Policy

NPCS 006 Blanket Restrictions

Executive Director lead	Executive Director of Nursing, Professions and Care Standards
Policy Author	Head of Mental Health Legislation; Deputy Director of Nursing (Operations); Clinical Psychologist, LD Services
Feedback on implementation to	Restrictive Practice Group

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Ratified By	Executive Directors' Group
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Target audience: All SHSC staff working into ward, residential, supported living, respite and day care environments.

Keywords	Blanket, restriction, service user, liberty, rights

Policy Version and advice on document history, availability and storage
This is Version 2.1, the Register of Blanket Restrictions, Section 14 added May 2018, revised April 2019.

This policy defines blanket restrictions in accordance with the Mental Health Act Code of Practice 2015. It has been updated to describe in more detail the actions to be taken in the event that a blanket restriction is unavoidable, including a new procedure to be followed if approval is needed urgently in response to a newly emerged risk. Duties in respect of the storage and return of private property, as required by The MHA Code of Practice have been included.

This policy is stored and available through the SHSC intranet and internet. This version of the policy supersedes the previous version (v1 September 2016). Any copies of the previous policy held separately should be destroyed and replaced with this version

Contents

Flowchart: Blanket Restrictions

Is this rule or policy, (being one which restricts service users' liberty or other rights) applied routinely to all patients/service users or to classes of patients/service users or within a service without individual risk assessments to justify its application?

The measures should be necessary and proportionate to manage risks identified for particular individuals

AVOID IF POSSIBLE

No – it is applied to this individual on the basis of an individual risk assessment

THIS IS NOT A BLANKET RESTRICTION

Explain in the individual's risk management or care plan why the rule or policy is **necessary and proportionate** for **this individual**.

Document the legal basis on which you are applying the rule – ie. part of their care/treatment under Mental Health Act or with informed consent or in their best interests under the Mental Capacity Act

Yes

THIS IS A BLANKET RESTRICTION

Is the blanket restriction on your local register and **expressly** authorised by SHSC policy – ie are the description of the restriction and its rationale appended to this policy?

Yes

Is this authorised policy being applied in a **secure setting** as part of the physical, procedural or relational security measures associated with patients'/service users' formally assessed need for admission to accommodation that affords enhanced security measures?

Yes

Is it necessary and proportionate to manage risk for **this individual**?

Yes

No

Consider a move to **less** secure conditions. Consider relaxing the measure if it will not compromise the overall security of the service

No

No

Does MDT/SMT consider that the rule or policy is **necessary and proportionate** to manage risks identified for particular individuals, **such that it is necessary to apply it in a blanket manner**

Yes

On admission, give and record an explanation of Trust-wide and local blanket restrictions and the impact of this blanket restriction has on them.
If further blanket restrictions become necessary, eg in response to emergent risk, explain and record impact as above

No

Apply restriction only to those requiring the risk management measure on individual risk assessment. Consider moving the individual(s) requiring this restriction to **more** secure conditions. Explain in the individual's care plan why the rule is **necessary and proportionate** for **this individual**. Document legal basis as above

Description of, and rationale for, new blanket restriction as agreed by EDG must be appended to this policy.
If urgent need to impose the restriction in response to emergent risk, seek immediate approval from Director/Associate Director and arrange for EDG approval as soon as possible – report as an incident
Consider moving the individual(s) requiring this restriction to **more** secure conditions

1. Introduction

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 service users], or to classes of patients [or service users], or within a service, without individual risk assessments to justify their application' (Mental Health Act Code of Practice 2015 Ch 8.5).

Blanket restrictions are sometimes needed in order to ensure safety within service areas operated by SHSC. 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 a person's right to a private life. This policy is in place to ensure that SHSC fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim of reducing them to a minimum.

2. Scope

This is a Trust wide policy and applies to all areas in which the Trust supports people in ward, residential, supported living, respite or day care environments.

3. Definitions

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 service users], or to classes of patients [or service users], or within a service, without individual risk assessments to justify their application' (Mental Health Act Code of Practice 2015 Ch 8.5).

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

Note that blanket restrictions, as defined by the CoP require:

a) a RULE or POLICY which
b) Restricts LIBERTY or other RIGHTS and
c) WITHOUT an individual risk assessment for each person affected, is
d) APPLIED TO ALL PATIENTS [or service users] or to CLASSES of PATIENTS [or service users] or WITHIN A SERVICE

4. Purpose

Paragraph 1.6 of the Mental Health Act Code of Practice (2015) 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.

