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Safe Use of Blanket Restrictions

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1 Introduction

Blanket Restrictions are defined as:

'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).

This definition is to be applied to all service areas within Tees, Esk and Wear Valleys NHS Trust (TEWV), not just hospital wards.

Blanket restrictions are sometimes needed in order to ensure safety within service areas operated by Tees, Esk and Wear Valleys NHS trust. However, as a Trust we recognise that such restrictions have the potential to have an impact 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 procedure is in place to ensure that TEWV fulfils its legal and good practice obligations in relation to blanket restrictions. The Trust will work with the overall aim of reducing restrictions to an individual, patient or group of patients.

2 Purpose

The purpose of the procedure 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 procedure 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 such restrictions where they exist.

3 Who this procedure applies to

This is a Trust wide procedure and applies to all areas in which TEWV supports people in ward and other services whereby TEWV is the responsible provider of care.

4 Related documents

- Supporting behaviour that challenge other policy
- Safety and Risk Management policy (formerly known as Harm Minimisation Policy)
- Rapid tranquilisation Policy
- Tear Proof clothing procedure
- Safe use of long-term segregation procedure
- Privacy and dignity policy

- Human Rights, Equality Diversity and Inclusion Policy
- Safe use of mechanical restraint equipment procedure
- Supportive observation and engagement procedure
- Physical health and wellbeing policy
- Health and safety policy
- Procedure for addressing verbal and physical aggression towards staff by patients, carers, and relatives
- CCTV Policy
- Visiting policy (inpatients)
- Searching of adult in-patients, their property, the environment, and visitors policy
- Safe use of seclusion procedure
- Interpreting and Translation Policy
- Interpreting and Translation Procedure
- Nicotine management policy

5 Blanket restrictions

Blanket restrictions, as defined by the Code of Practice require:

- **A RULE or PROCEDURE which Restricts LIBERTY or other RIGHTS and**
- **WITHOUT an individual risk assessment for each person affected, is**
- **APPLIED TO ALL PATIENTS (or service users) or to CLASSES of PATIENTS (or service users) or WITHIN A SERVICE**

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

Each area will have documentation detailing any Trust Wide blanket restriction as well as the blanket restrictions in place in that location. The patients 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.

Any Trust wide blanket restriction will be supported by a single rationale.

Each area will maintain a local register of any blanket restrictions.

Each blanket restriction will be identified and supported by the completion of an incident report.

Each area must review its practices; existing blanket restrictions and any discontinuation plans on a regular basis at trust positive and safe meetings (at least bi-monthly) in order to identify and minimise the use of blanket restrictions. A record of blanket restrictions must be maintained in the governance minutes.

In the event that a practice is newly identified as a blanket restriction, an incident form should be completed.

If it is immediately necessary for risk management purposes to impose the restrictions in a blanket fashion, this must be authorised by the senior nurse of the site / Service Manager or the named person deputising in their absence.

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

If it is not immediately necessary to apply the restriction in a blanket fashion, ensure that it is only applied to the patients whose presentation warrants the restrictive intervention or restrictive practice

All patients must be informed that the restriction is in place and why.

