POLICY TITLE:	**The Management of Banned and Restricted Items**
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Policy Owner:	Kris Irons, Speciality Director
Ratified by:	Kathryn Mason, Associate Director of Patient Safety & Experience / Occupational Therapy Professional Lead
Responsible signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • Aims to ensure there is clarity about banned and restricted items and how such items are managed.
Cross Reference:	H35 Clinical Risk Assessment and Management H97 Searching Patients and Visitors H118 Smoke Free Hospitals H97 Searching of Patients and Visitors H&S09 Control of Contractors OP04.1 Assessment and Control of Ligature Points, Ligatures and other Self-Harm Risks OP05.2 MCA Deprivation of Liberty Safeguards (England and Wales) OP49 Smoking

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email legalandcompliancehelpdesk@priorygroup.com.

THE MANAGEMENT OF BANNED AND RESTRICTED ITEMS

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1 SCOPE

1.1 This policy applies to all sites and services, within the Healthcare division, across England, Scotland and Wales. Where there are differences between nations, this will be clearly highlighted.

2 INTRODUCTION

2.1 It is impossible to create an entirely risk-free patient environment. Colleagues cannot remove or withhold every potential risk item from every patient. There are however, a number of items that are either banned or restricted within Healthcare sites to help optimise patient safety.

2.2 A specific risk assessment must be completed if a patient is considered a risk of harm to themselves or others if they have access to a particular item(s).

2.3 Note that Priory Healthcare community and residential homes are not covered by this policy however colleagues at those services must be mindful to the risk of patients having access to banned and restricted items (with the majority of banned items also being banned community and residential homes).

3 BANNED AND RESTRICTED ITEMS

3.1 **Banned items -** A banned item is an item that could affect the health, safety or wellbeing of patients, colleagues, visitors and others. The table below identifies the items that are banned and **will not be permitted** in which services.

3.2 **Restricted items –** These are items that could affect the health, safety or wellbeing of patients, colleagues, visitors and others, but they are not banned as this would have a disproportionate impact if all patients were not permitted access to these day-to-day items.

3.3 **A patient may have access to one or more restricted items in accordance with their risk assessment, their management plan and the overarching ethos of the service. Access to these items must be considered as part of the multi-disciplinary team (MDT) risk assessment process (refer to Policy H35 Clinical Risk Assessment and Management):**

1. Some or all restricted items may be withheld from the patient in accordance with their risk assessment. This arrangement is in place until a risk-based decision is made to permit the patient to have access to some or all restricted items (see 2 and 3 below).
2. The patient may have temporary access to some restricted items on an agreed basis in accordance with their risk assessment. Supervision of the patient may be required at these

times. Management of Restricted Items Recording Form (H Form: 24E) will be used for this purpose.

3. The patient may have access to some or all items that were previously restricted on an ongoing basis (without the need for supervision). It will be reflected on the patient's Restricted Items Inventory Form (H Form 24F) that these items have been returned to the patient's possession.
4. Certain items may be removed from the patient in response to an increase in risk and become restricted. These will be recorded on the patient's Restricted Items Inventory Form (H Form 24F).

3.4 The MDT must give consideration to patient access to, and the management of, particular restricted items where there is a significant challenge with a particular patient/group of patients. For example the management of a bladed razor handed to a patient each morning (exacerbated by this being a 'busy' time of day on the ward), to enable them to shave. The MDT must take into account the risk that:

a) the patient will be left alone with the item and/or
b) returning the item may be deliberately or inadvertently overlooked by the patient and/or
c) staff may lose oversight of the item and/or
d) the patient may 'share' the item with other patients.

3.5 Additional restrictions in respect of access to particular items (either on the list below or newly identified risk items) may need to be introduced temporarily or permanently within individual services. The additional restrictions may be necessary in response to:

a) The lessons learnt from near misses, incidents and serious incidents; and/or
b) Specific needs identified by the clinical team and/or the operational management team.

3.6 In the event of an increase in patient risk colleagues must in the first instance increase the level of supportive observations, identify, and where necessary remove items (not only the listed restricted items) that have the potential to cause harm.

3.7 Restricted items must be subject to a strict sign in/out process where the patient's risk assessment deems it necessary. This is to ensure that a level of accountability is in place and that any item that presents foreseeable harm is controlled so far as reasonably practicable. See also Paragraph 7.8.

3.8 With regard to cigarettes and e-cigarettes, refer to H118 Smoke Free Hospitals and OP49 Smoking.

4 BANNED AND RESTRICTED ITEMS LIST

4.1 The list has been developed in response to already known risks together with lessons learnt from incidents and near misses.