In addition, Chapter 8 of the Mental Health Act Code of Practice 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 on Human Rights (ECHR). It pays particular attention to the practice of implementing blanket restrictions.

No form of blanket restriction should be implemented unless expressly authorised by the Executive Directors Group (EDG) on the basis of the organisation's policy and subject to local accountability and governance arrangements (Code of Practice Ch 8.9)

Blanket restrictions which have been approved by EDG will be appended to this policy; any such appended restriction will be deemed to meet the Code of Practice requirement for being expressly authorised by the Hospital Managers on the basis of Trust policy.

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

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 and a proper process of consideration and documentation is applied to each such restriction.

5. Duties

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 the Executive Director of Operations is responsible for keeping the policy is updated and available for staff.

The Executive Directors Group is responsible for approving and monitoring blanket restrictions for use in specific service areas.

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

Ward/Team/Department Managers 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

All staff members are responsible for ensuring that their practice is safe and legal. All staff members are required to ensure they (and anyone they line manage) abide by SHSC requirements as set out in this policy.

6. Procedure

6.1 Principles of Practice

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

General principles

- Blanket restrictions 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 food/drinks, access to money or the ability to make personal purchases, or take 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. (MHA Code of Practice Ch 8.5)
- 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 individual's care plans. (CoP Ch 8.5)
- Sometimes restrictions are needed for risk management in relation to one or more service users, resulting in blanket restrictions which necessarily 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.
- 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 than can be shown to be necessary. (CoP Ch 8.6)

Legal frameworks

- If the patient/service user is not subject to the Mental Health Act (either detained, or consenting – under MHA s131- to informal admission and the attendant restrictions) the MHA CoP has no application. Due consideration must therefore be given to the alternative legal framework afforded by the Mental Capacity Act 2005 (MCA); ie any restriction, blanket or otherwise, is carried out with informed consent, or – if mental capacity is absent – in the patient/service user's best interests.
- If blanket restrictions amount to a deprivation of liberty as defined by the 'acid test' set in the *Cheshire West* case[1] (ie 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 under the MCA (if they are in hospital or a registered care home) or an order made of the Court of Protection (in any other setting).

[1] *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] AC 896

6.2 Process – prohibited items and searching

6.2.1 There is an agreed Trust-wide list of items not allowed in care areas (lighters/matches and fire hazard materials; illicit drugs/substances; alcohol; medication from home; weapons/sharp instruments; rope; pornographic materials; violent/racist materials). By local agreement, other items may be added to this list

6.2.2 If there is cause to search a detained patient or their belongings or surroundings, the search must be done in accordance with Trust policy and the MHA Code of Practice (Ch 8.29 – 8.46). 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 Personal Search policy

6.2.3 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 the MHA Code of Practice Ch 8.24

6.2.4 Please refer to the relevant policies for the management of property 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 with regard to other potentially illegal items, such as extreme pornographic materials.

6.2.5 Do not destroy or dispose of any property without specific permission from a relevant Director or, in their absence, Associate Director

6.2.6 An incident form must be completed to record the handing over of property for disposal by others, or the granting of permission to destroy or dispose of property by Trust staff

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

6.3.1 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
- tems 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

6.3.2 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

6.3.3 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

6.4 Identification and Documentation of Blanket Restrictions

6.4.1 The impact on each patient of any blanket restriction must be recorded.

6.4.2 Each care area will have a document detailing any Trust-wide blanket restriction in the blanket restrictions in place in that location. The patient will be informed of these restrictions as part of the process of explaining their rights under the MHA, and a record made that they have received this information

6.4.3 Any Trust-wide blanket restrictions will be supported by a single rationale

6.4.4 Each area will maintain a register of any blanket restrictions over and above the Trust-wide blanket restrictions

6.4.5 Each blanket restriction will be identified and supported by a blanket restriction identification and justification form (Appendix ?). The latter will describe a clear rationale for applying the restriction in a blanket fashion and any discontinuation plan

6.4.6 Blanket restrictions approved by EDG will be appended to this policy

6.4.7 Each area must review its practices, existing blanket restrictions and any discontinuation plans on a regular basis at its governance meetings (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 governance minutes

6.4.8 In the event that a practice is newly identified as a blanket restriction, an identification and justification form must be completed and submitted to EDG for approval