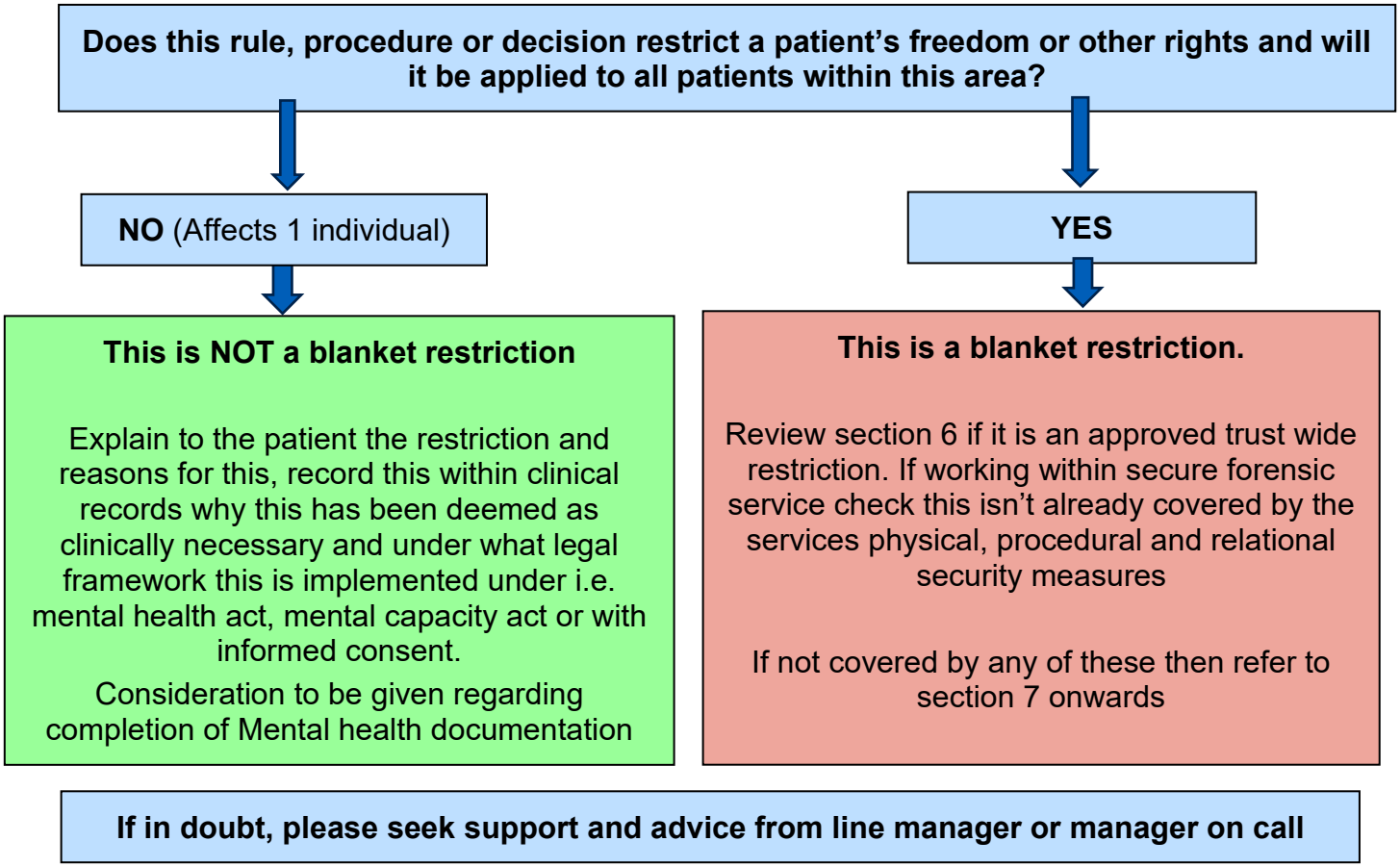
Any blanket restriction which is enforced needs to be regularly reviewed based on the type of restriction. This could be as frequently as shift-by-shift basis in some cases, but would be for the least amount of time required.

5.1 The need for blanket restrictions / What will not form part of any blanket restriction.

As far as possible blanket restrictions should be avoided unless they can be justified as a necessary and proportionate response to an identified risk. The risk would normally apply to a particular patient having been identified through their individual risk assessment. A risk management plan must be put in place. 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.

5.2 Blanket restriction decision making tool

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



6 Authorised blanket restrictions.

6.1 TEWV Authorised Blanket restrictions.

Whilst it is important that patient's human rights are not infringed there are times when a balance needs to be made based on safety for patients and staff. With this in mind, the Executive Management Team have authorised the following restrictions as being appropriate and proportionate to the provision of safe care within the Trust inpatient and day service facilities:

	Blanket restriction	Rationale
1	**Patients are not permitted to smoke when on staff escorted leave**	The Trust Patient and Visitor Harm Reduction Smoke Free Procedure does not permit patients to smoke whilst on staff escorted leave as it would expose staff to the inhalation of secondhand smoke.
2	**Alcohol and New Psychoactive Substances (NPS or legal highs)**	Are not permitted on Trust premises - Alcohol and legal highs are not allowed on the inpatient or day service 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 behavior which could place them and/or others at risk.
3	**Illicit drugs are not permitted on Trust premises**	No illicit drugs are allowed on Trust premises as the possession and distribution of these can constitute a criminal offence. Additionally, the potential adverse effects on a patient can be as described in the section above relating to use of alcohol.
4	**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 that it will be considered offensive to most people. Please note that this only applies to illegal pornographic material and not mainstream Adult Material.
5	**Items which can be used as weapons are not permitted on Trust premises**	The Trust would be negligent in its duty to protect the people under its care or employment if it knowingly allowed weapons onto its premises. Items carried with adherence to individuals' religious beliefs which may be considered a potential weapon. In the event of an individual (staff/patients/authorised visitor) needing to carry an object of religious importance, a suitable and sufficient risk assessment must be undertaken to effectively manage any risks.
6	**Material that incites violence or racial/cultural/ religious/gender hatred is not permitted on the wards**	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.

7	**All doors into clinical areas will be locked**	A safe and protective environment for patients, staff and visitors within in-patient areas is of the utmost importance to the Trust. To support this, access to and exit from in-patient areas needs to be managed. All main access points to bed-based clinical areas will have a system so that access and exit is managed by clinical staff and on a request basis. This is covered within the Controlling Access to and Exit from Inpatient Areas procedure. A patient's article 8 rights should be protected by ensuring any restriction on their contact with family and friends can be justified as being proportionate and in the interests of the health and safety of the patient or others.
8	**Access to courtyards and outdoor spaces at night**	To maintain a safe ward environment at night access to outside courtyard areas will be restricted. A ward will have the ability to open outdoor courtyards at night on an individual or group basis depending upon the specific circumstances at the time, as long as they can be assured that staffing arrangements allow this to be done safely.
9	**Lighters and matches**	To maintain safe ward environments lighters and matches are restricted within all inpatient environments. Staff members are expected to inform patients and visitors of the restricted items but are not expected to enter any confrontation that may put their personal safety at risk.
10	**Plastic bags**	Plastic bags will be restricted in all unsupervised patient areas in Adult Acute Inpatient Admission wards and in Psychiatric Intensive Care units. Plastic carrier bags and refuse bags – not permitted in unsupervised patient areas in the Secure inpatient service. In all other clinical areas access to plastic bags is individually risk assessed.

6.2 CQC Guidance on items that could be considered 'blanket restrictions'

The CQC clearly state that it is a matter for each service to determine their restricted items in accordance with the principle of adopting a least restrictive approach. CQC guidance can be found here: CQC Blanket Restrictions Guidance

Items that the CQC would not challenge if subject to a blanket restriction		
	All inpatient services Including secure services)	Additional considerations in Secure services
Prohibited within TEWV currently	Alcohol and drugs or substances not prescribed (including illicit and legal highs) Items used as weapons (firearms- real or replica, knives or others sharps, bats) Material that incites violence or racial/cultural/religious/gender hatred	Items considered as an escape aid
May be subject to restriction in some services or individually risk assessed in TEWV	Pornographic material (illegal material is prohibited in TEWV) Fire hazard items (flammable liquids, matches, incense) Clingfilm, foil, chewing gum, blue tack, plastic bags, rope, metal clothes hangers Laser pens Animals Equipment that can record moving or still images (camera, web cameras) Disposable cigarette lighters Toiletries- aerosols, razors Identity documents, bank cards, items of stationery Cutlery, tinned materials, glassware	Mobile phones Computers, tablets, games devices with hard drives or sharing capabilities Items with voice recording capabilities Other items with enabled WiFi/internet capabilities

6.3 CQC normative expectations

The CQC identified the following in their normative expectations (2025) regarding blanket restrictions at different security levels (see next page):

