Justifying blanket restrictions

Resource pack

1. Introduction

Blanket restrictions (restrictions applied across a group of patients in a ward/unit) are one of the most complex and confusing areas of practice in inpatient mental health and learning disability settings. This can be due to a combination of factors, namely:

- The complexity of balancing risk against depriving liberty for individuals and a wider group, and the confidence to take positive risks by relaxing restrictions.
- The lack of clear frameworks and guidance to manage this process including training, leadership, resource, staffing and governance.
- The definition of blanket restrictions is unclear and open to interpretation.
- The presence of institutionalised and overly-restrictive thinking and organisational culture.

As a result, the inappropriate use of blanket restrictions is one of the most common regulatory breaches at CQC inspections of mental health and learning disability services in England, but more importantly people are being unnecessarily deprived of their liberty, choice and dignity every day.

This resource pack is to guide staff and services to understand blanket restrictions, how they can be managed in practice and why it is important that we move away from institutionalised practices to ensure that blanket restrictions are always justified and as least restrictive as possible.

Who this resource pack is for:

It is written for staff working in various types of inpatient mental health and learning disability settings of various age groups and security levels. It is also useful for managers, policy writers, corporate quality and safety teams and executives/ board members, or anyone with an interest in blanket restrictions. It is also for anyone who is interested in blanket restrictions generally.

Contents:

2. Foreword

Throughout my fifteen-year career working at the Royal College of Psychiatrists, in NHS mental health settings and being a CQC mental health inspector, there is one area of practice I have found that consistently causes a lot of confusion for staff working in mental health and learning disability services; blanket restrictions.

Personally, blanket restrictions have caused me confusion me too. Every time I thought I had the concept figured out, new circumstances or types of risks presented themselves, which made me question my entire understanding, and I'm sure there will be more to come. I hoped to find some definitive guidance around blanket restrictions, but I came to realise that not only did it not exist, it couldn't really exist. Just as people don't come with guidance, every circumstance that could pose a risk depends on human, situational and environmental factors that can't be known or predicted.

I always believed that blanket restrictions should be avoided, but it wasn't until I started to think of blanket restrictions neutrally, with only how they were applied being the issue, that it really clicked for me. I started to refer to them as either 'justified blanket restrictions', or 'unjustified blanket restrictions', which enabled me to explain their use more easily to staff in services.

In the free time that the COVID 19 lockdown afforded me, I was finally able to everything that was collected up in my head about blanket restrictions down on paper. I was inspired by the parallels with the approach to lockdown and social distancing, especially the common-sense approach required by the public, as well as the lack of guidance which often left the national confused and unclear. This reminded me of situations I had been in where ward staff were assessing what the right approach was to restrictions.

I put this 'resource pack' together with frontline staff in mind who are making decisions about restrictions on a daily basis. I am not claiming to be the authority in this area, I just hope that my experiences can be useful. I would like to give staff some clarity in an area that has limited national guidance, enable them to feel confident with the process and try to create least restrictive environments as possible for people using services. I am happy for this to be used as part of training, for writing policy/guidance or just shared for discussion.

Unfortunately, after visiting hundreds of wards/units in England and Wales, I have seen overly-restrictive practices in use all too often. I've only seen very limited good practice in this area, especially around the meaningful involvement of patients/families. This indicates that there is still a long way to go in not only attitudes toward overly-restrictive practices as well as services becoming truly least restrictive. I'm however optimistic that there will be a shift in thinking and practice as services evolve and improve over time.

Graham Hinchcliffe

Quality Advisor, May 2020

Please note: This pack and its contents are based on my personal experience. Views are my own, not that of the CQC or NHS. I welcome any feedback or suggestions to graham@mangotreegroup.co.uk

3. The fundamentals of blanket restrictions

- Blanket restrictions are **restrictions applied uniformly to a group of people**. On mental health and learning disability wards/units these are commonly restrictions across all patients, such set times to do things, locked doors, restricted/supervised access to rooms, outside space or other areas, phones/devices, internet access, TV, drinks/snacks, and many more.

- Blanket restrictions are different from the **'rules'** of a ward/unit which are **more fixed** restrictions which don't need as regular assessment as they are less likely to deprive someone of liberty, for example violence, banned items like weapons and illegal substances.

- Blanket restrictions should be considered **flexible**, reflecting fluctuations in risk, especially after incidents or with every individual admission and discharge. How often and when the restrictions are flexed is at discretion of staff based on ongoing risk assessment. A service that manages this well will see flexing of restrictions that mirror risk, not only for individuals but blanketly.

