visiting times or times to access leisure activities.

The MHA Code of Practice (1983) states that blanket restrictions should only be used:

- When justified as necessary to manage an individual's (patients) risk.
- When they are proportionate to the individual's risk.
- When they continue to be needed and are regularly reviewed.

When considering the use of blanket restrictions staff should always consider Article 8 of the Human Rights Act which requires public authorities to respect a person's right to a private life.

Within the Trust there are two distinct types of blanket restrictions:

1. Those in place across the whole Trust to meet national guidance or legislation.
2. Those implemented by individual wards/ services on a short-term basis to maintain patient safety.

This policy should be read in conjunction with the Trust Least Restrictive Practice Policy.

3.0 Policy Requirements

Implementing a blanket restriction:

3.1 Determining the need for blanket restrictions.

As far as possible blanket restrictions should be avoided unless they can be justified as a necessary and proportionate response to an identified risk for a group of patients.

There may be occasions where the risk apply to a particular patient and have been identified through their individual risk assessment and a risk management plan put in place.

Risk assessments and personalised care related to restricted items.

The CQC brief guide to blanket restrictions (Feb 2025) describe this as:

‘Access to items will depend on many factors, some of which may be fixed and others subject to change. The risk assessment and ensuing management of access to security items should take a procedural and individualised approach, where possible in collaboration with the patient, which avoids the implementation of unreasoned blanket bans. For items that may be considered suitable only for restricted use, staff should complete a thorough risk assessment and provide the patient with a transparent rationale that explains the management outcome. A dynamic and personalised risk assessment considers:

- **Personal risk:** individual’s historical/ current risk and current mental state
- **Interpersonal risk:** direct risk to others - patients and staff
- **Environmental risk:** ward dynamics; general service safety (level of security, rehabilitative/acute)
- **A common-sense consideration** of the item in question

Restricted items should be reviewed using a proportionate, person-centred approach. Decisions around access can fall into the following categories.

- **Facilitated Access:** Access to the item can be supported through an individually developed care plan, informed by collaborative discussion with the patient. Services may adopt standardised guidance which can then be adapted to the individual.
- **Requires Further Review:** The available information and current risk assessment do not provide a clear basis for a decision. The matter should be escalated to the MDT, ward round, or Ward Sister/Charge Nurse for further scrutiny and shared decision making.
- **Access Not Currently Safe:** A personalised risk assessment has determined that access to the item cannot safely be supported at this time. The patient must be provided with a clear explanation, along with details of when and how the decision will next be reviewed.

Where the management of the risk for an individual patient impacts on the wider patient group it is classed as a blanket restriction and the implication of this restriction needs to be assessed for each patient it impacts on and documented in their clinical records.

When determining if the restriction they need to apply is a blanket restriction as defined within the policy they need to consider the following:

The MHA Code of Practice (1983, chapter 8) states that to not breach of a patient's human rights the following should not ordinarily be the subject of a blanket restriction (possible exceptions may apply in Phoenix Low Secure Unit or for patients subject to Multi-Agency Public Protection Arrangements (MAPPA) with specific restrictions in place):

- Access to, or a ban on, mobile phones and their chargers (with ligature risk considered).
- Access to the internet.
- Any in or outgoing patient mail.
- Visiting hours.
- Patient access to their money or the ability to make personal purchases.
- Preventing patients from taking part in preferred activities.

Further guidance is provided by the CQC Brief Guidance on Blanket Restrictions shown in appendix 2.

3.1.2 Flow chart to support decision making for a blanket restriction.

Does the rule or decision restrict a patient's freedom or other rights, and will it be applied to an individual or all patients in the area?

Individual

This is not a blanket restriction.
Explain to the patient and record in their clinical records why the action that has been taken is necessary and under what legal framework i.e. MHA, MCA or with informed consent.

All patients

This is a Blanket Restriction.
Check section 3.2 to determine if it is an approved Trust wide restriction.
If working in the Trust Low Secure Unit – Pheonix Ward check that it isn't already covered in the SOP under-
Prohibited and Restricted Items
Management of Pornographic and Sensitive Material.
Mobile phone and other devices.