	Security level				
	General (acute)	**PICU**	**LOW**	**MEDIUM**	**HIGH**
Banned items	All services will have banned and restricted items: alcohol, weapons, illicit drugs		All services will have banned and restricted items in addition to those found in general (acute) ward policies		
Random or routine searching	Not without specific cause	Procedure 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	Patients should be able to carry their own mobile phones, including smartphones. The ward should also provide a phone for patients to use in private, and internet access. Restrictions on access should be individually justified and not be a blanket measure. Wards may 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).		It is more common now for patients to have smartphones on low secure wards, with access on the basis of individual risk assessment.	Patients should have access to basic mobile phones (subject to individual risk assessment). Will commonly have access to smartphones on section 17 leave which may be kept at reception. On the ward, access to internet likely to be supervised and restricted as part of ward security.	All access to the 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	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				

takeaway food	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	Any restriction on access to food and drinks should have a clear rational for this, that is relevant to the current patient group and is subject to ongoing review. Such restrictions would normally be managed on an individually risk assessed basis.		
Smoke Free	See CQC Brief Guide BG025 Smokefree policies in mental health inpatient services		
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
Telephone monitoring	No legal powers to monitor patients' telephone calls. Patients can 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
Garden / Courtyard Access for fresh air	Either open access for all patients, or unsupervised/supervised access to be on an individual basis supported by a risk assessment. If the garden is locked at night, patients should still be able to access on request.	Access as described under general (acute), and the starting point should be free open access unless this is not possible. Where this is not the case, it should always be recognised as a blanket restriction with an explanation for why this is required for the current patient group on this ward, rather than a blanket policy across a service, and should be subject to regular review and appropriate governance processes.	Garden access is more likely to be supervised but there are high secure wards where this is not required. Should always be recognised as blanket restriction and subject to the same governance processes as described in the box to the left.

Additional notes from CQC guidance:

- Some specialised services, such as eating disorder units, will have restrictions in place related to the care pathway. These should be considered in line with guidance specific to those services.

- There are a small number of blended secure services which combine medium and low secure care. In conjunction with the normative expectations above, consideration should be given as to how restrictions are managed in a way that takes into account the differing levels of security required by individual patients.

All inpatient units have welcome packs which provide information advising that the above is prohibited and that patients are to speak with staff if they require more detail.

Even with this guidance it is very important to consider all aspects of Governance, involving patients and whether the blanket nature of restrictions is necessary and efforts to continually move away from such restrictions at the earliest and safest possible way must be made.

6.4 Secure services and blanket restrictions

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 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 an identified risk for individual patients and impose the least restriction possible. Where individual patients 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 patient should more appropriately be managed in a service that operates under conditions of lesser security.

The Code of Practice MHA (1983) is clear that on the basis it could constitute a breach of a patient's human rights the following should not ordinarily be the subject of a blanket restriction (possible exceptions may apply in the Trust low and medium secure units):

- Access to, or a ban on, mobile phones and their chargers.
- Access to the internet
- Restrictions to accessing/sending mail
- Restricting visiting hours
- Patient access to their money or the ability to make personal purchases.
- Preventing patients from taking part in preferred activities.

- Access to fresh air
- Access to food/drink (set times)
- Restricted access to communal areas

Code of Practice MHA (1983), chapter 8.

7 Implementation of blanket restrictions

7.1 Action to take when a Blanket Restriction must 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.
- Infection control or pandemic control measures may constitute an environmental risk and temporary blanket measures may be introduced to ensure patient safety which would be kept under review.

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 situation 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 blanket restriction can be identified the following action is to be taken:

- All patients affected by the 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 restriction on each individual patient is to be documented in their clinical record and included in their care plan.
- This must be logged on the service's blanket restriction log
  - 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,
  - date the decision will be reviewed.

- In addition to identifying this on the blanket restrictions log if the Senior Nurse Manager or Service Manager, On Call Manager were not involved in the original decision to impose the blanket decision the nurse in charge is to notify them and record this on the incident form.

- The Senior Nurse Manager, Service Manager or On Call Manager will make a judgment as to whether the implementation of the blanket restriction needs to be escalated to the Care Group Director.

