THE USE OF GLOBAL RESTRICTIVE PRACTICES (BLANKET RESTRICTIONS) IN INPATIENT UNITS (M-025)

Version Number:	2.1
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Executive Lead (name & job title):	Dr Kwame Fofie, Medical Director
Name of approving body:	Mental Health Legislation Committee
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*1 December 2023 (QPaS)*
Date EMT as approving body notified for information:	*December 2023*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

This policy describes the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within Humber Teaching NHS Foundation Trust.

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 (MHA Code of Practice 1.6).

Each ward area will operate procedures and protocols that match the needs of the patient group, to ensure therapeutic progress whilst minimising risks.

- Wherever possible, the least restrictive option principle shall be observed in order to maximise patient independence and experience.
- Where an individual needs a greater degree of restriction usually observed in a particular ward, this is risk assessed, discussed with the patient, clearly documented and reviewed.
- Where a ward area needs to operate a blanket restriction over and above that authorised across the Trust, this should be done for the shortest reasonable time and be monitored and reviewed by the Matron through the Division clinical governance arrangements and reported to the Mental Health Legislation Lead and Trust wide Reducing Restrictive Interventions Group (RRI). If the blanket restriction needs to be in operation for an indefinite period, this should be registered at Mental Health Legislation Steering Group and the Trust wide Clinical Risk Management Group.

2. SCOPE

This policy applies to all clinical staff working in inpatient mental health and learning disability areas.

3. POLICY STATEMENT

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 purpose of the policy is to ensure that HTFT 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 and can evidence there has been a process of consideration and documentation which has been applied to each such restriction.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive will ensure that systems are in place and regularly monitored to ensure that all inpatient units regularly review and minimise any blanket restrictions.

Chief Operating Officer
The chief operating officer has responsibility to ensure that this policy is understood and adhered to by all clinical staff, and that all the processes and allocation of resources are in place to ensure the policy is fully implemented.

Divisional General Manager and Clinical Lead
The divisional general managers and Clinical Leads will ensure that all staff are aware of this policy and operate within it. Divisions will have a forum within its governance arrangements that addresses the issues described in this policy, most notably for the reduction of restrictive practices and interventions.

The divisional general managers and Clinical Leads should ensure the Mental Health Legislation Steering Group and Reducing Restrictive Interventions Group (RRIG) are alerted to any blanket restrictions implemented that are not authorised by the Trust.

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

Matrons
- The responsible matron for each unit will monitor this policy at regular intervals.
- Blanket restrictions that are not authorised across the Trust must be implemented in line with the process for implementation (5.4.2) and be monitored and reviewed by the matron through the care group clinical governance arrangements.

Unit Managers
- Each ward area will operate procedures and protocols that match the needs of the patient group, to ensure therapeutic progress whilst minimising risks.
- Wherever possible, the least restrictive option principle shall be observed in order to maximise patient independence and experience.
- Where an individual needs a greater degree of restriction than is usually observed in a particular ward, this is risk assessed, discussed with the patient, clearly documented and reviewed.
- Where a ward area needs to operate a blanket restriction over and above that authorised across the Trust, this should be done for the shortest reasonable time and must be implemented in line with the process for implementation (5.4.2)

Unit staff
Unit staff will be aware of any blanket restrictions in place on the unit, and work within the limits set. If any restrictions are of concern to ward staff, they must raise their concerns in line with Trust policy.

PALS/Complaints
To record and report on any instances where complaints have been made concerning the application of blanket restrictions in inpatient units.

5. PROCEDURES

5.1. Definitions

Term	Definition
Restrictive Interventions	'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 than is necessary'. (DoH, 2014) These include: • Physical and mechanical restraint (e.g. DMI) • Chemical restraint (e.g. rapid tranquillisation) • Seclusion and long term segregation All are described in Humber Teaching NHS Foundation Trust policy.
Restrictive Practices	Those practices that limit an individual's movement, liberty and/or freedom to act independently in order to maintain the safety and security of the site, service users and staff. This policy provides guidance regarding restrictive practices. Examples of restrictive practice include: • Room searches and rub down searches • Limiting access to courtyards, kitchens and other rooms/areas • Monitoring of communications and visits
Blanket Restrictions	The Mental Health Act Code of Practice defines blanket restrictions as "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." The Code's default position is that "blanket restrictions should be avoided unless they can be justified as **necessary** and **proportionate** responses to risks identified for particular individuals". The Code allows that secure services may impose some blanket restrictions on their patients. Where blanket restrictions are identified as necessary and proportionate there should be a system in place which ensures these are reviewed within a regular time frame, with an overall aim at the reduction of restrictive practices.