If not covered by the above refer to section 3.3 onward of this policy.

If you are unsure contact your line manager or Matron/ Restrictive Practice Practitioner for advice.

Whilst it is important that patients' human rights are not infringed there are times when a balance needs to be made on the basis of safety for people who use the service and staff.

The Executive Management Team have authorised the following restrictions as being appropriate and proportionate to comply with legal requirements, national guidance and the provision of safe care within the Trust inpatient and community facilities:

Restriction	Rationale
No smoking in any Trust buildings.	This is in line with Government and NHSE guidance and the Trust commitment to improve people's physical health and the full rationale can be found in the Trust Smoke Free Policy. **This is not deemed a blanket restriction. (CQC 2025)**
Patients are not permitted to have ignition sources, such as lighters and matches on their person. If patients smoke on admission these should be stored in an appropriate safe area and available for patients when leaving Trust premises.	As patients are not permitted to smoke cigarettes, cigars or pipes in Trust buildings storing them in a patient locked cupboard reduces the risk of either accidental or intentional fire related incidents especially in areas gases are used.
Alcohol, Illicit Drugs and Novel Psychoactive Substances (NPS – drugs that replicate the effects of illegal drugs) are not permitted on Trust premises.	Alcohol and illicit drugs are not allowed on the inpatient or community areas as: They can have an adverse effect on a patient's ability to engage in their treatment program. • They may adversely interact with the patient's prescribed medication. • They can be a destabilizer for a patient's mental health and

	therefore have a negative impact on their recovery. • There may be patients on the unit recovering from alcohol or drug misuse and being in the proximity of these will negatively impact on their recovery. • For some people they can be a trigger for aggressive, violent or sexually disinhibited behaviour which could place them and/or others at risk.
No illegal pornographic materials are allowed on Trust premises.	This is not permitted on the basis that it is illegal due to the extreme nature of it and would be considered offensive to most people.
Items which can be used as weapons are not permitted on Trust premises. (for example, pen knifes)	The Trust would be negligent in its duty to protect the people under its care or employ if it knowingly allowed weapons onto its premises. However, as it is recognised that knives may be carried for reasons other than as a weapon, for example religious practices and staff should discuss the safe storage of items whilst the person is an inpatient.
Materials that incite violence or racial/cultural/ religious/gender hatred is not permitted on Trust premises.	This is not permitted on the basis that the use and/or distribution of such material could constitute a criminal offence. Additionally, such materials can be considered offensive in nature and may cause distress to others.
All clinical areas which have medication cupboards, medical equipment and substances hazardous to health stored in them, will be kept locked when not in use.	This is on the grounds of patient safety due to the potential consequences of a patient gaining unsupervised access to the medication, substances and equipment held in these rooms.

In addition to the above the Trust Executive Management Board (EMB) has also endorsed the following which could be considered blanket restrictions.

Restriction	Rationale
Controlled access and egress to all inpatient wards.	This is to ensure that a safe protective environment is provided to patients, staff and visitors by controlling who has access to the ward areas at any given time and those requiring detention under the Mental Health Act. This does not affect informal patients who can leave the ward on request.
The locking of access to outdoor space at night, with access based on individual/ group risk assessment.	This is to maintain the safety of patients, staff and visitors during the night when visibility in these areas will be limited (for example ward gardens, outside areas, hospital grounds, main reception doors). However, ward staff/ Duty Managers/ Coordinators will facilitate the use of these outdoor areas at night on an individual or group patient basis as long as the circumstances and assessment of risk indicate it is safe to do so.
Protected Mealtimes – Eating Disorders Ward	Most Eating Disorder wards have food available at set times and during this time the visiting on wards is restricted to allow people to eat without distraction as part of treatment/ care plans. Any variation to this should be discussed with the nurse in charge.
Plastic bags on the Acute Adult and Children's Mental health wards, Psychiatric Intensive Care Unit (PICU), Forensic services, Eating Disorder Wards, Rehabilitation and	This is due to suffocation and ligature risks identified by local serious incidents and national learning;

MHSOP wards (risk assessed) and Learning Disability Services.	alternative provision is available to patients.

