Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Policy:
Managing Access and Exit Policy

Executive or Associate Director lead	Clive Clarke, Executive Director of Operations
Policy author/ lead	Sharon Ward –Ward Manager, revised in line with Code of Practice by Dave Palfreyman
Feedback on implementation to	Service User Safety Group

Date of draft	May 2016
Dates of consultation period	June 2016
Date of ratification	21 July 2016
Ratified by	Executive Directors Group
Date of issue	July 2016
Date for review	July 2019

Target audience	All staff on wards and working in residential and respite care services

Policy Version and advice on document history, availability and storage
Version 3 replaces the previous Managing Access and Exit Policy

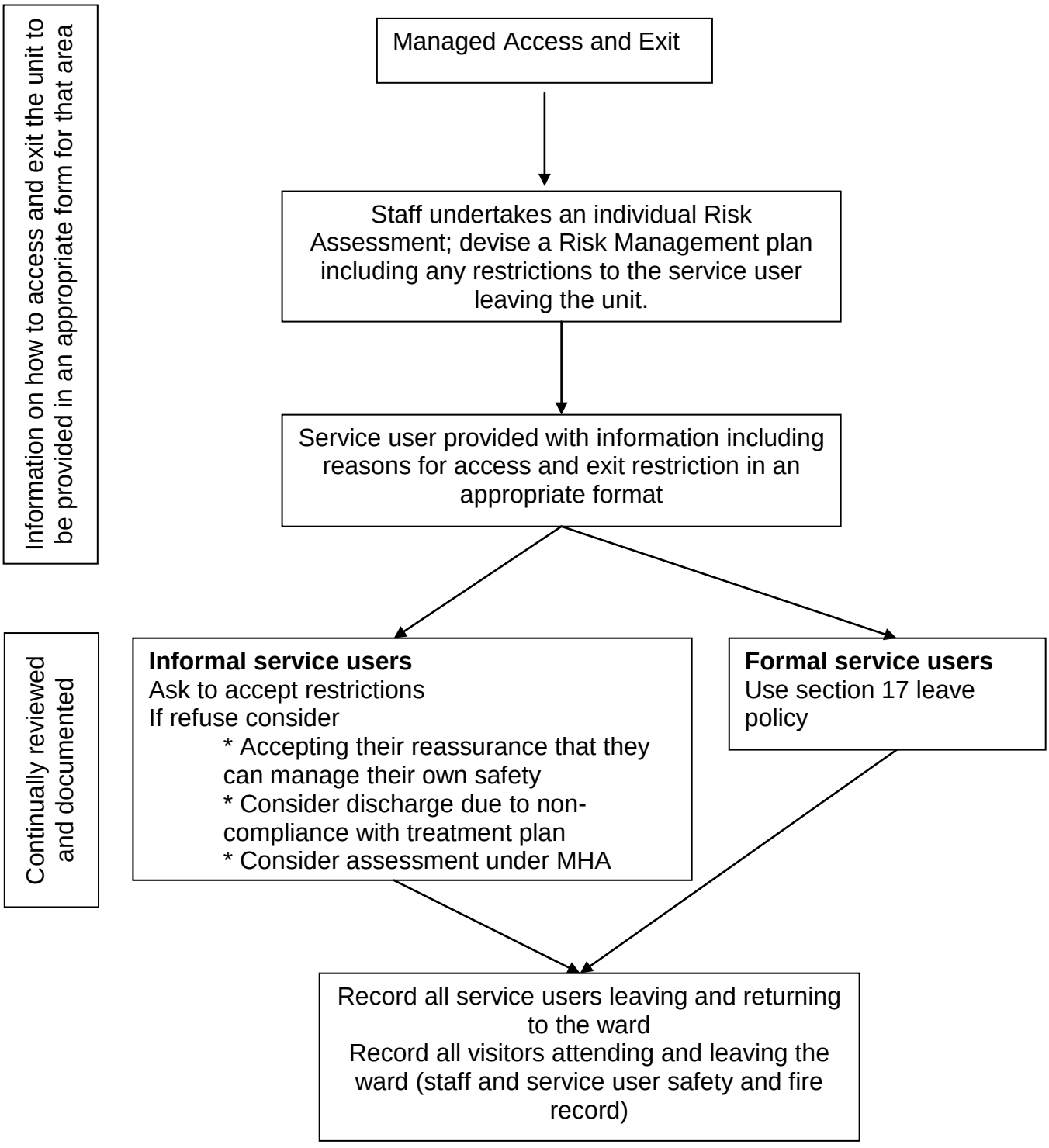
This policy provides advice and guidance to staff who work in in-patient, residential and respite care units who have to control access or exit to a unit or department.

