Policy:

OPS 014 –
Managing Access and Exit Policy

Executive Director lead	Chief Operating Officer
Policy Owner	
Policy Author	Senior Operational Manager

Document type	Policy
Document version number	V4
Date of approval	26/05/2020
Approved by	Quality Assurance Committee (QAC)
Date of issue	09/06/2020
Date for review	31/05/2022

Summary of policy Provide a summary description of the policy

Target audience	Senior managers, Ward managers, Unit manager, inpatient, residential and step down staff

Keywords	Access, exit, locked door, information, service user, carer, visitor

Storage Version 4 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (v.3July 2016). Any copies of the previous policy held separately should be destroyed and replaced with this version.

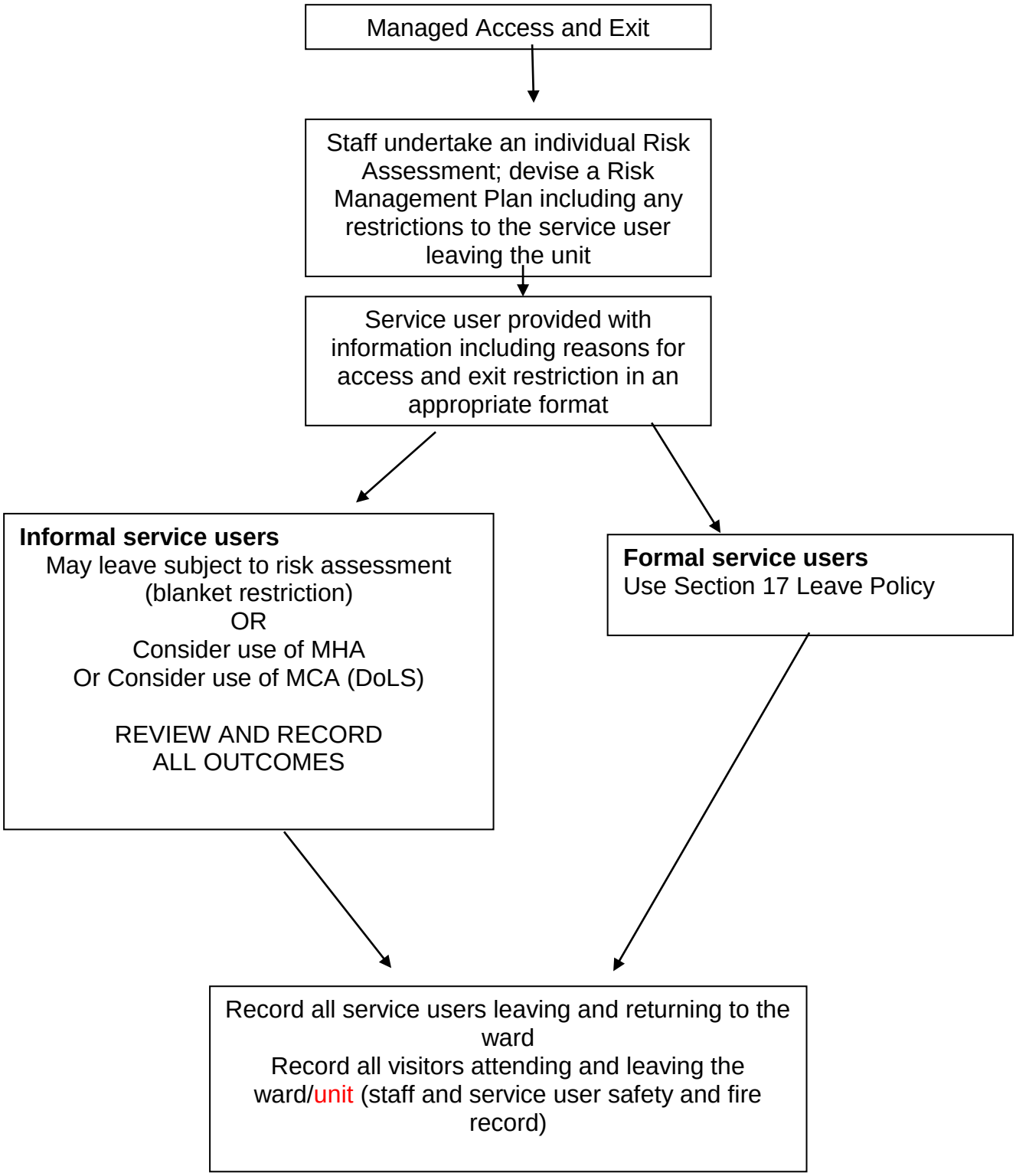
Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
3.0	Review / approval / issue	May – July 2016	Full review completed as per schedule
4.0	Review	Feb – May /2020	This policy has been transferred into the latest Policy on Policies format The policy no longer references a Locked Door Policy (previously removed) The policy now refers to the Blanket Restrictions policy The policy now refers to local Standard Operating procedures The term Respite Unit has been removed and replaced with Step- down Unit The policy offers greater clarity regarding the informal patient and their capacity to consent to reside in hospital, and how this should be assessed and recorded in the clinical notes. The policy refers to the Deprivation of Liberty Safeguarding Policy for informal patients who lack capacity and for whom the MHA does not apply The policy refers to Standard Operating procedures for internal locked doors