5.2. The need for blanket restrictions

The 2015 Mental Health Act Code of Practice allows for the use of blanket restrictions only in very specific circumstances.

Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records (MHA Code of Practice 8.5). Patient should be informed what the alternatives are during the period the blanket restriction is in place. Once discussion has taken place with each individual patient this must be recorded on Lorenzo in the 'blanket restriction impact discussion' communication note in the MHA and Legal tab in clinical charts.

Sometimes restrictions are needed for risk management in relation to one or more service users, but 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 restrictions, 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. Individual care planning may be required if there are reasonable and proportionate restrictions required for an individual at a certain time.

A 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 (MHA Code of Practice 8.6).

Within secure services, blanket restrictions can form part of the broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public (Mental Health Act Code of Practice 8.8).

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 (Mental Health Act Code of Practice 8.9).

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

5.3. Trust-wide blanket restrictions

Blanket Restriction	Rationale
No smoking on Trust premises	The policy supports the Public Health Guidance PH48 which prohibits smoking on Trust premises and grounds. This blanket restriction is Trust approved. Full details can be found in the Trust Smoke Free Policy.
No alcohol on Trust premises	Alcohol is not allowed as: • It can undermine the person's treatment programme • It can be a significant destabiliser for a person's mental health, negatively impacting on recovery • It can be a disinhibitor for aggressive and violent behaviour and/or self-harm, placing the service user and others at potential harm • It can interact negatively and potentially dangerously with prescribed medication and other drugs • It can be used to trade with or to coerce other people • Once on a unit its onward distribution cannot be controlled See Alcohol Withdrawal on Psychiatric Wards Guidance (G349).
No illicit drugs on Trust premises	Illicit substances are not allowed as: • Possession and distribution can constitute a criminal offence • It can undermine the person's treatment programme • It can be a significant destabiliser for a person's mental health, negatively impacting on recovery • It can be a disinhibitor for aggressive and violent behaviour and/or self-harm placing the service user and others at potential harm • It can interact negatively and potentially dangerously with prescribed medication • It can be used to trade with or to coerce other people • Once on a unit its onward distribution cannot be controlled

No New Psychoactive Substances (NPS) on Trust premises	NPS are not allowed since: • They have unpredictable effects on physical and mental health • They can be a significant destabiliser for a person's mental health, negatively impacting on recovery • They can be a disinhibitor for aggressive and violent behaviour and/or self-harm placing the service user and others at potential harm • They can interact negatively and potentially dangerously with prescribed medication • They can be used to trade with or coerce other people • Once on a unit its onward distribution cannot be controlled
Contraband and controlled Items List	The Trust has a duty to ensure the safety of staff and users of its services. A contraband and controlled items list is approved by the Trust, full details of these items are found within the Trust's Search (inpatient) Policy. All patients, staff and visitors are required to comply with this requirement. Additional items are prohibited within secure forensic services due to the level of security and risk matrix. The Forensic Prohibited and controlled items SOP FPS 010 provides the overarching rationale, and the contraband list is on display at all of our secure sites and regularly reviewed via the Forensic security committee. Regarding knives, it is recognised that some individuals may wish to hold a knife for religious reasons. This will be discussed with the service user and an individualised risk assessment agreed and updated on a regular basis.
All doors into inpatient clinical areas will be controlled	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 controlled. All main access points to bed based clinical areas will have a system so that access and exit is controlled by clinical staff and on a request basis. This is covered within the Entry and Exit for Non-secure Mental Health and Learning Disability Inpatient Units Policy. A patient's article 8 rights should be protected by ensuring ay restriction on their contact with family and friends can be justified as being necessary and proportionate and in the interests of the health and safety of the patient or others. The impact of a locked door policy on each patient should be considered and documented in the patient's records (MHA Code of Practice 8.12). A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction or a deprivation of liberty (MHA Code of Practice 8.10). To ensure appropriate implementation all patients must be informed about the locked door policy on admission, and informal patients must be able to leave at any time they wish to. All patients will be made aware individually and through appropriate signage. See Trust Policy Entry and Exit for Non-secure Mental Health and Learning Disability Inpatient Units Policy.