All wards and day service areas have been issued with posters for display in patient areas advising that the above are prohibited and that patients are to speak with staff if they require more detail. The basic poster is shown in appendix 1 but can be adapted to consider specific requirements in different settings.

3.3 Action to take when a blanket restriction has to be implemented at short notice due to immediate safety concerns.

There may be times when in the interest of patient, public and / or staff safety a decision is made to prohibit or restrict access to items that would not normally be prohibited or restricted. Examples of this may be:

- When an environmental risk occurs which cannot be individually managed
- The need to restrict certain food items on the ward area, such as nut base products due to the admission of a patient with a known allergy.

Wherever possible in these cases the restrictions should be implemented following a Multi-Disciplinary Team (MDT) review which has considered and ruled out all other alternatives to the blanket restriction for managing the situation.

However, it is accepted that in some urgent situations the decision will have to be made by the nurse in charge and reviewed by the MDT as soon as possible.

Where no alternative to the local blanket restriction can be identified the following action is to be taken:

- All patients affected by the local blanket restriction are to be notified of what the restriction is, why it has been applied, when it will be reviewed and who they can talk to if they have any concerns about the restriction.
- Any impact of the local restriction on each individual patient is to be documented in their clinical record and included in their care plan.
- An incident form (e-IRF) is to be submitted categorised as a non-patient safety incident with full detail of:

- the nature of the blanket restriction, including the impact on the individual effected.
- the reason for its application,
- who was involved in making the decision,
- the number of patients affected by the blanket decision,
- the anticipated duration of the restriction,

In addition to completing the incident form if the Matron or Deputy Head of Nursing were not involved in the original decision to impose the blanket decision the nurse in charge will notify them. Out of hours this notification will be to the on-call manager. The Matron, Deputy Head of Nursing or on call manager will make a judgment as to whether or not the implementation of the blanket restriction needs to be escalated to the Director. For example, a patient is admitted that requires restricted access to water at that time and based on their risk assessment the patient access to drinks stations would need to be restricted. As this would impact on other patients it should be logged as a blanket restriction.

The risk will be added to the risk register and the blanket restriction logged on the record of blanket restrictions and the form sent to the Compliance Team lep-tr.compliance@nhs.net.

The MDT will review the need for the blanket restriction to remain in place daily and in full no later than 7 days after its implementation. The outcome of this review is to be reported to Matron/ Deputy Head of Nursing and the risk updated/ removed.

It is important that locally implemented blanket restrictions are reviewed and in place for as short a period as possible.

All blanket restrictions should be reviewed using the restraint reduction networks 4R's blanket rules framework tool, as shown below:

Rules – Identify the blanket restrictions and name them as such.

Reason – Let everyone know the reason they are being used and the risk they are there to manage.

Rights – Let everyone (Patients, staff, visitors) know the reason they are being used and the risk they are there to manage.

Review – What can be done to remove the need for the blanket restriction? How can we monitor and if possible, mitigate the impact the restriction has on people effected**?**

3.4 Implementing a blanket restriction at the request of a patient group.

There may be occasions when a patient group makes a request for a blanket restriction to be imposed. Examples of this may be a request that:

- A kitchen area is locked due to patients purchased food being removed from the fridge.
- A laundry room being locked when not in use to prevent clothes from being misplaced.

In these circumstances it is important that all other possible solutions are explored before a blanket restriction is imposed and that all the patients affected by the proposed restriction:

- Are in agreement with its implementation.
- Have the capacity to make an informed choice.
- Are not affected by it to a greater extent than any of the other patients.

If all the above points are met staff should follow section 3.3.

In the event that one or more of the patients affected by the restriction either don't agree to it or do not meet the above bullet points staff will either have to consider what alternative ways there are of managing the situation or through an MDT discussion agree if the blanket restriction will need to be applied on a local level and if yes follow the guidance as set out in section 3.3 of this policy.