4.2 The list is not exhaustive as it is impossible to list every item that may, in certain circumstances, pose a risk to the health, safety and wellbeing of patients, colleagues, visitors and others.

4.3 Remember: A patient may have access to one or more restricted items in accordance with their risk assessment, their management plan and the overarching ethos of the service.

4.4

ITEM	BANNED	RESTRICTED
Adhesive tape of any kind (e.g. sellotape)	CAMHS	Acute, BIS, ED, Forensic, PICU and RR
Aerosol containers		All services
Alcohol	All services	
Wireless ear buds		All services
Bath oil/bubble bath/shower gel		All services
Batteries, including lithium batteries		All services
Blu Tack	CAMHS, Forensic, PICU	
Candles and incense	All services	

Cans and tins		All services
Charging cables		All services
Chewing gum		All services
Cigarettes, chewing tobacco, e-cigarettes and vaping devices	CAMHS	Acute, BIS, ED, Forensic, PICU and RR
Cigarette lighters/matches	CAMHS, Forensic and PICU	Acute, BIS, ED, and RR
Curling tongs/hair straighteners/hair dryers		All services
Dental floss		All services
Explosives including fireworks	All services	
False nails		All services
Glass and metal nail files		All services
Glass bottles		All services
Herbal remedies		All services
High caffeine drinks e.g. energy drinks	Forensic, Addictions and ED	Acute, BIS, CAMHS, PICU and RR
Hot water bottles		All services
Toxic and poisonous substances: illicit drugs, 'legal highs', psychoactive substances and poisons e.g. sodium nitrite/nitrate	All services	
Knives excluding cutlery	All services	
Magnets	Acute, CAMHS, ED, PICU and RR	BIS
Mirrors		All services
Mobile phones, SIM cards and smart devices with access to the internet and/or a recording/camera facility		All services
Mouthwash	CAMHS, Forensic	Acute, BIS, ED, PICU and RR
Nail clippers		All services
Nail polish remover		All services
Non-prescription medication	All services	
Pencil sharpeners		All Services
Plastic bags for personal use e.g. carrier bags		All services
Razor: bladed	CAMHS	Acute, BIS, ED, Forensic, PICU and RR
Razor: 'cut throat'	All services	
Scissors		All services
Sharp and pointed items e.g. sewing and knitting needles, pins		All services
Shower sponge puff (mesh)	CAMHS	Acute, BIS, ED, Forensic, PICU and RR
Solvents/glue	All services (but may be used under restriction as part of therapy)	
Stilettos and steel toe cap boots	CAMHS, Forensic, PICU	Acute, BIS, ED and RR
Tin foil	CAMHS, Forensic, PICU	Acute, BIS, ED and RR
Weapons or replica weapons	All services	
Wire coat hangers	All Services	
Wooden coat hangers		All services
Wire bound books		All services

Wool/string		All services

4.5 Clothing may also need to be restricted dependent on the patient's risk assessment and type of service being provided. Removal of any item must be subject to individual risk assessment. Examples of clothing known to be of particular risk from lessons learnt are below:
(a) Belts
(b) Clothing with belt loops
(c) Clothing with draw strings
(d) Dressing gown cords
(e) Hoodies
(f) Shoelaces
(g) Scarves
(h) Tights
(i) Leggings
(j) Underwear

4.6 Staff must be alert to the contents of particular sets and kits e.g. manicure sets, cosmetics cases, stationary sets and sewing kits, as these items will contain banned and restricted items.

5 CHANGES TO THE BANNED AND RESTRICTED ITEMS LIST

5.1 Individual sites may find it necessary to change the status of a banned or restricted item for their site. This could be a permanent or temporary change. Any such changes to the banned and restricted lists must be notified to the relevant Specialist Director, and approval of the change must then be approved by the Director of Risk Management.

6 ENSURING AWARENESS

6.1 Banned and Restricted Items posters (**H Form: 24A, 24B, 24C and 24D**) should be displayed in all hospitals and outside of the units/wards.

6.2 It is essential that families and carers are helped to understand the content of the banned and restricted items list and the justification for having such lists. This will help in ensuring that families and carers do not breach this policy by deliberately or inadvertently bringing items into the unit for a patient. Restricted item(s) can be discussed with the nurse in charge and the item can, where necessary, be retained by staff, pending a decision about whether it can be given to the patient.