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

The CQC Brief Guide for Inspectors states that banning the following 'prohibited' or 'contraband' items SHOULD NOT BE CHALLENGED as a Blanket Restriction:

- 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
- Clingfilm; foil; chewing gum; blu-tack; plastic bags; rope; metal clothes hangers
- Laser pens
- Animals
- Equipment that can record moving or still images
- Smoke-free policies are deemed to be justifiable blanket restrictions

The CQC Brief Guide also refers to searching:

- General Acute Wards: Random or routine searching permitted if there is a specific case
- 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

5.4. Authorisation & monitoring of restrictions on a specific unit

If there is a need to introduce a blanket restriction on the grounds of risk of harm towards service users or staff, (at short notice), then immediate approval should be sought from the Matron / Service Manager (or whoever is authorised to carry out their duties in their absence) and arrangements made to have the situation considered by the local management team (Multidisciplinary Team and ward management team) as soon as possible.

5.4.1. What should not form part of a blanket restriction (exceptions may apply to secure units – see section 5.4.3 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) 8.7 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”.

Mobile phones and other electronic devices commonly have functions including cameras and video and voice recording capability. There is therefore the potential for patients and visitors to use such equipment in a way that interferes with the confidentiality, dignity and privacy of other patients, staff and visitors. Staff should be mindful of enabling patients and visitors to maintain communication and contact while protecting others against the misuse of such technology (MHA Code of Practice 8.17).

Please note that having ‘reasonable’ visiting times is not classed as a blanket restriction. It allows for planning staff resources, room booking, catering, and the arrangement of effective feedback / update where needed. If the ward had too many visitors to manage at any one time this would compromise the safety of patients and staff.

The MHA Code of Practice 11.5 states: “Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. **Reasonable and flexible visiting times**, access to refreshments and pleasant surroundings will all contribute to a sense of respect for the patient’s entitlement to be visited”.

Set hours should be clearly displayed, with the option to make individual arrangements outside those hours if required. It is seen as good practice for the units to use welcome packs, which state the visiting hours but also inform patients and their carers/families that visiting outside of normal

hours can be arranged and be flexible if needed. **This information should also be displayed on the visiting hours sign in the reception area**.

5.4.2. Process for implementing and managing a blanket restriction on a specified ward area

All service areas must identify blanket restrictions that are in place, using the CQC brief guide to Blanket Restrictions guidance

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 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?

All blanket restrictions identified must be added to the Trust blanket rules register and follow governance structure as described below.

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

- Access to certain service-user areas (for example kitchen), due to environmental risks that cannot be individually risk managed.
- Access to garden area due to service user being serious AWOL risk.
- Access to certain snacks and foods due to a service user having a severe food allergy.
- Access to takeaways limited to a certain frequency.

The expectation is that the need for such a blanket approach to manage the situation be fully explored before implemented, other alternatives must be considered first, including extra staffing / increased engagements, and it must be demonstrated that all other alternatives have been explored. Any such restriction must be time limited to manage the immediate risk or to put mitigations in place to manage that risk. Discussions should include the matron(s) and / or service manager. If an alternative cannot be identified and the blanket restriction still deemed necessary, ensure the following:

- The blanket restriction is in place for the shortest possible time.
- All affected service users must be made aware of why the decision was made. Any impact the restriction may have on each service user should be documented in the electronic patient record in the specific "blanket restriction impact discussion" note in MHA & Legal tab.
- All inpatients must be informed what the alternatives are during the period the blanket restriction is in place.
- The Mental Health Legislation Lead should be informed at the earliest opportunity for entry onto the Trust blanket restriction register and monitoring through the MHL Steering Group and Reducing Restrictive Interventions Group (RRI).
- The decision should be escalated through the Division Clinical Governance structure to the Divisional Clinical Lead and General Manager .
- Any blanket restriction which is enforced needs to be reviewed on **a shift by shift basis** so that it can be ended as soon as possible.
- The Mental Health Legislation Lead should be informed at the earliest opportunity of the end date and time.
- If the blanket restriction needs to be in operation for an indefinite period, this should be registered at Mental Health Legislation Steering Group and the Reducing Restrictive Interventions Group.