6.4.9 If it <u>is not immediately necessary</u> to apply the restriction in a blanket fashion, ensure that it is only applied to the patient/s whose presentation warrants the restriction

6.4.10 If it <u>is immediately necessary</u> for risk-management purposes to impose the restriction in a blanket fashion, this must be authorised by the Service Director or the person formally deputising for the Service Director

6.4.11 The imposition of an immediately necessary blanket restriction must be reported by completion of an incident form

6.4.12 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)

6.4.13 The identification and justification form must be provided to the Service Director or his/her deputy as soon as is practicable

6.4.14 If the need for the blanket restriction continues, it must go before the EDG at the first opportunity

6.5 Issues specifically relating to secure services (MHA Code of Practice Ch 8.8)

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.

SHSC has a low secure unit (Forest Lodge), a locked Psychiatric Intensive Care Unit (PICU - Endcliffe Ward) and locked intensive rehabilitation provision at Forest Close.

Each of these areas has specific criteria for admission and protocols for discharge which conform to the requirements of the Code of Practice in respect of the need for the care of an individual patient to be delivered in conditions of enhanced security

6.6 Governance arrangements

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

6.6.2 Any blanket restriction identified by the CQC during inspections or MHA monitoring visits will be addressed by the resulting Trust action plan or the ward's Provider Action Statement (PAS), respectively

6.6.3 CQC action plans are monitored by the Care Standards Team and reported into EDG, QAC and Board

6.6.4 MHA PAS are monitored by the MHA Committee, and reported into EDG, QAC and Board

6.6.5 The Restrictive Interventions Group will maintain oversight of all blanket restrictions and will include details in Quarterly reports to EDG, QAC and Board

6.7 Communication

Details of prohibited items will be communicated to staff and patients by a range of means , including posters, leaflets, booklets, letters and in patient forums

The existence of Trust-wide blanket restrictions and any locally necessary blanket restrictions will be communicated to staff at induction/preceptorship, staff meetings and by e mail.

7. Dissemination, storage and archiving (Control)

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 Digest immediately following publication.

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8. Training and other resource implications

There is no specific training implication for this policy. However, it is an expectation that consideration may be given to it in other SHSC mandatory training (specifically Mental Capacity Act, Deprivation of Liberty Safeguards, Mental Health Act and RESPECT training).

9. Audit, monitoring and review

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Directorates to be assured that policy is being followed in their service areas	Audit	Service Director	Annual	Reducing Restrictive Practices Project group	Reducing Restrictive Practices Project group	Executive Directors Group

Review date for policy – July 2019

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via all staff e mail	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of ratification	

11. Links to other policies, standards and legislation (associated documents)

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
Substance Misuse and Harmful Substances on Inpatient Wards Policy
Security Policy
Search Policy

12. Contact details

Title	*Name*	*Phone*	*Email*
Head of Mental Health Legislation	Anne Cook	0114 226 4913	anne.cook@shsc.nhs.uk
Assistant Clinical Director, Specialist Service – Older Adults	Anthony Bainbridge	0114 226 4267	anthony.bainbridge@shsc.nhs.uk
Clinical Psychologist	Zara Clarke	0114 226 1562	zara.clarke@shsc.nhs.uk

13. 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

Sheffield Health and Social Care NHS Trust - Inpatient – Trust Wide Blanket Restrictions Register – April 2019

To be read in conjunction with SHSC Policy, Code of Practice, CQC Guidance on Blanket restrictions, justification forms and Individual team registers.

Revised Register Approved at Clinical Operations meeting 28th March 2019.

Blanket Restriction	Areas Applicable to	Description of Blanket Restriction	Identification and Justification form complete (Y/N, Date)	SHSC Policy/ Code of Practice	Date of Authorisation by EDG	Date of Review
Leave Risk Assessment	Stanage Burbage Dovedale Maple Endcliffe Forest Close(B1, B1a and B2) Forest Lodge (Assessment and Rehab) Firshill Rise G1	Everyone routinely risk assessed prior to being allowed leave.		Mental Health Act Section 17 – Authorisation of Leave Policy November 2016- October 2019	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Visiting Times and Visiting Areas	Stanage Burbage Dovedale Maple Forest Close(B1, B1a and B2) Firshill Rise	Each area has set visiting times, applied to everyone routinely – this is negotiable in some		Trust Visitors Policy April 2016 – March 2019 Review March 2019 –	17th May 2018	November 2018 Reviewed November and December 2019 and remains necessary and proportionate