- The MDT will review the need for the blanket restriction to remain in place at the earliest opportunity and no later than 72 hours after its implementation.

- The outcome of this review is to be reported via positive and safe governance.

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

7.2 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:

- Agree 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 7.1 above.

In the event that one or more of the patients affected by the restriction either doesn't agree to it or it does 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.

7.3 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 i.e. gym out of use, occupational therapy room not accessible, will have a major longer-term impact on patients this is to be escalated via the Directorate Manager.

In these cases, the Service Management will:

- Determine the review time frame, as every 7 days.
- 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 6 of this procedure.

7.4 Process for Care Quality Commission notification.

In any instance where a blanket restriction has been assessed as having a major long-term impact on patients the Trust Compliance Officer will notify the Care Quality Commission and agree with them as to the frequency of their required updates.

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

7.5 Information to Patients and Carers

Relatives /friends of the patient are to be informed by clinical staff as to 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 patients, each ward and service will also ensure that blanket restriction grids for areas are displayed within patient areas and are reviewed monthly with patients.

7.6 Action if a Blanket Restriction is identified during a CQC inspection (including MHA)

Whilst it is hoped that through their awareness of this procedure staff will be able to recognise when a particular practice constitutes a blanket restriction it is accepted that there may be occasions when this is not the case. In the event of the Care Quality Commission raising a blanket restriction which the Trust is not aware of this procedure will be retrospectively applied and the

action taken reported back to the Care Quality Commission via the required action plan or provider statement.

8 Recording, review and monitoring of ongoing blanket restrictions

8.1 Identification and Documentation of Blanket Restrictions

- Each service area will hold a local register of the blanket restrictions in place in that location (see appendix 4). 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 (Record of Conversation) will be held on their electronic care record.
- Each area will maintain a register of any blanket restrictions over and above the Trust-wide blanket restrictions.
- All blanket restrictions will be supported by a clear and concise rationale for applying for the restriction utilising the Restraint Reduction Networks 4R's - Rule, Reason (risk), Rights, Review, and Impact for the blanket restriction.
- Trust wide blanket restrictions approved by the Chief Nurse and Medical Director
- Each area must review its practices and existing blanket restrictions on a regular basis (at least quarterly) at its governance/business meetings in order to identify and minimise the use of blanket restrictions. A record of these reviews is to be documented in the minutes of the meeting and held by that service area.
- A formal review of each service area register will be completed as a minimum on a 12-monthly basis by the service Associate Director of nursing and General manager.
- If it is not immediately necessary to apply the restriction in a blanket fashion, ensure that it is only applied to the patient/s whose presentation warrants the restriction.
- If it is immediately necessary for risk-management purposes to impose the restriction in a blanket fashion, this must be authorised by the Care group medical director or the Care group director of nursing and quality.
- The imposition of an immediately necessary blanket restriction or any change the blanket restriction log must be updated as soon as possible.
- 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)
- The updated version of the register must be provided to the Medical Director, or the Chief nurse or their deputy as soon as is practicable.

8.2 Governance Arrangements

- In addition to the local arrangements described in sections 8.1, each directorate should put in place processes for identifying and appropriately responding to blanket restrictions within its service areas.
- The care groups positive and safe care governance will maintain oversight of all new blanket restrictions and will include details in Quarterly governance reports

- No form of blanket restriction should be implemented unless expressly authorised by the hospital managers based on the organisation's policy and subject to local accountability and governance arrangements.