The policy also requires service users to be provided with information about why the wards/residential/respite units have managed access and exit.

The policy also requires service users and visitors to be provided with clear information about how to access or exit the unit.

Contents:

Flow Chart


Information on how to access and exit the unit to be provided in an appropriate form for that area
Managed Access and Exit
Staff undertakes an individual Risk Assessment; devise a Risk Management plan including any restrictions to the service user leaving the unit.
Service user provided with information including reasons for access and exit restriction in an appropriate format
Continually reviewed and documented
Informal service users
Ask to accept restrictions
If refuse consider
* Accepting their reassurance that they can manage their own safety
* Consider discharge due to non-compliance with treatment plan
* Consider assessment under MHA
Formal service users
Use section 17 leave policy
Record all service users leaving and returning to the ward
Record all visitors attending and leaving the ward (staff and service user safety and fire record)

1. Introduction

Sheffield Health & Social Care Trust (SHSC) has a duty to provide care and treatment to a range of service users in a variety of settings including working age adults, older age adults, people with a learning disability and substance misuse. Occasionally young adults are also in receipt of care from in-patients wards.

SHSC needs to be compliant with Care Quality Commission Standards. This policy complies with Outcome 10(c) of the Safety and Suitability of premises. And the Mental Health Act Code of Practice section 8. Blanket locked door policy. Though SHSC operates a locked door policy on wards to prevent unauthorised entry or exit, **patients should be informed at their induction** the procedure for exiting a ward.

SHSC has a duty to provide hospital, residential and respite units that are safe and protected. By having managed access and exit, we are able to ensure and maintain a safe and therapeutic environment.

Ensuring in-patient and residents safety requires the need to restrict the access and exit to SHSC wards and units.

2. Scope of the Policy

This policy covers all Trust premises where a service user is resident whether for short or long term care.

3. Definitions

Service user – describes patients, clients and residents, in all residential and in-patient settings.

Locked door – any mechanism used that prevents someone opening the door, e.g. for people with Learning Disabilities or Dementia this may include two handle mechanism, twist lock, etc that other people may be able to open.

Managed access or exit – the process for managing who enters or exits a ward/department/unit. This includes displaying notices for all visitors of how to access/exit.

Person-in-charge – the person with overall responsibility for the shift on a ward/residential unit

4. Purpose of this policy

The purpose of this policy is to give guidance and clarity about managing the access and exit to in-patient wards, residential and respite care units.

Bathroom and kitchen doors are covered by the Drowning & Scalding Policy.

This policy applies to all doors leading into and out of the ward/residential/respite care units

This policy provides clarity on the management of the informal patient

The policy provides information on providing information to service users, carers/families and visitors.

5. Duties

Clinical/Service Directors

- Responsible for ensuring and supporting ward/unit managers with adequate controls for managing access/exit. This will include: adequate staffing where the needs are identified, etc.

Ward Managers/Residential Managers

- Ensuring this policy is followed
- Monitoring and reviewing implementation of this policy to protect service users, staff and others
- Monitoring and reviewing incidents
- Ensuring that the ward environment and activity support the service users wish to remain on the ward
- Ensure adequate signs are in place to inform patients and visitors how to exit the ward

Person-in-charge/Shift coordinator

- Is responsible for the care and protection of service users and staff. Also the maintenance of a safe environment

Individual staff

- To maintain a safe environment for service users and families/carers to visit
- To be familiar with and adhere to this policy

6. Specific details

All in-patient wards, residential and respite units will have restricted access and exit through either locked doors or a managed entrance/exit.