- Blanket restrictions should only be put in place if the level of **risk** to a patient or a group of patients clearly **outweighs** depriving the group of patients of their **liberty**. Individual and group patient risks should be clearly assessed because of the significant impact of depriving a group of people of choice, rights and dignity.

- Blanket restrictions often occur when **restricting one patient means restricting the whole ward/unit**. Although the wider group will likely not have the same risk, they are deprived by proximity. Every individual in the ward/unit should therefore be considered as part of any restriction that impacts upon them. This can become a complex and time-consuming undertaking, especially as this should be clearly justified and documented for each patient.

- Blanket restrictions have historically been put in place in an **unjustified** way, reflecting outdated, institutionalised and overly-restrictive practices. This is unfortunately still commonplace today. This practice should be moved away from, in favour of patient choice, dignity, rights and create least restrictive and therapeutic relationships. Encouraging this change is high on the CQC's agenda.

- Blanket restrictions themselves should be thought of **neutrally**, with only how they are applied being in question. They should be thought of as either being **"justified blanket restrictions",** or **"unjustified blanket restrictions"** depending the appropriateness of the action taken to justify them.

- The impact of depriving a group of patients of their liberty is very significant, therefore their justification should always be **clearly documented**, much like how Mental Health Act paperwork has to be comprehensively completed and checked.

- It is commonly thought that all blanket restrictions should be avoided because of the way they have been historically implemented. They are however **absolutely necessary** to keep patients safe, but the emphasis should be on always clearly justifying and documenting their use.

- **Involving patients** in the assessment of blanket decisions is key. These should be discussed individually with patients as well as in ongoing patient/community meetings. This should not be a tokenistic afterthought. One of the most powerful ways to justify a restriction is the backing of

the group of people it concerns. It also takes out the guess work of how patients will react to imposing restrictions which may cause upset down the line.

- The principles of blanket restrictions are similar to **individual restrictions**. The resulting care plan should be based on a clear ongoing risk assessment. The approach to both individual and blanket restrictions should follow the same principles and assessment methods in a service.

- Blanket restrictions require a **common-sense approach**. There is no magic bullet for every situation. There can be no definitive guidance about how to deal with every eventuality, as endless situations and risks could present themselves. This is what makes them particularly intimidating as assessing staff won't really know that they have dealt with every restriction in the best way. Mistakes will be made along the way but learning from these is key to improving how they are dealt with.

- The **Mental Health Act Code of Practice** outlines the definitions and approach to blanket restrictions in law.

<u>Common challenges in getting blanket restrictions right:</u>

- Blanket restrictions require dedicated **time to assess**, which is at a premium in mental health services. Balancing administrative tasks with patient facing time is one of the most common staff challenges. Striking a balance between clinical work, discussing the adjustment of restrictions and comprehensively documenting them is a huge challenge, especially without clear leadership, training and a clear framework to work within.

- Implementing justified blanket restrictions requires consideration of **less restrictive alternatives**, for example, increasing staffing levels and observation levels as opposed to locking a door. Many services are already **struggling to meet minimum staffing levels** and often a decision to increase staffing where viable is a decision out of their hands.

- Staff who are **used to working to static policies** with set review timeframes often don't see blanket restrictions as an ongoing assessment but fixed rules, either because it is easier to manage the process this way or because blanket restrictions aren't understood. Making this shift in thinking individually as well as organisationally requires time, effort, leadership and training.

- Unjustified blanket restrictions are often put in place based upon assumptions through **unconscious bias** about how 'mental health patients' behave as a cohort, not as individuals. Although restrictions may be put in place with good intentions of keeping patients safe, the impact of depriving someone of liberty is less obvious, especially to vulnerable groups who don't want to, know to, are afraid to, or are unable to object.

- Blanket restrictions are seldom covered in sufficient detail risk management or Mental Health Act mandatory training, due to an overall lack of guidance in this area, therefore **staff often aren't equipped with the skills** that they need to manage this process effectively.

- Justifying blanket restrictions requires the **confidence to take positive risks**. This comes from being provided with skills, support from the team, service and organisation and a framework to work within and a forward-thinking organisational culture. Often where there is a poor or institutionalised culture, staff don't feel empowered to take positive risks. Staff can also feel

disempowered to speak up against unjustified blanket restrictions for fear of retribution, especially should an incident occur when restrictions were relaxed upon their recommendation.