3.5 Action when a blanket restriction needs to be implemented which will have a major longer-term impact on patients.

Where it is immediately evident that a locally imposed blanket restriction will have a major longer-term impact on patients this is to be escalated via the Head of Nursing who will notify the Director of Nursing, AHP's and Quality and the Medical Director.

In these cases, the Director of Nursing and Medical Director will:

- Determine the review time frame, as every 7 days may be too frequent.
- Agree if any further action is required to mitigate the need for the blanket restriction.
- Consider if it needs to become a Trust endorsed blanket restriction and as such added to section 3.2 of this policy.

In any instance where a blanket restriction has been assessed as having a major long term impact on patients the Trust Compliance Team will discuss if the CQC should be notified and agree with them as to the frequency of the required updates.

Once the blanket restriction is lifted the Compliance Officer will inform the CQC.

3.6 Information to patients and carers

Relatives / friends of the patient are to be informed by clinical staff what items are restricted and the reasons why and asked that they check with staff before handing such items to the patient during a visit.

In addition to staff verbally telling them, each ward and community service will also display the Trust approved poster (see appendix 1) and include relevant detail in their ward/service information booklets.

3.7 Governance of blanket restrictions

All locally imposed blanket restrictions will be reported on the Trust incident reporting system at the time they are implemented and entered onto the ward log and sent to the Compliance Team (see email in section 3.3) by the nurse in charge. This will be held on the central log.

The Directorate Management Team (DMT) will review all blanket restrictions to ensure they are proportionate and required via reporting through the directorate Quality and Safety meetings **monthly** and send any changes to the Compliance Team.

The Least Restrictive Practice Group will review all blanket restrictions and incidents related to these **quarterly** and ensure any learning is shared with teams and services via learning boards.

4.0 Duties within the Organisation

Policy Author – To ensure the policy is reviewed in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the Directorates and appropriate governance group.

Lead Director –The Director of Nursing, AHP's and Quality is responsible for ensuring that this policy is carried out effectively and is addressed and managed effectively across the organisation. Will communicate, disseminate, and ensure Directorates commence implementation of the policy and provide assurance through the Trust's Quality Governance Framework.

Directorate Directors, Clinical Directors, Heads of Professions, Heads of Service are responsible for:

- Raising clinical staff awareness of this policy.
- Overseeing implementation and compliance with this policy.
- Authorising any local blanket restrictions in the Directorate and ensuring they are logged with the Compliance Team.

Service Managers, Deputy Heads of Nursing, Deputy Clinical Directors, Team Leaders and Matrons are responsible for:

- Raising clinical staff awareness of this policy and ensuring any training is completed.
- Supporting the implementation and compliance with this policy.
- Ensuring that any locally authorised blanket restrictions are:
    - the only option available to the clinical team and other less restrictive options have been explored.
    - Reviewed in line with this policy.
    - Implemented for the shortest time possible.
- Addressing any concerns or complaints made by patients, family, staff or others regarding the use of a blanket restriction.
- Take appropriate action where staff fail to comply with this policy.

Responsibility of Ward Sisters or Charge Nurses:

- Raising clinical staff awareness of this policy and ensuring any training is completed.
- Implementation of the policy.
- Ensuring that any ward/ locally authorised blanket restrictions are:
    - the only option available to the clinical team and other less restrictive options have been explored.
    - Reviewed in line with this policy.
    - Entered onto the ward log and confirmed with the Compliance Team.
    - Implemented for the shortest time possible.

- Addressing any immediate concerns or complaints made by patients, family, staff or others regarding the use of a blanket restriction.
- Take appropriate action where staff fail to comply with this policy.

Responsibility of Staff working in clinical wards/ settings:

- Ensure that they understand the policy and comply with the requirements of the policy.
- If they are the Nurse In Charge at the time the local blanket restriction is put in place they must explain the restriction to patients and staff and complete an incident form.
- The Nurse In Charge should ensure the rationale for the local blanket restriction is recorded in patient notes and a care plan is in place.
- Report any breach of the policy to their line manager and complete an incident form.

Responsibility of the Trust Safeguarding Team

The Trust Safeguarding Team will be responsible for considering and advising on any safeguarding implications for the implementation of any blanket restrictions following contact from the Directorate or Compliance Team.