In all in-patient wards, residential and respite care sites there is a need to control access and exit because of the increasing need to monitor the service user's movement to and from the ward for their safety either through an assessed risk of harm to self, absconding or vulnerability. It is also important that staff, maintain a safe environment, are aware of people attending the ward and their purpose.

6.1 On the Ward/Unit

6.1.1 On admission, all service users will have a risk assessment, risk management and care plan including whether restrictions will be placed on their ability to leave the ward/unit.

6.1.2 There will be clear Information for service users as to why access and exit of the ward/unit is restricted. This will be provided in an appropriate format for the ward/units service user population.

6.1.3 There will be clear signage at the entrance and exits explaining the procedure for how to access and exiting the ward/unit.

6.1.4 All wards/residential/respite units will have a system for the recording of service users leaving and returning to the ward.

6.1.5 All wards/units will have a system for recording visitors attending and leaving the ward

6.2 Informal patients

6.2.1 Informal patients should be able to leave when they request however should, on assessment, their level of risk determine it appropriate for restrictions be in place they should be formally asked to consent in writing that they agree with the restrictions.

If they refuse this option the care team should reconsider the risk management plan either

- Accept the service users perception of their own risk and care plan accordingly
- Consider discharge on the grounds that they are unwilling to comply with a treatment request and could be safely managed elsewhere
- Consider the use of the Mental Health Act on the grounds that they are refusing treatment for their own safety.

6.2.2 The decisions process and outcome should be clearly recorded within the clinical notes.

6.2.3 In social care settings, the validity of the decision to restrict free movement should be recorded by the assessor prior to admission and be included in the contract of care and single assessment process (SAP) documentation. Any restrictions must be regularly reviewed as part of their overall care and treatment.

6.2.4 Service users requesting to leave the ward should be reviewed as per SHSC leave policy.

6.3 Management of internal door(s) to Outside Space/Smoking Area.

6.3.1 Due to the smoke free regulations, service users must use the designated area. There is now a need for access to and from the garden during a 24 hour period.

6.3.2 During unsocial hours access to outdoor space should be restricted to that by which clinical staff can safely observe service users outdoors e.g. restriction to large garden areas, areas that may cause a disturbance to service users and/or the general public.

7. Dissemination, storage and archiving

Previous version of the policy (Locked Doors Policy, Date of Issue: January 2007) should be removed.

The policy will also be available on the Trust Intranet.

Previous versions of this policy will be archived by the Integrated Governance Team.

8. Training and other resource implications for this policy

Knowledge and understanding of the policy will be by launching the policy to Ward Managers/Unit Managers and representatives for them to inform and support other staff in their areas. The Supervision process will support this.

9. Audit, monitoring and review

NHSLA Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A)	Staff, service users and visitors not being able to walk straight onto a ward/unit	All SHSC staff	Continuous	Ward/unit manager		
B)	Clear documentation DRAM and BRAM or other approved risk management documentation	Clinical staff				
C)	Evidence of visitor book being used	Ward/unit manager	Monthly			
D)	Reduced incidents of AWOL reported incidents	Service and Clinical Directors	Quarterly	Service and Clinical Directors	Directorates Senior Management Teams	
E)	Monitoring/Audit of complaints and service user and carer feedback	Service and Clinical Directors	Quarterly	Service and Clinical Directors	Directorates Senior Management Teams	

This Policy will be reviewed in two years or before this date if sufficient concern exists or should changes on national guidance require more frequent reviews. The formal Policy review will consider the appropriateness and effectiveness of the outlined approaches based on:

a) Information regarding prevalence based upon incident reporting including Absent without Leave notifications.
b) other sources of feedback, such as complaints, service user forums, national reports/ guidance subsequently published
c) lessons learned from incidents

10 Implementation plan

Implementation of the policy will be required at a team level.