9 Definitions

Term	Definition
Blanket Restrictions	Defined 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. (MHA, Code of Practice 2015) There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there are specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records. The care team should consult the PSS Team before introducing blanket restrictions and ensure that least restrictive options are considered first Blanket restrictions should be recorded on the Blanket Restrictions Log, (Appendix 1) that is kept on the ward and reviewed regularly by the care team. All restrictions must be reported to the care group safety meetings, that will maintain a care group log. Care group restrictive practice logs will be reported to the PSS meeting as standing agenda of the meeting
PICU	Psychiatric intensive care unit
CQC	Care Quality Commission
MHA	Mental Health Act
MDT	Multi-Disciplinary Team
Restrictive interventions	Defined as deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: • Take **immediate control** of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and • End or significantly reduce the danger to the person or others; and • Contain or limit the person's freedom for no longer that is necessary. Examples of restrictive interventions include: • Physical interventions

	• Rapid tranquillisation • Seclusion These are covered by the relevant Trust policies and procedures.
Restrictive practices	Those practices that limit an individual's movement, liberty and/or freedom to act independently to **maintain** the safety and security of patients, staff, and the site. This policy provides guidance regarding Restrictive Practices. Examples of restrictive practice include: • Room searches and rubdown searches. • Access to courtyards, kitchens, and calm rooms. • Monitoring of communications and visits. Use or bringing on the ward of contraband items

10 How this procedure will be implemented

- This procedure will be published on trust intranet and public website
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

10.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All inpatient patient facing staff	Positive and safe training Level 2	Initial 5 days 2-day update	Yearly

11 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	New Blanket restrictions monitored via the	Board: every 3 months	QAC QUAIG/ Speciality service meeting

	Positive & Safe Dashboard and governance groups	Directors of Operations: Quarterly Clinical Directors: Quarterly Heads of Service Monthly Ward leadership teams: monthly Positive and safe governance meetings: monthly	Care group Board Leadership Huddles/ Supercells Monthly to Directors of nursing and quality
2	Positive & Safe annual report	Annually Quarterly updates	Linked to the Positive and Safe strategy reviewed annually and approved via QuAC

12 References

- Department of health and social care (2015) Code of practice: Mental health act (1983).
- Care Quality Commission – Brief Guide – Blanket Restriction on In-Patient Wards
- 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
- CQC Blanket restrictions Guidance

13 Document control (external)

To be recorded on the procedure register by Procedure Coordinator

Required information type	Information
Date of approval	13 March 2026 (v3.1) 03 February 2026 (v3)
Next review date	03 February 2029
This document replaces	CLIN-0089-v3 Blanket restrictions Procedure
This document was approved by	Chief Nurse (v3.1) Executive Clinical Leaders Subgroup (ECLS) (v3)

This document was approved	13 March 2026 (v3.1) 21 January 2026 (v3)
This document was ratified by	EDG (pending retrospective ratification) (v3.1) Executive Directors Group (EDG) (v3)
This document was ratified	Pending (v3.1) 03 February 2026 (v3)
An equality analysis was completed on this procedure on	April 2025 (v3)
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
v3	03 Feb 2026	**Amended from policy to procedure document*** Amendments to care group structure Amendments to job titles Addition of normative expectations Addition and Amendments to governance monitoring Addition of trust wide blanket restriction log and FAIR tool Lone instances of term “service user’ amended to ‘patient’ at request of EDIHR team. Added lighters and matches at request of CQC team and in line with nicotine management policy	Withdrawn
v3.1	13 Mar 2026	Clarified the plastic Bag restriction in the grid in section 6.1. Updated the guidance from CQC in 6.2 to match TEWV position and added link to guidance. Reference section updated with CQC link. Amended Appendix 3 for service completion. Approved for immediate publication by Chief Nurse pending retrospective formal approval at ECLS and retrospective formal ratification at EDG.	Approved for immediate publication

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Procedure and Equality Impact Assessment Guidance can be found on the procedure pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Positive and safe care
Title	Safe use of Blanket restrictions
Type	Procedure
Geographical area covered	Trust wide
Aims and objectives	Blanket Restrictions are defined as: 'Rules or policies that restrict a patient's or service user'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). This definition is to be applied to all service areas within Tees, Esk and Wear Valleys NHS Trust (TEWV), not just hospital wards. Blanket restrictions are sometimes needed in order to ensure safety within service areas operated by BSMHFT. However, as a Trust we recognise that such restrictions have the potential to have an impact 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. The purpose of the procedure 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 procedure 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 such restrictions where they exist.
Start date of Equality Analysis Screening	April 2025
End date of Equality Analysis Screening	April 2025