- It is often unclear exactly what should be **documented** around blanket restrictions, how often and how much detail to go into. Often individual restrictions are documented in care plans for one patient, but without the reasoning for this, the next review date, or the impact on the wider group. Without the documentation as evidence, the assessment didn't happen, especially in the eyes of the CQC.

- Some decisions will be **less clear cut** than others, where it could appear equally reasonable to have a blanket restriction or not. These are difficult for staff to feel confident with. These might be the restrictions that are implemented or lifted very gradually and with great care.

- The difference between**, rules (including banned items), individual restrictions and blanket restrictions** can be confusing. There are also blanket restrictions that can be considered **semi-fixed**, as they are less likely to change but should still be reviewed with less regularity. These should be clearly defined by a service using a scale to where these fall between more static policy and ongoing assessment.

Managing blanket restrictions effectively:

Organisations require a clear framework to work within to manage rules and restrictions within. This might include the following:

Policy:

Blanket restrictions should form part of organisational policy, whether this be as part reducing restrictive interventions, risk assessment or patient safety, or a standalone policy. The policy should clearly guide staff how to navigate the process including;

  - What the service defines as rules and restrictions e.g. banned items, restricted items, and how these are communicated patients/visitors.
  - A flow chart for staff to follow about what constitutes a justified and unjustified blanket restriction.
  - Clear guidance about what should be considered during an assessment.
  - A blanket restriction register that defines rules and blanket restrictions, including review. timescales. The register should be reviewed regularly in the appropriate governance meeting at divisional/corporate level.
  - How to, where and how often to document effectively.
  - Expectations and guidance for the forum/safety huddle where they will be discussed.
  - Training expectations.
  - Ongoing accountability, governance, audit and reporting processes.

Forum for discussion:

- Blanket restrictions should be discussed and documented in time protected multi-disciplinary forum such as a safety huddle/meeting. This should take place at a set regularity.
- Staff should be empowered to establish a forum that works for them and define quoracy/membership.

- A proforma or minute template should be produced to guide discussion and allow succinct discussion and recording. This should be attached to each patient record or integrated into care planning.
- The forum should enable staff to escalate issues that have prevented them from being least restrictive i.e. staffing levels, unsafe environments.
- Any blanket restrictions should be discussed with patients as part of their ongoing reviews and/or at community meetings. Their input and views should be included as part of the assessment process, not as an afterthought.

Training/ skills

- Blanket restrictions training should be mandatory for clinical staff and include:
  - Impact of blanket restrictions on patient liberty. Why it is important to get this right.
  - Avoiding unconscious bias, signs of poor organisational culture and historic misuse.
  - Empowering staff and patients / positive risk taking.
  - Involving patients/families.
  - Unjustified and justified blanket restrictions- the differences and examples.
  - Examples of what factors to consider in the risk assessments.

- Blanket restrictions should be included as part of ongoing competency checks and supervision.

Leadership

- The importance of leadership can't be stressed enough as staff look to see that managers or leaders make confident assessments and decisions, as well as how they handle set-backs and mistakes.

Governance framework

- This process should be attached to a minuted governance meeting such as restrictive interventions, risk, patient safety or incident reporting, so that it is integrated in a governance for accountability and consistency of application across services.
- The use of blanket restrictions should be reported into this meeting alongside restrictive interventions. This should have board scrutiny.
- Rules and prohibited/restricted items should also be reviewed at service or organisation level, especially with rapid advances in technology, mobile apps and increases in cyber bullying.

4. Assessing blanket restrictions in practice

The following is not an exhaustive list, but a guide of steps that should be considered as a minimum when assessing the need for blanket restrictions, which will complement a common-sense approach to assessing:

- What is the blanket restriction that we have in place or are thinking about bringing in?
- Why is this needed? (for existing restrictions consider if it's just a historic rule)
- What is the gut feeling about how appropriate the blanket restriction is?
- Would it be based on risk or is it just to encourage behaviour? Could it be seen as punitive?
- What are the impacts of having the blanket restriction in place for the individual and the group i.e. patient liberties, trust, choice? How might this impact on therapeutic relationships?
- What are the possible consequences if the blanket restriction was not put in place for individuals and the group? i.e. risk of harm.
- What is the patient/family view? What would they prefer?
- Have we considered recent incidents or changes to risk, or likely changes to risk?
- Have we considered recent admissions and discharges? What new risks are there?
- Have we considered all the less restrictive alternatives? i.e. staffing, observations, environment
- **Decision:** Are we confident that we have enough justification for applying the blanket restriction, or is it more justified to go with a less restrictive option?
- Clearly document the discussion and reasoning in risk assessments / care plans
- Which restrictions need review more/less regularly? Decide review regularity and review on that basis.