	G1	circumstances. This is clearly communicated at ward level via ward Booklets and Information posters. Review and Update Child Visiting SOP now in place.		additional guidance has now been provided on child visiting		
Visiting Times and Visiting Areas specific to Endcliffe and Forest Lodge	Endcliffe Forest Lodge (Assessment ward and Rehab Ward)	All visits to Endcliffe ward must be pre-booked into set slots. Visitors are generally limited to the visitor's room or interview room. All visits are supervised and covered by CCTV. Visiting slots are as flexible as possible to ensure those wishing to visit have opportunity to do so. Visiting to Forest Lodge is pre booked and generally		Trust Visitors Policy April 2016 – March 2019. Commissioning Guidelines for Secure Services/Low Secure Quality Standard	17th May 2018	November 2018. Reviewed November and December 2018 and remains necessary and proportionate

		escorted unless risk assessment indicates this is not required. Visitors are asked for identification Review and Update Endcliffe A SOP is being devised to cover the handing in of bags of visitors' due to concerns and actual incidents of supplying restricted items and illegal substances. Currently this is done on a case by case basis where there is cause for concern and is incident reported.				

Smoke Free	Stanage Burbage Dovedale Maple Endcliffe Forest Close(B1, B1a and B2) Forest Lodge (Assessment and Rehab) Firshill Rise G1	Smoking is not permitted on any Trust site.		Nicotine Management & Smoke Free Policy April 2018 – May 2020	17th May 2018	November 2018. Reviewed November and December 2018 and remains necessary and proportionate
E-Cigarette / Location of use	Stanage Burbage Dovedale Maple Endcliffe Forest Close(B1, B1a and B2) Forest Lodge (Assessment and Rehab) Firshill Rise G1	The type of e-cigarettes is restricted to Trust permitted products. The use of e-cigarettes is restricted to external garden areas or local designated areas		Nicotine Management & Smoke Free Policy April 2018 – May 2020	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Garden Access	Maple Firshill Rise	Garden door is locked at dusk every night and unlocked on request if service users wish to use the garden. Review and update Firshill		Risk Management policy	17th May 2018	November 2018 New authorisation required

		Garden doors are locked at all times and access is managed by staff on request and is supervised. This is related to the gardens having easy access points, inadequate fencing and being out of view of the main ward. This is being reviewed to establish if any changes can be made to make this safe and therefore reduce this restriction. A sign on the door is to be made to explain the rationale for this. Maple Ward Has been restricted since October 2018 following a serious incident and the current practice is the door is locked,				

		staff observe and man the door at all times and observe users at all times in the garden. This applies to all service users.				
Garden Access	Dovedale	Garden door is locked at 8pm every night and unlocked on request if service users wish to use the garden.		Risk Management policy	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Garden Access	Forest Lodge Assessment ward Rehab ward Endcliffe	Doors are locked and opened on request. Garden Access is supervised Doors are locked at night and open during the daytime Review and update Identified risk issues in garden requiring garden to be placed on constant observations. At		Risk Management policy	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate New authorisation required until work completed to remove posts

		times this had meant that the garden has had to be locked. This has been incident reported. The ward await removal of the risk items at which point it will revert to open access and routine observations and will no longer constitute a blanket restriction.				
Access to Maple Ward from Place of Safety Suite	Place of Safety	Access from the 136 suite onto the main body of the ward is subject to risk assessment		Mental Health Act 136 Policy November 2017 – March 2019 136/Place of Safety Policy & Guidelines	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Search (Property and Personal)	Endcliffe Forest Lodge (Assessment and Rehab)	Every service user is searched on admission and following any leave where the service user has been out of sight for any time. Any restricted or prohibited items		Search Policy June 2017 – September 2019	17th May 2018	November2018 Reviewed November and December 2018 and remains necessary and proportionate

		are removed at this point. The use of a metal detector Wand is used. Review and Update Endcliffe and forest Lodge In the process of implementing a body scanner. This will be supported by a SOP				
Energy Drinks	Endcliffe	Energy drinks are removed if found			17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate

Beverage Bay	Endcliffe	Generally open and accessible. Hot drinks are always available but this area can be locked subject to risk assessment which will then impact on all the service users on the ward. This would be reported as an incident and immediate authorisation sought and added to the register.		Risk Management Strategy November 2017 – November 2018	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Access to Drinks via kitchen/kitchenette	G1 Firshill Rise Forest Lodge(Assessment)	Managed access. If hot weather then cold drinks are available at any time. If unable to request drinks, these are routinely offered. Posters are displayed to advise service users to ask staff. Review and Update		Risk Management Strategy November 2017 – November 2018	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate

		Firshill Cool water/sink unit drinks station on both corridors (9.1.19)				
Glassware	G1 Forest Lodge Firshill Endcliffe	Removed and stored.		Risk Management Strategy November 2017 – November 2018	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate
Toiletries (i.e. Razors)	Forest Lodge (Assessment and Rehab) Firshill Endcliffe	Managed access. Allowed once individual risk assessment undertaken. Endcliffe have individual restricted items cupboards in individual bedrooms. Forest Lodge have personal boxes in reception area. Firshill have to store in office safe. Personal safe storage is being pursued		Risk Management Strategy November 2017 – November 2018	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate

Egress of Dining Room at Meal Times	Forest Lodge Assessment Ward	All service users are asked to remain in the dining area until other service users have finished their meal so that all cutleries can be accounted for. Any service user who is unable or unwilling to remain is kept under eyesight of staff until all cutleries are accounted.	To manage and support service user and staff safety and level of security		Royal College of Psychiatrist's Forensic Services Quality Standards	New authorisation required
Monies	Firshill	Removed and stored in office safe. Unit in process of looking at individual safes to support personal self-storage. Review and update November 2018 Newly fitted hotel style safes have now been installed in all		Security Policy February 2016 – August 2018. Service User Property and Money Policy November 2016 – August 2019	17th May 2018	November 2018 To remove from register

		bedrooms. Subject to capacity assessments to manage own money				
Takeaways	Forest Lodge (Assessment and Rehab) Forest Close(B1, B1a and B2)	Forest Lodge 2 times per week Wednesday and Saturday Forest Close only allow takeaways on 1 or 2 set days a week – this is regularly reviewed at community meetings. Service Users are able to access take-aways whilst on leave.		Nutritional and Hydration Strategy March 2017-March 2019	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate

Locked Doors	Stanage Burbage Dovedale Maple Endcliffe Forest Close(B1, B1a and B2) Forest Lodge (Assessment and Rehab) Firshill Rise G1	All entrance and exit doors are managed via a staff security system in varying forms. Doors can only be opened by staff. This is to ensure anyone entering or exiting the wards can be accounted for and to ensure security and safety of all. In addition some areas of the wards have locked doors. These are either staff only areas or where the room is for specific use or has access to items that are deemed dangerous or could cause harm. Each team register has a full list of locked doors and the reasons for this. Review and		Security Policy February 2016 – August 2018. Managing Access and Exit Policy July 2016 – July 2019	17th May 2018	November 2018 Reviewed November and December 2018 and remains necessary and proportionate

		Update Endcliffe and Firshill Service users continue to need to ask staff for access to their bedrooms due to a design fault on doors. This is being progressed as several new access means have been trialled.				

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	Draft policy creation	June 2016	No previous policy
0.2 – 0.3	Updated following consultation	July 2016	Amendments made during consultation
0.4	Re-formatted for new policy document template	Sept 2016	Re-formatted for new policy document template. Appendices updated.
1.0	Ratification and issue	Sept 2016	
0.2		August 2017	Amendments to policy and flow chart to ensure that both match the MHA CoP and address issues raised in CQC inspections and CQC MHA monitoring visits

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	Sept 2016	Targeted Clinical Leads/ Service Mangers	Communications Digest Sept 2016 – all staff
2.0			

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
DISABILITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
GENDER REASSIGNMENT	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
PREGNANCY AND MATERNITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
RACE	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
RELIGION OR BELIEF	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.

SEX	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
SEXUAL ORIENTATION	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.