Action / Task	Responsible Person	Deadline	Progress update
Put new policy onto intranet and remove old version	Chief Nurse	Within a week of ratification	
Make Ward manager/Unit Managers aware of new policy via appropriate forums	Service/Clinical Director	Within two weeks of ratification	
Teams to be made aware of the policy	Ward Manager/Unit Managers	Within two months of ratification	
Check staff awareness through Supervision	Ward/Team Manager		
Audit plan to be developed by each Directorate to monitor implementation of the Policy	Clinical/Service Directors		

11. Links to Other Policies

Mental Health Act 1983 Code of Practice (2015)
Joint Policy on the Prevention and Management on the Use of Restraint
Prevention and Management of Violent Behaviour
Mental Capacity Act Guidance
Deprivation of Liberty Safeguards Guidance
Incident Reporting and Investigation Policy
Missing Patient Policy
Safeguarding Adults Policy
Observation of In Patients - Safe and Supportive Observations of Patients at Risk
Leave for Patients (not under the Mental Health Act)
Authorisation of Leave Policy - Section 17
Security Policy
Visits by Children to in-patient or residential care-settings
Fire Safety Policy
No Smoking Policy

12. Contact details

Some staff may presume that the restriction of having a managed access and exit to an area is a deprivation of liberty. If anyone has doubts, they can refer to the following

Title	***Name***	***Phone***	***Email***
Senior Nurse – Patient Safety	Charlie Turner	22 63377	Charlie.turner@shsc.nhs.uk
Clinical Risk Manager	Carol O'Neill	27 16371	Carol.oneill@shsc.nhs.uk
Complaints and Litigation Lead	Wendy Hedland	2718956	Wendy.hedland@shsc.nhs.uk

12. References

Where it can be demonstrated that most service users, if allowed to leave the premises unescorted, would be at significant risk of harm due to their highly vulnerable conditions.

Reference – Mental Health Act (1983), Code of Practice (2015 edition)

Human Rights Act – Right to Life, Right to Security, Right to Freedom

Appendix A – Template notice advising how to access/exit the ward

This door is locked for the safety and comfort of service users, and visitors.

Please ring the bell and wait for a member of staff.

Thank you.
Ward/Unit Manager

Supplementary Section A - Stage One Equality Impact Assessment Form

1. Have you identified any areas where implementation of this policy would impact upon any of the categories below? If so, please give details of the evidence you have for this?

Grounds / Area of impact	People / Issues to consider	Type of impact		Description of impact and reason / evidence
		Negative (it could disadvantage)	Positive (it could advantage	
Race	People from various racial groups (e.g. contained within the census)			Policy 6.3.5 - Issues surrounding safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards. These areas should be explored as part of the assessment on admission, and also when reviewing care. The relevant Trust Policies and Guidance should be used as appropriate/required. Also where the patient is detained under the Mental Health Act there is an expectation in law that their human rights are considered as per Human Rights Act Article 2 – right to life.
Gender	Male, Female or transsexual/transgender. Also consider caring, parenting responsibilities, flexible working and equal pay concerns			
Disability	The Disability Discrimination Act 1995 defines disability as *'a physical or mental impairment which has a substantial and long-term effect on a persons ability to carry out normal day-to-day activities'.* This includes sensory impairment. Disabilities may be visible or non visible			
Sexual Orientation	Lesbians, gay men, people who are bisexual			
Age	Children, young , old and middle aged people			
Religion or belief	People who have religious belief, are atheist or agnostic or have a philosophical belief that affects their view of the world. Consider faith categories individually and collectively when considering possible positive and negative impacts.			

2. If you have identified that there may be a <u>negative impact</u> for any of the groups above please complete questions 2a-2e below.

2a. The negative impact identified is **intended** ☐ **OR** **2b**. The negative impact identified **not intended** ☐

2c. The negative impact identified is **legal** ☐ **OR** **2d**. The negative impact identified is **illegal** ☐ **OR (see 2e)**
(i.e. does it breach antidiscrimination legislation either directly or indirectly?)