5. Blanket Restrictions: Common questions and challenges

These are some most common questions, statements and challenges posed by staff in mental health services around blanket restrictions, along with responses:

- **Are blanket restrictions the same as restrictive interventions?**

Blanket restrictions often get confused with more publicised and reported 'restrictive interventions' which are practices like restraint, rapid tranquillisation and seclusion. They are often covered under the same policy or discussed in the same parts of meetings. They are both types of 'restrictive practice', but they are different categories and should be approached separately.

- **All patients admitted to our ward automatically pose enough risk to justify certain restrictions, so we don't need to review them. Its part of our service specification.**

This may the case for the rules/banned items of a ward, which should be clearly defined. This may also be more applicable for forensic/secure services (see CQC brief guide[1] and Mental Health Act Code of Practice), but this way of thinking should be avoided generally. Individual circumstances are complex so every person shouldn't be put in one category of risk. Being under a section certainly doesn't give carte blanche to restrict people, so service specification shouldn't do the same. Each patient should be assessed as an individual with differing levels of risk. There will always be exceptions to what staff consider atypical risks. Think least restrictive in this regard.

- **Our rules have already been decided by the service and they are fixed, which includes locking doors. This has been approved at trust level.**

This doesn't mean to say that they are right. What is the justification? and will it always be this way? All rules should be reviewed at some point, even the ones that are less likely to change. Even policies have review date. If you suspect that the rules of the service are depriving patients of their liberty, they probably are, and should be reviewed.

- **How can restrictions be individualised when restricting one patient means restricting all patients? e.g. locking ward doors.**

This often can't be avoided. Ensure justification is clearly documented with impact on not only the individual but the wider group. Consider if there is anything else less impactful that has been considered e.g. could this be managed through other means such as observations or staffing levels. The key here is making sure that it is documented in each patient record how restrictions on others affect them.

- **Locking the doors to outside spaces protects our patients from intruders, just like you would lock your doors at home, especially at night. We have signs to say patients can ask to go outside.**

This should be avoided as a way of thinking; it is always going to depend on multiple factors like security issues, intruders, drug risk, environmental risk in outside spaces, absconsion risk, ligatures, smoking, recent incidents vs the impact of limiting accessing outside space for fresh air or exercise. If this is assessed as a justified restriction, patients are involved in this assessment, this could be documented and implemented but always subject to ongoing review as circumstances may change. It may be more reasonable to lock the doors at night but still should be discussed and not fixed, especially as daylight hours change.

- **We've fully assessed and documented impacts of locking the entrance/exit to the ward. We have decided to keep this locked for all our safety, with informal patients clear that they**

should ask if they want to leave. This is now a fixed rule because it's not going to change anytime soon. We don't have time to discuss at every single huddle/meeting.

Making this a fixed rule should be avoided, it should be kept on the table for ongoing discussion, but perhaps at less regular intervals as a semi-fixed restriction, less often than perhaps the outside space access might be discussed. It could be the case that this might need to change in the future if there are informal patients only or fewer patients. This may be difficult for services to imagine, but it can happen and then it is written in a rule which is harder to change back and might get lost in the years that go by and changes to staff. A solution could be to categorise restrictions into rules, semi-fixed restrictions and flexible restrictions, all with different review schedules. A traffic light system could work here to make this clear. Some services could have prompts to discuss certain restrictions when there are new admissions or significant changes to the service.

- **There are ligatures in the patient kitchen, communal bathrooms and in the garden. There is a hot water geyser in the patient kitchen. That's why they are kept locked as they are fixed risks.**

Every environment will likely have risks like ligatures, it is the management of these that is key, not locking off access to the space. Are patients actively trying to ligature and have been incident more recently; this would make it more justifiable to restrict access temporarily. Having access to hot water may be a risk for some, and not for others. Locking it away assumes that all patients can't be trusted with hot water. If the risks are greater than the impact of depriving access, these restrictions are justified and can be implemented. They require ongoing review as risks change and shouldn't be considered rules. CAMHS services require more thought; Would a child be allowed to access a kitchen unsupervised at home? Should teenagers be deprived of making themselves a cup of tea? What do parents think? In older peoples and LD services; have capacity assessments and best interests been considered?