- The decision will be reviewed by the Mental Health Legislation Lead and Division Matron / Service Manager and if necessary, can be escalated to the Executive Management Team and the Mental Health Legislation Committee. It will be logged in the Reducing Restrictive Interventions MHL Committee quarterly report as an exception.
- Each area must review its practices, existing blanket restrictions and any discontinuation plans on a regular basis at Divisional Clinical Governance meetings (at least 6 monthly) in order to identify and minimise the use of blanket restrictions. A record of blanket restrictions must be maintained in the governance minutes.

5.4.3. Secure/Forensic Services

Within secure service settings some restrictions may form part of a broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public. The individual's need for such security measures should be justified to meet the admission criteria for any secure service. In any event, the application of security measures should be based on the needs of and identified risks for individual service users and impose the least restriction possible. Where individual service users in secure services are assessed as not requiring certain security measures, consideration should be given to relaxing their application, where this will not compromise the overall security of the service. Where this is not possible, consideration should also be given as to whether the service user should more appropriately be managed in a service that operates under conditions of lesser security.

The same level of oversight must be maintained as 5.4.2.

5.4.4. Individualised approaches to risk-based care planning

A service user would normally have access to all the activities and opportunities associated with that unit. However, for clinical and/or risk-based reasons, it may be appropriate for an individual service user not to have to access to one or more of those activities. This decision must be based upon a multi-disciplinary risk assessment, with a clear rationale why it is not appropriate at the current time, and when restrictions will be reviewed.

The service user must be made fully aware of why the decision was made, as well as how and when it is to be reviewed. This discussion will be documented on the electronic patient record (as described under 5.2 above), as well as the impact the restriction may have on the service user.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This policy is applicable to all people who are in receipt of mental health and learning disability services from the Trust and seeks to ensure that they receive safe, high quality care. People who have barriers to communication due to a disability or not speaking English as a first language will be made aware of the provisions of this policy in other ways.

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Deprivation is a matter of type, duration, effect and manner of implementation rather than nature of substance. Restrictions applied cumulatively may become deprivation (SCIE, 2013). A patient without the capacity to consent to remain voluntarily on units must have their rights safeguarded as set out under the Mental Capacity Act (2005). The use of the Mental Health Act (1983) should also be considered if an Informal patient is attempting to leave the ward and there are concerns for theirs or others wellbeing/safety. If the patient does not meet the criteria for detention under the Mental Health Act a DoLS application should be considered.

8. BRIBERY ACT

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to 10 years.

For further information see http://www.justice.gov.uk/guidance/docs/bribery-act-2010-quick-start-guide.pdf.

If you require assistance in determining the implications of the Bribery Act please read the Trust Anti-Bribery prevention policy available on the intranet or contact the Trust Secretary on 01482 389194 or the Local Counter Fraud Specialist on telephone 0191 441 5936 or email counterfraud@audit-one.co.uk

The Bribery act applies to this policy.

9. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy .

10. MONITORING AND AUDIT

All blanket restrictions are reported in a Mental Health Act exception report via the Mental Health Legislation Steering Group and monitored by the Mental Health Act Clinical Manager to ensure that the Trust are considering the least restrictive interventions for our patient group and that these are reviewed in a timely manner and mitigated against, and/or removed at the earliest opportunity.

The Trust blanket restriction register will provide appropriate oversight of blanket restrictions from "ward to board" and enable units to review with the wider MDT to ensure the management of any restrictions are regularly considered.

Each decision should be escalated through the Division Clinical Governance structure to the Divisional Clinical Lead and General Manager and also reported to the Mental Health Legislation Steering Group and Trust-wide Reducing Restrictive Interventions Group (RRI).