2e. I **don't know** whether the negative impact identified is legal or not ☐
(If unsure you must take legal advice to ascertain the legality of the poli

3. What is the level of impact?

☐

HIGH - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ MEDIUM - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ LOW - Consider questions 4-6 below

4. Can any low level negative impacts be removed (if so, give details of which ones and how)

5. If you have not identified any negative impacts, can any of the positive impacts be improved? (if so, give details of which ones and how)

6. If there is no evidence that the policy promotes equality and equal opportunity or improves relations with any of the above groups, could the policy be developed or changed so that it does?

7. Having considered the assessment, is any specific action required - Please outline this using the pro forma action plan below
(The lead for the policy is responsible for putting mechanisms in place to ensure that the proposed action is undertaken)

Issue	Action proposed	Lead	Deadline

8. Lead person Declaration:

8a. Stage One assessment completed by : Charlie Turner…….(name) ……..……(signature) August 2010……(date)

8b. Stage One assessment form received by Patient experience and Equality Team ……..(date)

8c**.** Stage One assessment outcome agreed ☐ ……..……*(sign here)*…….…. *(*Head of Patient Experience and Equality)

OR …… (date agreed)

8d. Stage One assessment outcome need review ☐ …….. ……*(sign here)*…….…. *(*Head of Patient Experience and Equality)

…….. (date returned to policy lead for amendment)

(if review required – please give details in text box below)

If a full EQIA is required the stage 1 assessment form should be retained and a completed EQIA report submitted to the relevant governance group for agreement by the chair. The chair will forward the completed reports to the Patient Experience and Equality team for publication.

Any questions relating to the completion of this form should be directed to the Head of Patient Experience and Equality.

Supplementary Section B - Human Rights Act Assessment Form and Flowchart

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

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.SHSC.nhs.uk/humanrights-273.asp (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

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

☒ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

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

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

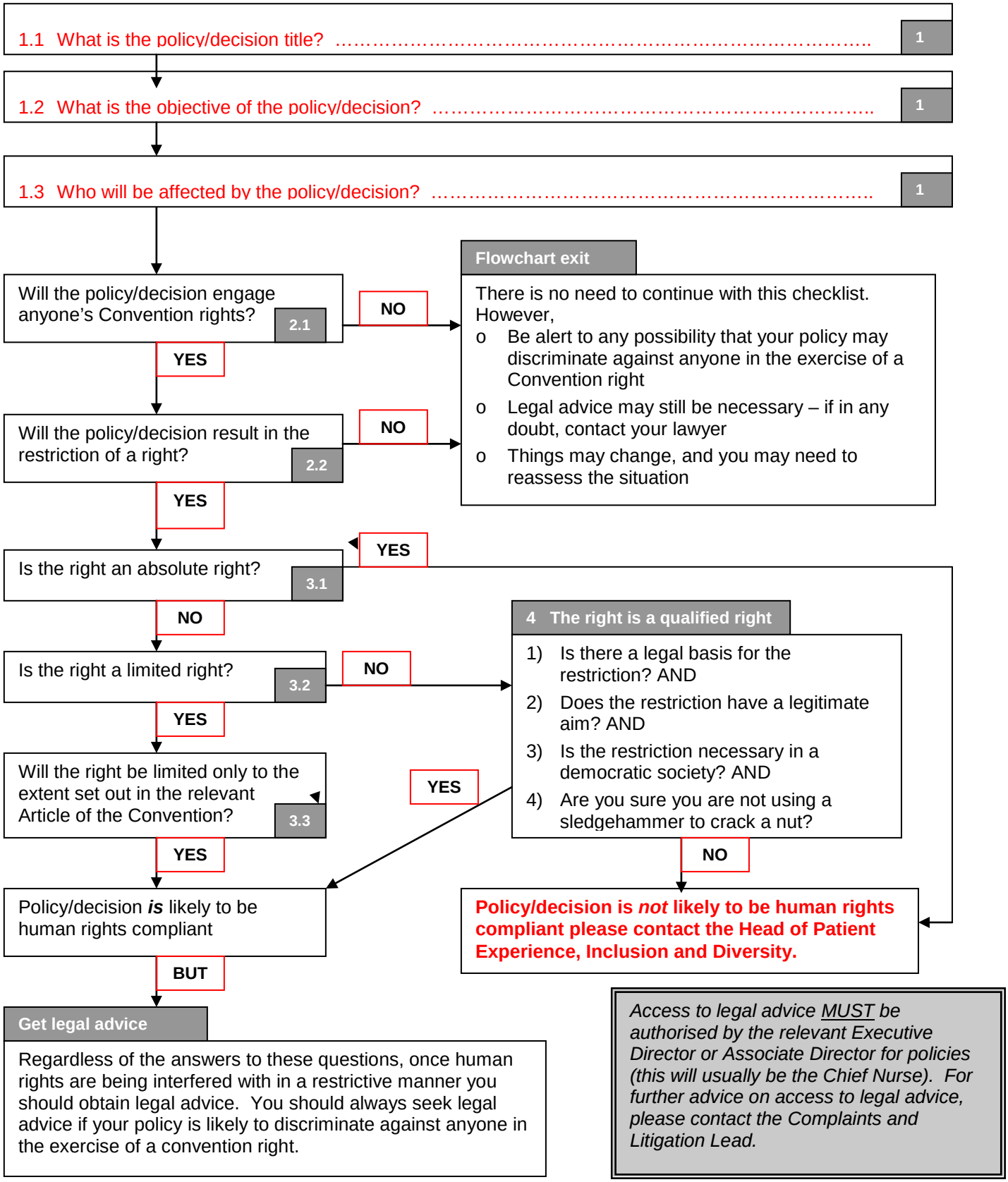
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