- **We can't realistically update documentation and care plans with every change in risk and restriction. This would take a lot of admin time which could be better spent with the patients. How much do we need to be writing down to get this right?**

Striking a balance here is a skill and relies on a framework fit for the service and a common-sense approach. There is no right or wrong answer to how much should be written, it's whether the right factors have been assessed. Not every restriction can be fully written up with every slight change of risk. Discussions around day to day flexing of restrictions could for example be documented in daily safety huddles or daily notes. Depending on the severity of the risk, these could the feed into ongoing monthly patient reviews and an overall restrictions care plan or risk assessment could updated accordingly. The service should come up with something that works for them and be confident with it, especially at a CQC inspection. A good question to ask is; if agency staff on their first shift needed to find out what restrictions were in place, would it be clear to them? If not, the documentation isn't likely to be sufficient.

- **Patients feel they are being treated unfairly if there are different restrictions for some and not for others e.g. mobile phone access. Individual restrictions can also reveal certain issues that they would rather their peers didn't know about. This is causing incidents. How do we manage this? It might be easier to have one rule for all.**

This is a complex issue, but the key is ensuing good communication with patients about restrictions. What do they think about the restrictions in place, what would they not to be shared? The patient voice should be integrated into the ongoing assessment and documentation around restrictions. Discuss restrictions at patient/ community meetings e.g. the patients have decided they want the bedroom doors locked during the day—as long as this is assessed, proportionate, documented,

regularly reviewed, this is based on their individual wishes. Involving patients from the start takes out the guess work and likely diffuses any potential problems.

- **We are encouraging healthy sleep with set bedtimes and restricting access to devices. We don't want patients in bed all day missing out on therapy and activities.**

Restrictions should be based on risk only. Positive encouragement based on good care planning should be used to encourage good sleep, and not punitive measures e.g. limiting access to devices. Think about if a patient uses their device to self-soothe, or their only chance to video call with relatives in a different time-zone was at night. This also goes for set bedtimes and turning off TV times; these are very often blanket restrictions because it would be difficult to justify that a punitive measure would be better than good communication and understanding with patients, which can be built with a trusting patient staff relationship. Empowering patients is likely to prompt a better response.

- **What if we remove a blanket restriction and an incident happens?**

If risk has been properly assessed related to restrictions it is unlikely that the incident occurred because of poor risk management. There will always be certain risks to carry but these have to be managed; patient freedom shouldn't be taken away as a default because something might happen. This is why it is important to flex restrictions gradually and carefully. Getting the balance right here is a challenge. If incidents do occur, documentation will show the reasons why the restriction was not in place at that time. It may also be a good reason for a restriction to be put in place. Mistakes are bound to be made and confidence will build up in a team as they become more experienced.

CAMHS

- **We have a responsibility to keep the children and young people safe in absence of their parents under 'loco parentis'. That is the justification for our restrictions. We have to be the parents when they aren't here.**

True, but this isn't a good enough reason alone to impose a blanket restriction. Impacts of restrictions should be discussed with parents/families or guardians to gather their views, not bypass them. The views of parents may be different from one to the other based on their values or the patient's age e.g. some 10-year olds may be allowed phones or fizzy pop. These discussions should be documented in a restrictions care plan, alongside patient/family views, forming an overall group view. Punitive measures should not be used to try to get patients to behave. i.e. no access to devices if does not do as told. Positive encouragement should be used. Being a child or young person shouldn't mean that choices and rights can be taken away any more than an adult.

- **The age gap between children and young people can be significant on our ward, as well as levels of competence and understanding. We currently have an 8-year-old and a 13-year-old on the same ward. What do we do here for example kitchen and device access?**

This is a good example of the need for restrictions to be individualised and not one size fits all. Discussion should take place considering these factors and any restrictions applied accordingly. If the restriction of younger patients impacts the older ones, this should be documented in all patient records.

Older peoples'/Dementia services

- **Locking the entrance on a ward is a given in our service. A common part of dementia is confusion, wandering and absconsion. We also have Deprivation of Liberty Safeguards (DoLS) in place (adult social care services).**

Even the more obvious restrictions like locking the entrance door on an older people's/ dementia ward should still be discussed and documented and not treated as a rule, but perhaps less often as semi-fixed. The key is not to take this off the table as it assumes the behaviours of every single patient using the service. Having a DoLS in place doesn't meant that this is a rule and DoLS are not fixed. A solution could be to categorise restrictions into rules, semi-fixed restrictions and flexible restrictions, all with different review schedules.