Responsibility of the Compliance Team

The Trust Compliance Team is responsible for:

- Maintaining the Trust data base of blanket restrictions
- Providing a copy of the central database to the LRP Group quarterly for review.
- Liaising with the CQC regarding any blanket restriction considered to be reportable
- Providing access/ information from the data base to the Directorate Governance Teams and Least Restrictive Practice Group.

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place.

Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

6.0 Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Compliance with this policy will be overseen by the Least Restrictive Practice Group. The purpose of monitoring is to provide assurance that the agreed approach as set out in this policy in relation to blanket restrictions is being followed. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
3.3/3.4 – page 11-13	Blanket restrictions are logged and reviewed.	Reported to Directorate Management	Head of Nursing/	Monthly

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
		Team (DMT) and Compliance Team	Compliance Team	
3.7- page 14	How the organisation ensures that blanket restrictions are appropriate and proportionate	Reported to Directorate Management Team Least Restrictive Practice Group	Least Restrictive Practice Group	Quarterly
3.7, page 14	Lessons learnt from the review of blanket restrictions will be shared in team meetings and Directorates and/or trust wide.	Review of blanket restrictions by directorates in the DMT/ Least Restrictive Practice Group.	Least Restrictive Practice Practitioner	Least Restrictive Practice Group/ Safety Forum

7.0 References and Bibliography

Care Quality Commission Brief guide: the use of ‘blanket restrictions’ in mental health wards (February 2025) ww.cqc.org.uk

Equality Act 2010 (Amendment) Regulations 2023

Health and Social Care Act Regulations (2014)

Mental Health Act (1983).

Mental Capacity Act (2005).

Mental Health Act (1983) Code of Practice (2015).

Mental Health Units Use of Force Act (2018)

Restraint Reduction Network (2021) Reducing the use of Blanket Restrictions

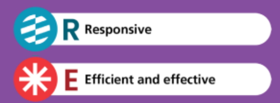
Policy benchmarking with other MH/LDA Trusts.

8.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

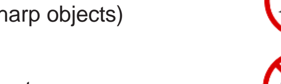


Keeping everyone safe

Items to give staff or leave at home

To help keep everyone safe and maintain a respectful environment, please do not bring the following items directly onto the ward or keep them in your possession:

Any kind of weapon (like knives or sharp objects)

 Animals or pets

Lots of money

Alcohol (like beer or wine)

Jewellery that is expensive or special to you

Drugs that are illegal or not given to you by a doctor

Plastic bag

Lighters or matches

Strong-smelling substances that could be misused

Books, magazines, or other things that are rude, hurtful, or show violence or sexual content

The following items will be safely looked after by staff and given back to you when allowed by the ward rules:

- Things with long cords or strings (like phone chargers or clothes with drawstrings)
- Cigarettes, vapes, or anything with tobacco or nicotine
- Matches and lighters
- Cans of drink
- Personal electrical items (like hairdryers or speakers, unless staff say it's safe to use them)
- Sharp items (like scissors or razors)
- Glass bottles of any kind
- Spray cans (aerosols)

We encourage patients to look after their own belongings when they can. There are lockers on the ward where you can safely keep small items and small amounts of money.

Any medicine you bring in will be safely stored by the ward nurse.

Please remember:
The Trust is not responsible if your things get lost or broken, unless they have been officially recorded and you were given a receipt.

The CQC Brief guide: the use of ‘Blanket Restrictions’ in mental health wards (Feb 2025) — Appendix 2

Normative expectations regarding blanket restrictions at different levels of security