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

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



Supplementary Section C - Development and consultation process

- Comments from previous policy and from Acute Care Forum Patient Safety sub-group

- Small working group to look at all information
  - Trust Incident Data
  - Learning from incidents
  - Comments from various people eg staff, service users, carers
  - Coroner
  - Other Trusts
  - National Research – Malcolm Rae, Len Bowers, etc

- Draft 1 of policy
  - A greater focus on the management of the process of access and exit
  - Safety and security of service users and staff
  - An evaluation of clinical risk, including vulnerability and safeguarding of adults
  - Safety and security of the environment, property and location of premises
  - A review date
  - Changed to new Policy template

- Focus group meetings with service users and carers - comments collated and fed into draft

- Workshop and discussion at Acute Care Forum - comments collated and fed into draft

- Draft 2 of policy – reviewed by working group. Included flowchart

- Draft 3 of policy – Circulate to staff and focus group attendees for comments

- Draft 4 of policy – changes made from consultation process, including reviewed flowchart

- Final review/consultation with Draft 4 – including Clinical Risk Manager to consider lessons from incidents, practical aspects of using the policy.

- Final Draft 5 – for approval and ratification

Appendix to Policy on Policies – Record of consultation

Name of Policy **Managing Access & Exit**	**Name of Policy Lead** **Charlie Turner, Senior Nurse**
Date October 2012	**Contact Details Tel: 22 63377**

Consultation Plan:

- Who will be significantly affected by the policy (or need to implement it?): Anyone using or visiting in-patient or residential areas.
- List staff groups, service users and carers, other stakeholders below: In-patient staff and residential staff, service users, carers, governors,

Is this a big change to a current policy or a new policy? **YES**

If NO Consultation via email and discussion at relevant governance groups is sufficient

If YES Consider a wider consultation process eg with focus groups, attendance at team or directorate meetings

RECORD OF CONSULTATION (interactive)

Group or individual consulted	**Date of consultation/ response received (approximate dates)**	**Comments on draft policy**	**Your response (say if policy amended – if not, say why not)**
Service User/Carer focus groups for Acute Care	Jan/Feb 2010	Noted in Supplementary Section C - Development and consultation process	Noted in Supplementary Section C - Development and consultation process
Acute Care Forum	March 2010		
Small working group from Acute Adult, Learning Disabilities & FMI Directorates	July 2009 – Apr 2010		
A number of email consultations	Aug 2009 – July 2010		
Clinical Risk Manager	June/July 2010		
Following revision of a number of e-mail consultations	August/September 2012		