Stage 4 – Policy Revision - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended

Impact Assessment Completed by (insert name and date) Anne Cook, Head of MH Legislation, 15/03/2018

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

X **Yes. No further action needed.**

2. On completion of flow diagram – is further action needed?

X **No, no further action needed.**

☐ **Yes, go to question 3**

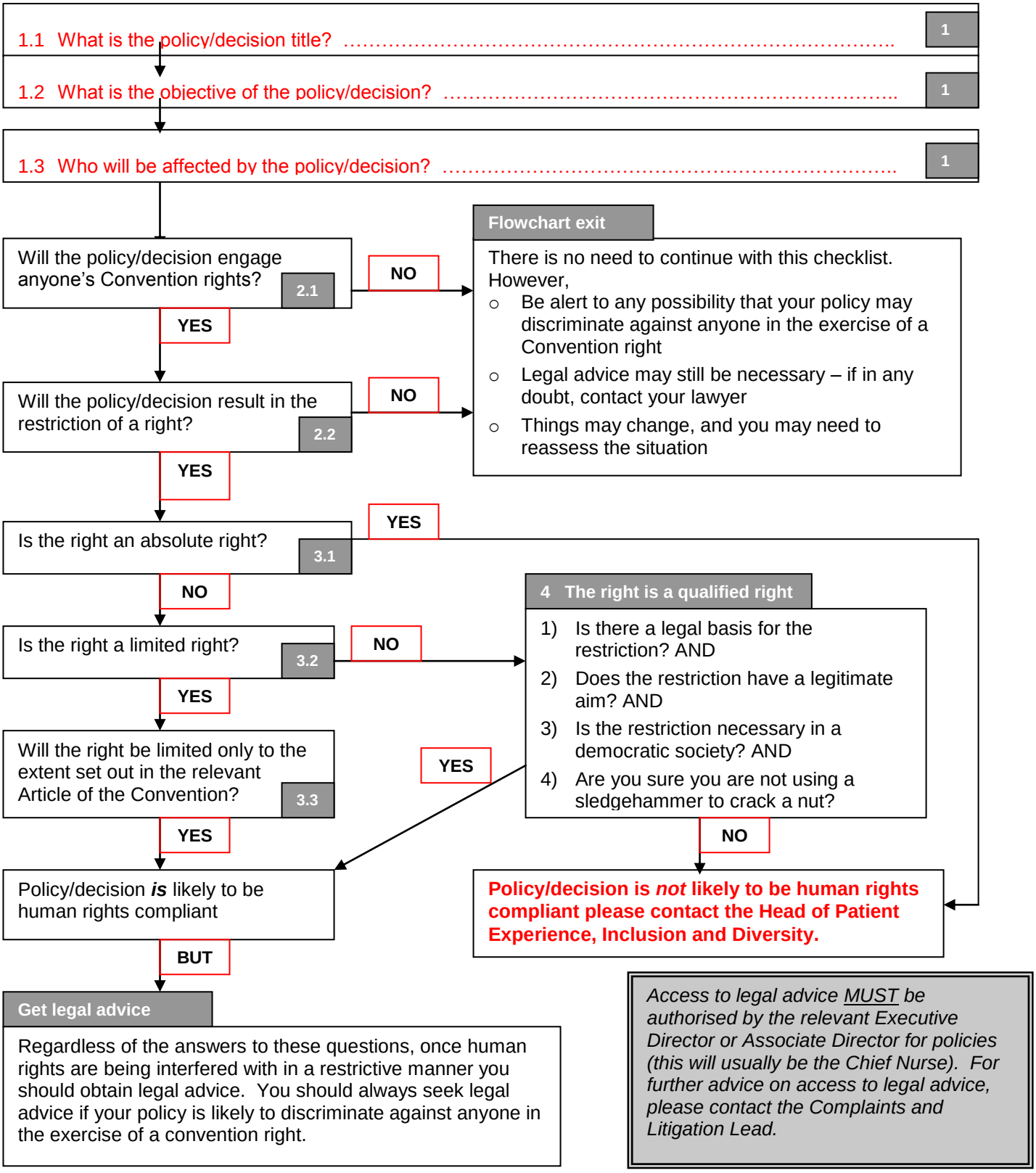
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

- *Policy Authors: Zara Clarke, Anne Cook, Anthony Bainbridge*
- *Guidance followed; Mental Health Act Code of Practice 2015 / Mental Capacity Act 2005*
- *Groups and individuals consulted: SHSC Restrictive Interventions Project Group*
- *Any changes made as a result of the consultation process: Consultation held between 30.06.2016 – 19.07.2016. 3 drafts produced by authors. No other comments received.*
- *Which governance group verified the document: Restrictive Intervention Project Group (RIPG) on 25 August 2016.*

V2

- *Policy Authors: Zara Clarke, Anne Cook, Anthony Bainbridge; Revised by Anne Cook*
- *Guidance followed; Mental Health Act Code of Practice 2015 / Mental Capacity Act 2005*

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Document type ✓
- Document status ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart ✓

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ✓

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