Section 2	Impacts

Who does the Procedure, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All TEWV staff
Will the Procedure, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications Yes** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	It has been identified that there could be Human Rights implications when carrying out this procedure If any absolute rights are being restricted or interfered with by carrying out this procedure then staff must prioritise upholding these rights, this could mean taking reasonable steps to ensure that the least restrictive practice is used. If non-absolute rights are being restricted, the NHS must ensure any restrictions are lawful, for a legitimate reason, and necessary and proportionate.
Describe any positive impacts / Human Rights Implications	The Human Rights Act 1998 ensures that restrictions on rights must be proportionate, necessary and justified rather than broadly or arbitrarily applied.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See reference list
Have you engaged or consulted with patients, carers, staff and other stakeholders including people from the protected groups?	yes
If you answered Yes above, describe the engagement and involvement that has taken place	Consultation with whole trust completed
If you answered No above, describe future plans that you may have to engage and involve people from different groups	Review to be arranged within coming 12 months for policy to be co-produced prior to next review

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	no
Describe any training needs for patients	no
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	yes	
Is it clear whether the document is a guideline, procedure, protocol or standard?	yes	
2. Rationale		
Are reasons for development of the document stated?	yes	
3. Development Process		
Are people involved in the development identified?	yes	
Has relevant expertise has been sought/used?	yes	
Is there evidence of consultation with stakeholders and users?	yes	
Have any related documents or documents that are impacted by this change been identified and updated?	yes	
4. Content		
Is the objective of the document clear?	yes	
Is the target population clear and unambiguous?	yes	
Are the intended outcomes described?	yes	
Are the statements clear and unambiguous?	yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	yes	
Are key references cited?	yes	
Are supporting documents referenced?	yes	

6. Training		
Have training needs been considered?	yes	
Are training needs included in the document?	yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	yes	
Have Equality and Diversity reviewed and approved the equality analysis?	yes	April 2025
9. Approval		
Does the document identify which committee/group will approve it?	yes	
10. Publication		
Has the procedure been reviewed for harm?	yes	
Does the document identify whether it is private or public?	yes	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	yes	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	yes	
Do all pictures and tables have meaningful alternative text?	yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	yes	

Appendix 3 – Blanket restrictions

Appendix 3a - Service blanket restrictions log

- image of form here
- to use and print use this link to word doc

Appendix 3b - Current blanket restriction monitoring log

- image of form here
- to use and print use this link to word doc

Appendix 3c - Closed blanket restrictions monitoring log

- image of form here
- to use and print use this link to word doc

Appendix 3a – Service blanket restrictions log

Restricted items Log for display in communal areas on the ward

Please list in the chart below any blanket restrictions in your service and use the associated colour code

Restricted for all		**Individually assessed restriction**		**No restrictions**	

Care Group:		**Ward Name:**	
MDT Members:		**Date of review:**	

Item subject to restrictions (include description and sample image)	**Level of restriction (colour coding)**	**Reason for restriction**	**Date of review**

Add further rows as necessary

Appendix 3b - Current blanket restrictions monitoring log

Care Group	
Ward Name	
MDT owners	

Name of restrictive intervention	Escalated via Positive and safe	Date Escalated	Date Commenced	Days on Register	Approved by (Name & Designation)	Rationale for approval	Incident Number if due to incident on ward	How will it be reviewed	When was it last reviewed	When is next review	Date removed/ closed	Removal approved by (Name & Designation)	Description of governance regarding review	Date discussed with Service Users/Patients	Other comments

Appendix 3c - Closed blanket restrictions monitoring log

Care Group	
Ward Name	
MDT owners	

Name of restrictive intervention	Escalated via Positive and safe	Date Escalated	Date Commenced	Number of Days on Register	Approved by (Name & Designation)	Rational for approval	Incident Number if due to incident on ward	How will it be reviewed	When was it last reviewed	When is next review	Date removed/ closed	Removal approved by (Name & Designation)	Description of governance regarding review	Date discussed with Service Users/Patients	Other comments