Learning Disability Services

- **Our patients have been assessed as lacking capacity, so we have more blanket restrictions in place. We can't always ask patients what they think on an ongoing basis. They are the most vulnerable, so we need to keep them protected.**

This should be avoided as a way of thinking. Blanket restrictions are no less impactful on any particular group of patients or individuals. Specialist services should be more equipped to involve and communicate patients in this regard, looking at innovative ways of gathering views. There should be specific capacity assessments related to blanket restrictions, not relying on admission/ treatment capacity assessments, as well as best interests' processes. DoLS does not give license to take discussion about restrictions off the table. Saying "we have a DoLS for that" is a red flag to a CQC inspector.

Forensic/Secure services

- **Blanket restrictions don't count for us as we are forensic/low/medium/high secure.**

Although there are different and more set thresholds for forensic/secure services, especially around Relational Security (see Mental Health Act Code of Practice and CQC brief guide on Blanket restrictions), the principles of least restrictive practice still apply. This should be avoided as a way of thinking.

6. Scenario: Understanding the impact of blanket restrictions on patients

Think about being a patient on an acute mental health ward/unit. You don't have your freedom, you're unwell and feel helpless, scared, confused and alone. You're in an unfamiliar place with people you don't know and without your loved ones.

You want to make yourself a cup of tea (one of life's simple pleasures) or make some toast, but the kitchen is locked. You are told that it's "too risky for patients to go in the kitchen" or "this is for your safety". There are no other tea making facilities available.

You have to ask staff or be supervised each time you want a drink or snack. You also have to ask each time to go into the garden area, the toilet, your bedroom, separate lounge area. You are told that there are too many risks in these areas.

In addition to this, there are set bedtimes and TV turn off times, smoking/vaping times, limited access to phones/tablets/internet, limited access to your favourite snacks and you eat with plastic plates and cutlery like a toddler.

How might you feel?

- I'm obviously not trusted here.
- I'm just another patient, I'm not seen as me.
- I'm punished for being unwell; being unwell must be being bad.
- Disempowered, undignified, no rights or choice.
- Tired of having to ask each time, or don't want to be a nuisance; I'll go without.
- Things are just that way; it's an institution after all.
- They are locked for a reason; I shouldn't ask to go in there.
- I'm not engaging with anyone; why trust them if they don't trust me?
- I'll be a risk if they think it anyway.

(This is an example to illustrate the impact on patients; although unlikely, the restrictions above may be necessary based on the individual assessments of each patient)

7. Examples of blanket restrictions- justified or unjustified?

An unjustified blanket restriction:

- Patient kitchen locked.
- Drinks and snacks not available- patients have to ask.
- Staff say that this is 'just the way things are'.
- No documentation around why this is in place.

Still an unjustified blanket restriction:

- Patient kitchen locked.
- Drinks and snacks available.
- Documented in patient records that the kitchen door is locked (but not why).

Justified blanket restriction:

- Patient kitchen locked.
- Drinks and snacks available.
- Documented that door is locked, the reasons why on based individual risks, considering the wider group risks, recent incidents and exploring least restrictive alternatives.
- Documented on-going review/discussion and future review date.

An example of least restrictive practice- No restriction:

- Patient kitchen open.
- Documented that the risk has been considered for the individual patients i.e. access to hot water, ligatures, sharps and will be managed through e.g. observations as opposed to locking off access, as the patients do not pose enough risk having considered their risk factors and any recent incidents.
- Documented on-going review/discussion and future review date.

8. Blanket restrictions: A CQC inspectors' perspective

Looking at blanket restrictions through the eyes of a CQC inspector undertaking an inspection is a useful way of understanding if they might be justified or not. CQC inspectors are trained and experienced in making timely judgements about the appropriateness of restrictions at inspections. Services should be assuring themselves of good practice on an ongoing basis, not waiting for inspections to find out.

It is important to note that CQC inspectors are not trying to catch services out. They are not looking for perfection, but that there is a common-sense approach that is being applied confidently, consistently and in the least restrictive way with patients in mind overall.