	Security level				
	General (acute)	**PICU**	**Low**	**Medium**	**High**
Banned items	All services will have banned and restricted items: alcohol, weapons, illicit drugs (see appendix 2).		All services will have banned and restricted items in addition to those found in general (acute) ward policies (see appendix 2).		
Random or routine searching	Not without specific cause (see appendix 2)	Policy on searching should require clear rationale given on the purpose of any search.	Random searching likely, may be routine at times in response to specific issues	Routine searching likely. Pre-discharge/ recovery wards may have random searching.	Expected to be routine due to inherent risk of population.
Access to mobile phones and the internet.	Wards should provide personal access to the internet and mobile phones, particularly to communicate with friends and family. Restrictions on access should be individually justified and not be a blanket measure. Wards may provide non-camera phone handsets and arrange for safe charging of patients’ electronic items (electrical leads can be a ligature risk), e.g. with short-lead chargers or charging in the nursing office).		Some units are piloting access to mobile phones. Dependent on the risk profile of the patient group. Access to internet likely to be supervised and restricted as part of ward security.		All access to internet will be supervised and restricted as part of ward security.

Access to money	Restrictions on access to money should be based upon individual risk assessment, and justifiable on grounds of best interests.	Restrictions on access to money will be part of security fabric of ward.
Buying takeaway food	**Restrictions on take away food may be in place to ensure that therapeutic activity of the ward environment is not undermined (i.e. set times when takeaway food can be ordered). As a part of managing healthy weight initiatives, services may try to restrict the frequency of takeaway food purchase and make arrangements that such purchases are made instead of, rather than as well as, normal evening meals.**	
Food restrictions	During inpatient care staff should review the physical health of the patient as well as the mental health. Advice and encouragement should be given to patients to have a healthy well balanced diet. Restrictions of access to certain foods should not be the main focus of this and can be viewed as a blanket restriction if not handled sensitively and with patient involvement.	
Smoke free	NHSE have issued guidance on mental health units becoming smoke-free. **This should not be raised as a blanket restriction.**	
incoming or outgoing mail	Staff have no legal powers to interfere with postal items but may withhold outgoing post from a detained patient where addressee has requested that this be done (MHA s.134(1)(a)). Staff may ask patients to open mail in front of them if there are concerns over contraband items or the patient's likely reaction to mail. Staff should justify as necessary and proportionate to an identified risk. It should not amount to an interference with the postal item itself. Staff should not read patients' mail in such arrangements.	Security directions allow monitoring and interference with postal items (see appendix 3 of guidance).
Telephone monitoring	No legal powers to monitor patients' telephone calls. Patients should expect privacy when using the telephone. In exceptional cases (e.g. when a patient makes nuisance or unwarranted emergency service calls) access to the telephone might be restricted.	Security directions allow monitoring of phone calls (see appendix 3 of guidance).

Blanket Restrictions Log

Appendix 3

Blanket restriction	Description of blanket restriction if 'other'	Current practice on ward	Rationale	Action plan to eliminate/reduce	Date restriction put in place	Date of last review (red indicates > 28 days since last review)	Length of restriction (time from restrictio place to date of au
Bedroom keys – no possession		Staff unlock bedrooms	Keys unlock all doors so access must be controlled	New locks being sourced	01/01/2026	02/01/2026	

Note – Areas will have this log as an excel spreadsheet.

Restrictions to be considered available in the first drop down column in the Excel sheet, please log those with restrictions only:

- Limited or no access to the Internet
- Restrictions on use of ward telephone
- "Limited access to telephones
- (including mobile phones)"
- Limited/No access to mobile phone/ device chargers
- Limited access to certificate 18 media
- Limited access to kitchen
- Limited access to hot drinks
- No control over portion size of meals
- No food provided outside set meal times
- No choice of food at meal times
- All service users use plastic knives and forks/cutlery
- Limited access to laundry
- Limited access to grounds/garden
- No garden access after sundown
- Toilets locked in communal areas
- TV turned off at certain time
- Rooms unavailable overnight, e.g. lounges
- No access to bedrooms at certain times of the day
- No possession of bedroom keys
- No lockable spaces for service users to store possessions
- Toiletries locked away
- Limited access to own money
- Set time to get up in the morning
- Set bed times
- Routine bedroom/personal searches
- Not able to wear own/preferred clothing
- Set smoking/vaping times
- Rigid visiting hours
- Restrictions on incoming and outgoing mail
- Not able to take part in preferred activities/no meaningful choice of activities
- Cultural/religious needs not met
- Automatic use of enhanced obs on admission
- Supervised visits

Appendix 4 Training Needs Analysis

Training required to meet the policy requirements must be approved prior to policy approval. Learning and Development manage the approval of training. Send this form to lpt.tel@nhs.net for approval.