6.3 Banned and restricted items may not be taken on to these units by families and carers:
- Forensic units
- CAMHS LSU
- PICU Units
- Brain Injury Services

6.4 Reference is made to Banned and Restricted Items in H Form 35: Welcome to Priory.

6.5 Contractors and official visitors e.g. engineers and MHRT members, working on any Priory Healthcare units should be made aware of the banned and restricted items list. Working arrangements will need to be agreed in advance between the Hospital Director (delegated to others as required) and the lead contractor/official visitor. This will assist in ensuring that patients do not have any access to tools or other devices that the contractor/official visitor requires the use of as part of their role (also refer to H&S09 Control of Contractors) or has in their possession.

7 SAFEKEEPING AND MONITORING OF ITEMS

7.1 Where possible banned items belonging to a patient will be given to families/carers to take home. Where this is not possible, they will be stored securely, separately from restricted items (ideally in an off ward location) and this will be documented in the patient's health record.

7.2 A sufficiently experienced colleague deemed competent in managing restricted items, will be allocated responsibility for oversight and management of patients restricted items per shift (see Section 10: COMPETENCE: INDUCTION AND TRAINING).

7.3 Restricted items will be stored securely on the ward. This must be a dedicated restricted items space and not in an area that the patient could gain unauthorised access to such as a bedroom (including locked cupboards within this). An example of good practice for storage would be a locker (not in the nursing office) of adequate size to store multiple items, with limited access other than the staff member responsible for managing the restricted items on each shift.

7.4 Patients may request for non-restricted items to be stored by staff such as excess clothing or valuables. These should not be stored together with restricted items. H Form: 53 Patient Property List must be used for recording these items.

7.5 Items which require frequent access, such as vapes, cigarettes and lighters may be stored and managed separately to other restricted items. The management of these items must also involve the use of a patient's restricted item inventory (H Form: 24F) and the use of the signing in/out form (H Form: 24E).

7.6 Upon admission, at any point during admission and following periods of leave, any items restricted to the patient should be removed, placed in the patient's restricted items storage space and documented on the restricted items inventory form (H Form: 24F). Additionally, when items are used e.g. perfume finished, aerosol spray empty, these are to be appropriately disposed of by staff and recorded as disposed of on the patients restricted items inventory (H Form: 24F) to maintain an accurate record.

7.7 Each patient's restricted item inventory (H Form: 24F) should be crosschecked against actual stored restricted items at a frequency described below in accordance with service line requirements. Ward Managers (or equivalent) and site Patient Safety Leads should be assured that this process is working effectively, which may include carrying out their own cross checks as a means of audit.

7.8 H Form: 24H Restricted Items Spot Check Audit Tool must be used for the cross checking of restricted items inventory with patient actual restricted items in storage. The frequency of checking within each service line are as a minimum:

- Acute: Every two weeks
- CAMHS: Every two weeks
- ED: Once a month
- Forensic Services: Every two weeks
- PICU: Every two weeks
- Rehabilitation and Recovery: Every two weeks

7.9 Where an item is given to a patient (as per the management arrangements reflected in the patient's risk assessment on CareNotes), the item must be logged out and logged back in using the Management of Restricted Items Recording Form (H Form: 24E).

7.10 A single form will be completed to monitor all restricted item movements per shift. This will provide an 'at a glance' overview of all restricted items in use at any point in time. The Management of Restricted Items Recording Form (H Form: 24E) must form a part of the handover process between shifts and where appropriate, items returned to safe storage.

8 REMOVAL OF ITEMS

8.1 In the event of a particular patient presenting as a serious risk of self-harm or harm to others, consideration must be given to removing other potentially risky items from the patient and from their bedroom. This is to be first considered at the point of a patient's admission by both the Doctor and Nurse responsible for admitting the patient and this must be discussed with the patient

as part of the risk assessment. The review as to what may constitute a potential risk item is to be continuous thereafter and this is a collective responsibility of all colleagues caring for and working with our patients.

8.2 Where it is felt necessary to remove such items from a patient's possession, the Nurse in Charge of the shift is to do so at the earliest opportunity and a multi-disciplinary discussion is to be facilitated as soon as practicable thereafter. Where a patients risk management plan warrants the removal (or consideration of removal) of personal belongings, consideration should be given to increasing the level of observation. Removing a patient's personal items is a sensitive matter and should only be undertaken when a risk assessment indicates that it is in the best interests of the patient to take this course of action. In these circumstances the risk management plan must be amended and a record made in the daily progress notes with relevant information shared at handover.

8.3 Removal of a patient's personal items in those instances where the patient is detained under a section of the Mental Health Act is not an issue in respect of MCA Deprivation of Liberty Safeguards (DoLS), providing there is evidence that the patient has been appropriately communicated with and risk assessed. Items can be removed from an informal patient if there are immediate concerns for their safety. There is however a requirement for the consideration of a Mental Health Act assessment to be arranged in such cases (See also OP05.2 MCA Deprivation of Liberty Safeguards (England and Wales)).