The blanket restriction will be logged in the Reducing Restrictive Interventions Mental Health Legislation Committee quarterly report as an exception.

Each area must review its practices, existing blanket restrictions and any discontinuation plans on a regular basis at Divisional Clinical Governance meetings (at least 6 monthly) in order to identify and minimise the use of blanket restrictions. A record of blanket restrictions must be maintained in the governance minutes.

Oversight and approval of the policy will be by the mental health legislation committee, in accordance with the remit of that group and on behalf of the hospital managers.

Matters can be brought to the attention of the Clinical Risk Management Group (CRMG) on an exceptional basis should urgent consideration be required of a potential blanket restriction. The CRMG meets weekly.

If the blanket restriction needs to be in operation for an indefinite period, this should be registered at Mental Health Legislation Steering Group and the Trust wide Reducing Restrictive Interventions Group.

Unit managers are responsible for ensuring that blanket restrictions are only applied when required, are used for the minimal period of time they are needed for and are not in place to either punish patients or in response to inadequate staffing. In coming to such a determination, the Responsible Clinicians and Modern Matron for that ward area must be consulted. Wards should escalate the imposition of a blanket restriction through the Matron and Service Manager.

11. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

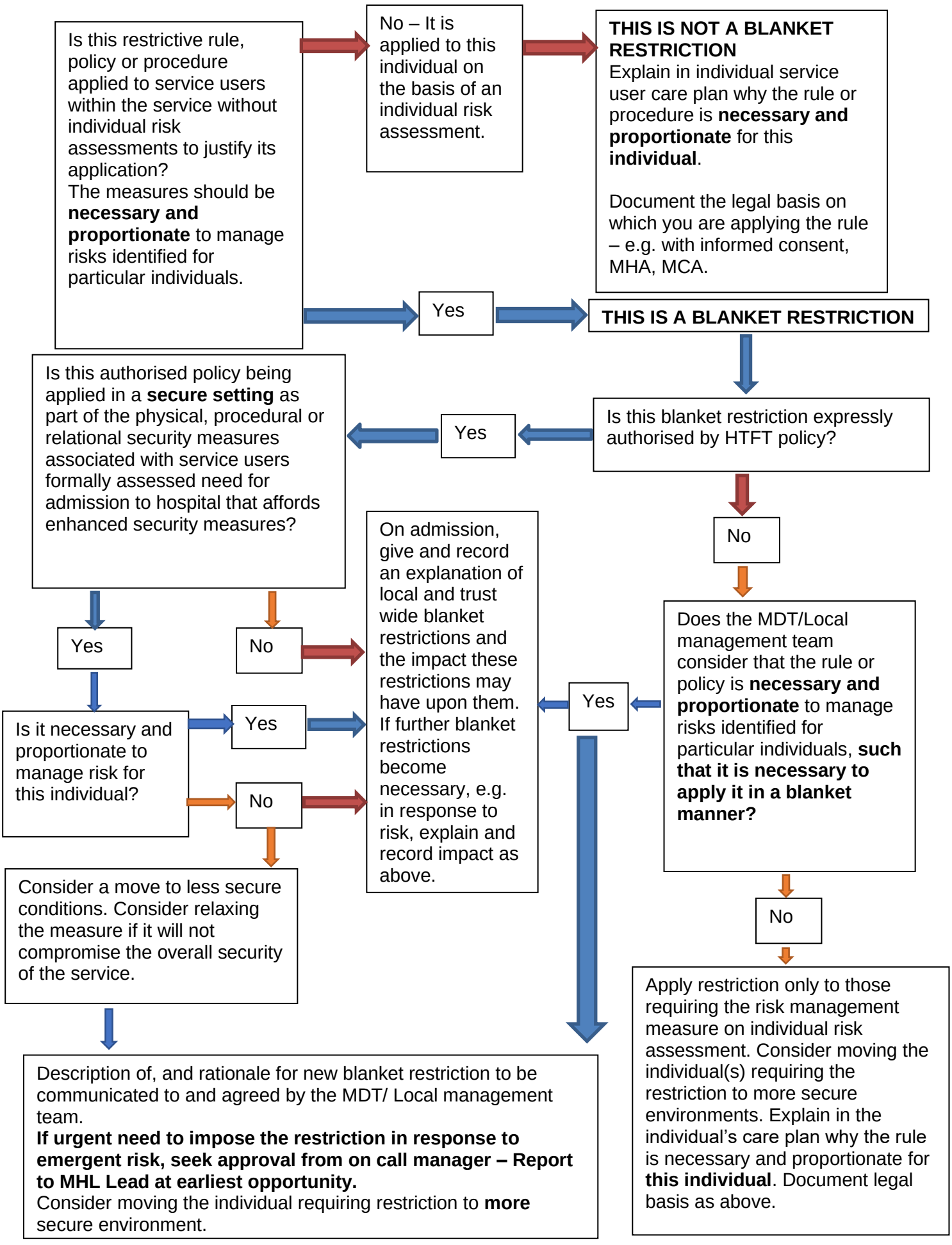
References/Evidence

- Brief guide: the use of ‘blanket restrictions’ in mental health wards. Care Quality Commission. (2017)
- Mental Health Act Code of Practice. Department of Health. (2015).
- Mental Capacity Act. Department for Constitutional Affairs. (2005).
- Positive & Proactive Care; reducing the need for restrictive interventions. Department of Health. (2014)
- Social Care Institute for Excellence (SCIE). (2013)
- Blanket Restrictions Policy, Birmingham and Solihull Mental Health NHS Foundation Trust
- Blanket Restrictions Procedure, Avon and Wiltshire Mental Health Partnership

12. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

- Search Policy Inpatient
- Seclusion (use of) or long term segregation
- Rapid Tranquillisation
- Physical Restraint

Appendix 1: Blanket Restrictions Flow Chart



Appendix 2: Document Control Sheet

Document Type	Policy – The use of Global Restrictive Practices (**Blanket Restrictions)** in inpatient units (M-025)		
Document 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		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and date	10.10.23	Reducing Restrictive Interventions Group	