Training topic/title:	No required		
Type of training: (see Mandatory and Role Essential Training policy for descriptions)	X Not required ☐ Mandatory (must be on mandatory training register) ☐ Role Essential (must be on the role essential training register) ☐ Desirable or Developmental		
Directorate to which the training is applicable:	☐ Directorate of Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Estates and Facilities ☐ Families, Young People, Children, Learning Disability and Autism ☐ Hosted Services		
Staff groups who require the training: (consider bank /agency/volunteers/medical)			
Governance group who has approved this training:		Date approved:	
Named lead or team who is responsible for this training:			
Delivery mode of training: elearning/virtual/classroom/ informal/adhoc			
Has a training plan been agreed?			
Where will completion of this training be recorded?	☐ uLearn ☐ Other (please specify)		
How will compliance with this training to be audited?	Manager ulearn report Local manager personal records StatMand (Flash) topic compliance report Other please specify		
Signed by Learning and Development Approval name and date	[signature] ALISON O'DONNELL	Date: 22.8.25	

The NHS Constitution Appendix 5

- **The NHS will provide a universal service for all based on clinical need, not ability to pay.**
- **The NHS will provide a comprehensive range of services.**

Shape its services around the needs and preferences of individual patients, their families and their carers Yes.

Respond to different needs of different sectors of the population yes.

Work continuously to improve quality services and to minimise errors yes.

Support and value its staff yes.

Work together with others to ensure a seamless service for patients yes.

Help keep people healthy and work to reduce health inequalities yes**.**

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes.

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Appendix 6 Due Regard Screening Template

Section 1	
Name of activity/proposal	Blanket Restriction Policy
Date Screening commenced	March 2025
Directorate / Service carrying out the assessment	Enabling
Name and role of person undertaking this Due Regard (Equality Analysis)	Michelle Churchard- Smith, Deputy Director of Nursing and Quality
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy supports staff to provide care to patients in the least restrictive way. However, it is recognised that there may be times when in the interests of patient safety, a decision may be made that has direct impact on patients' ability to carry out an activity or move around freely. Where such decision takes place and are applied to everyone who uses the service or part of a service, these are referred to as blanket restrictions and this policy supports staff decision making and the recording blanket restrictions.	
OBJECTIVES: To ensure where blanket restrictions are required they are necessary and proportionate and kept to as minimal time as possible.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	No as all blanket restrictions are based on impact on individuals, individual and group risk assessments are completed prior to any restrictions.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	**X No**

High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor		Date	28 /03/2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	08/05/25

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Appendix 7 Data Privacy Impact Assessment Screening

<table>
<tr><td colspan="4">Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.</td></tr>
<tr><td>Name of Document:</td><td colspan="3">Blanket Restrictions Policy</td></tr>
<tr><td>Completed by:</td><td colspan="3">Michelle Churchard-Smith</td></tr>
<tr><td>Job title</td><td colspan="2">Deputy Director of Nursing and Quality</td><td>Date 28/03/25</td></tr>
<tr><td colspan="2">Screening Questions</td><td>Yes / No</td><td>Explanatory Note</td></tr>
<tr><td colspan="2">1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td><td>All information should be known to the care team.</td></tr>
<tr><td colspan="2">2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td><td>All information should be known to the care team.</td></tr>
<tr><td colspan="2">3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?</td><td>Yes</td><td>The CQC if required.</td></tr>
<tr><td colspan="2">4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?</td><td>No</td><td></td></tr>
<tr><td colspan="2">5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.</td><td>No</td><td></td></tr>
<tr><td colspan="2">6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?</td><td>Yes</td><td>If a restriction is applied to the individual based on risk assessment.</td></tr>
</table>

7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via **Lpt-dataprivacy@leicspart.secure.nhs.uk** **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**		
Data Privacy approval name:	**SRatcliffe**	
Date of approval	**21/08/2025**	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

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