8.4 Patients must be given the right to appeal against any decision to remove items from them. In the first instance the multi-disciplinary team should respond. If the patient remains dissatisfied, they should be assisted to make a complaint as per the complaint policy (OP03 Complaints).

8.5 Please also refer to Policy H97 Searching Service Users and Their Belongings in a Treatment Environment and Policy OP04.1 Assessment and Control of Ligature Points, Ligatures and other Self-Harm Risks.

9 MANAGEMENT OF INCOMING MAIL AND ON-LINE DELIVERY SERVICES

9.1 In most instances, patients are able to access the internet and by virtue of this, they are able to 'shop' on-line. This can result in numerous items of mail arriving at hospitals and wards, addressed to patients with consequences that may influence the safety of the patients and others.

9.2 Hospitals and wards must devise a local procedure for managing incoming mail for example who can receive and sign for the items, where they are stored and who is responsible for the items during this time, identifying set times for passing the items to the addressees and the systems in place for supervision when the items are opened.

9.3 **On-line delivery services -** Colleagues must be mindful of the risk items for example analgesics, alcohol, ligatures and energy drinks that can easily be purchased and promptly delivered via on-line delivery apps.

9.4 **Incoming letters, parcels and on-line deliveries -** The following arrangements must be in place in respect of patients who are an **active / potential risk of suicide, self-harm or harm to others:**

a) Patients who are at significant risk to themselves and others must have a specific risk assessment / risk management plan in place in respect of managing the risks involved in having access to incoming letters, parcels and on-line deliveries.
b) Regardless of prevailing risk patients must be encouraged to give details to colleagues about their on-line purchasing activity for example from Amazon and Deliveroo. Where necessary colleagues will remind the patient of any banned and restricted items in respect of the items to be purchased or that have been purchased. If an item being purchased is a restricted item, where possible the patient should be reminded of the need to be given prior approval by the multi-disciplinary team to be able to access the

item. If the item being purchased is banned and colleagues have been told about / are aware of the order then ideally the order must be cancelled or failing that intercepted and held back from the patient and stored or disposed of safely.

c) Incoming letters, parcels and deliveries must be monitored by colleagues with a check made, where possible, on the sender details etc. In certain instances, for example in secure services and psychiatric intensive care units consideration must be given to scanning the package with a metal detector.

d) Staff should be attentive and inquisitive in respect of incoming letters and parcels from overseas (it is understood that toxic substances which are freely available overseas can be ordered from within the UK and delivered to addresses in the UK).

e) Incoming parcels and deliveries can be opened by staff in a suitable area with the patient present, if the patient consents to this arrangement. If the patient does not consent, arrangements must be made to enable the patient to open the parcel / delivery in a suitable area and with staff at arm's length and vigilant to intervene if necessary. These arrangements must form part of the risk management plan referenced at paragraph a. above.

10 COMPETENCE: INDUCTION AND TRAINING

10.1 Colleagues allocated to manage Banned and Restricted Items must have been given a satisfactory induction to the unit they are working on, must ensure they know how banned and restricted items are to be managed and must be familiar with the patients and their risk profile.

10.2 A current H Form: 24G Banned and Restricted Items Competency Checklist should be in place for permanent or bank colleagues. A copy of the completed Competency Checklist should be kept in their human resources file.

10.3 H Form: 24G Banned and Restricted Items Competency Checklist must be completed where it is identified that colleagues have fallen short of the requirements of this policy (this may be identified as part of the routine actions of the manager/person in charge or in the event of an incident, near miss or complaint).

11 ASSOCIATED FORMS

13.1 **H Form: 24A** Banned and Restricted Items ED Services Poster (PG04755)
H Form: 24B Banned and Restricted Items All Healthcare Units Poster (PG04756)
H Form: 24C Banned and Restricted Items CAMHS Poster (PG04757)
H Form: 24D Banned and Restricted Items Forensic Poster (PG04758)
H Form: 24E Management of Restricted Items Recording Form
H Form: 24F Management of Restricted Items inventory sheet
H Form 24G Management of Restricted Items Competency Check Sheet
H Form: 24H Restricted Items Spot Check
H Form: 24K Banned and Restricted Items Brain Injury Services Poster
H Form: 24L Banned and Restricted Items PICU Poster
H Form: 35 Welcome to Priory
H Form: 53 Patient Property List
H-SOP18: Management of Banned and Restricted Items