	18.10.23	Mental Health Legislation Steering Group	
Approving Committee:	QPaS	Date of Approval:	1 December 2023
Ratified at:	Trust Board	Date of Ratification:	December 2023
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:			

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
V1.00	*New policy*	*May 18*	*New policy approved*
V2.00	*Full Review*	*Dec 20*	*5.2 Emphasis on need to discuss with each patient the impact of the blanket restriction (as per Code of Practice). Tightened up monitoring and Audit section (10).*
V2.1	*Full Review*	*Oct 23*	*Monitoring and audit arrangments tightened (Page 10), locked door impact (Page 7), considerations for mobile phones (Page 7).* *Approved at QPaS (1 December 2023).*

Appendix 3: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Policy on the use of global restrictive practices (blanket restrictions) in inpatient units
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Legislation Lead
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
This policy describes the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within Humber Teaching NHS Foundation Trust.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**LOW**	The purpose of this policy is to describe the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within Humber Teaching NHS Foundation Trust, and applies to the care delivered to all service users, regardless of age, disability, sex, marital status, pregnancy, race, religion, gender identity or sexual orientation.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	**LOW**	
Sex	Men/Male Women/Female	**LOW**	
Marriage / Civil Partnership		**LOW**	
Pregnancy/ Maternity		**LOW**	
Race	Colour Nationality Ethnic/national origins	**LOW**	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**LOW**	The purpose of this policy is to describe the arrangements for authorising, monitoring and reviewing restrictive practices, including global blanket restrictions, in use on wards within Humber Teaching NHS Foundation Trust, and applies to the care delivered to all service users, regardless of age, disability, sex, marital status, pregnancy, race, religion, gender identity or sexual orientation.
Sexual Orientation	Lesbian Gay Men Bisexual	**LOW**	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**LOW**	

Summary

Please describe the main points/actions arising from your assessment that supports your decision. No actions identified – this is a policy that applies to all inpatient areas, regardless of the patient group/profile.	
EIA Reviewer: **Michelle Nolan, Mental Health Legislation Lead**	
Date completed: **11 October 2023**	Signature: **Michelle Nolan**