The following are the key areas that inspectors may look at inspection:

When observing the ward/unit environment:

- Posters/signs with blanket restrictions e.g. locked rooms, set times. Always on display?
- Poster/leaflet of rules or banned items. Are these appropriate?
- Locked doors which could potentially be unlocked i.e. kitchen, outdoors. Why locked?
- Interactions between staff and patients- positive or negative?

When talking with patients:

- Are there many rules or restrictions here? Do they change? i.e. access to bedroom
- Are you asked what you think about them? Are they fair?
- What happens when people don't follow them? (punitive practice).

When talking with staff/managers:

- What kinds of restrictions are in place across the ward? e.g. locked doors, set times.
- Why are these in place? (Red flag: "It's the way it's always been", or "don't know")
- Do these tend to change if risks change? How is this decided? Are you involved?
- Are these restrictions necessary at the moment? Why?

When looking at patient records/documentation (corroborating what has been seen and said above)

- Do records clearly show the blanket restrictions that are in place, and why?
- Is it documented that they consider the individual and the wider group?
- Are there review timescales that have been followed?
- Is the patient /family view included? Or best interests' documentation?

General red flags

- Blanket restrictions for the convenience, or lack of staff i.e. set times to do things.
- Plastic plates and cutlery, limited access to drinks and snacks and bedtimes.
- Clusters of blanket restrictions in one ward/unit.
- Ligatures as a reason for blanket restrictions. These should be managed/removed.
- Lack of documentation in patient records. "We don't have time".
- Punitive language in care plans e.g. Patient can't have leave/device unless they adhere.
- Poor approach to restrictive interventions (overuse) and Mental Health/Capacity Act.
- Lack of restrictions policy or framework, reporting, forums for discussion.
- Lack of leadership, safety focus, transparency, reporting and speaking up culture.
- Poor wider organisational culture, governance, uninformed board.

Good practice

- Confident staff who know their blanket restrictions and can explain how they are justified/reviewed.
- Demonstrate flexibility of blanket restrictions and staff say that restrictions change depending on patients on risk. e.g. minutes of huddles.
- Most staff are on the same page because blanket restrictions are regularly discussed at local meetings and up the organisation.
- Minuted discussions in patient meetings about blanket restrictions.
- An organisation with a clear and transparent safety culture, staff and patients are empowered to speak up and strong leadership at all levels. The board are clear on blanket restrictions.

Indicators of outstanding practice

- Up to date individual care plan/risk assessments specific to “blanket restrictions” in addition to individual restrictions.
- A well-publicised and clear organisational campaign or slogan around restrictions.
- Patient-led initiatives to review blanket restrictions.
- A whiteboard displayed on the ward/unit showing restrictions currently in place, which is kept up to date.

9. The problem with the Mental Health Act definition of 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**. Blanket restrictions **should be avoided** unless they can be justified as necessary and proportionate responses to risks identified for particular individuals"*[2].

The definition contradicts itself because it defines a blanket restriction as being 'routinely applied' and without 'individual risk assessment' in the first sentence, making it impossible to be "justified as necessary and proportionate responses to risk identified for particular individuals", as specified in the second sentence.

This definition is also problematic because the emphasis is on blanket restrictions being avoided, where in fact blanket restrictions themselves are neutral; only how they are applied in practice determines if they should be avoided or not:

- Blanket restrictions can be **unjustified**, for example where there is no/little consideration of individual risk, needs, dignity, rights, views or any ongoing review.

- Blanket restrictions can also be **justified**, for example where a restriction is put in place across a ward/unit that is based on individual risk to ensure everyone's' safety, which is properly documented and subject to ongoing review.

They are both blanket restrictions.

Blanket restrictions should instead be thought of as either **justified or unjustified blanket restrictions**. Just as there are either justified or unjustified individual restrictions. This is a simpler and clearer concept to understand.

It is understandable why the definition is written with this least-restrictive emphasis, as practice in England is historically overly-restrictive and we strive to move away from institutionalised practices toward more therapeutic and least restrictive environments.

The consequence is however that it doesn't provide the neutral basis needed to make an unbiased assessment. The unclear definition is a barrier staff from practicing in this area effectively, as focus is on trying to understand and debating their application. Service written policies around blanket restrictions based on this definition are often reflect this confusion, and are open to interpretation at local level, which means that local practice varies greatly in this area.

[1] CQC Brief guide: the use of 'blanket restrictions' in mental health wards
[2] Mental Health Act 1983: Code of Practice, Chapter 6 Pg 64