Contents

Flowchart

Information on how to access and exit the unit will be clearly displayed in each area



1 Introduction

Sheffield Health & Social Care Foundation 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 inpatients 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 with the Mental Health Act Code of Practice section 8.10-8.15 in respect of the Trust's Blanket Restrictions policy. SHSC has locked doors on wards/units to prevent unauthorised entry or exit (see Blanket Restrictions Policy), and **patients and visitors should be informed on arrival** of the procedure for exiting a ward.

SHSC has a duty to provide hospital, residential and step-down units that are safe and protected. By having managed access and exit, we can 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

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

3 Purpose

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

Bathroom and kitchen doors are covered by the Drowning & Scalding Policy.
Other internal rooms may be locked according to local Standard Operating Procedures e.g. Green rooms

This policy applies to all doors leading into and out of the ward/residential/step down 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 all visitors.

4 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/ unit

5 Detail of The Policy

Please refer to Section 1 of this policy

6 Duties

Directors and Associate Directors and Senior Operational Managers:

- 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/unit
- Ensure adequate signs are in place to inform patients and visitors how to exit the ward/unit

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

7 Procedure

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

In all in-patient wards, residential and step-down 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/unit 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, and have a record of people attending the ward and their purpose.

7.1 On the Ward/Unit

7.1.1 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. This will depend on whether they are detained or not – if detained, then s17 is the only lawful authority for them to be absent from the hospital, if not they are free to leave, subject to SHSC Blanket Restrictions Policy as it relates to risk assessment

7.1.2 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.

7.1.3 There will be clear signage at the entrance and exits explaining the procedure for how to access and exiting the ward/unit. Specifically, it will make clear that informal patients are free to leave, subject to the Trust's blanket policy of risk assessment for anyone wishing to exit the ward.

7.1.4 All wards/residential/step-down units will have a system for the recording of service users leaving and returning to the ward/unit.

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

7.2 Informal patients

Capacity to consent to informal admission should be recorded on Form CAT1, which details the information that has been given in order to obtain informed consent; the consent is for all the restrictions that apply

CAT1 includes being free to leave, subject to holding powers.

If the informal patient, through risk assessment, meets the criteria for using the holding powers under s5(2) or s5(4) then they should be held under those powers as set out in the Mental Health Act (1983)

7.2.1 Form CAT1 should be completed before admission for informal patients, in order that they are informed of the conditions under which they will be admitted, including the right to leave at any time, subject to risk-assessment.

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

7.2.3 If the risk assessment determines that the person ought to stay on the ward, then the use of holding powers under the MHA should be considered if the relevant criteria are met

7.2.4 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. Staff should to adhere to the requirements of the Mental Capacity Act, and the Deprivation of Liberty Safeguards as they are set out in the Deprivation of Liberty Safeguarding Policy 2017

7.3 Management of door(s) to outside space.

7.3.1 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 public. Unit/ward staff should adhere to their individual Standard Operating Procedure regarding the appropriate management of outdoor space/garden areas

8 Development, Consultation and Approval

Version 4 of this policy was developed in consultation with:

Unit and Ward Managers
Unit and Ward Deputy Managers
Senior Operational Managers for Crisis and Emergency Care Network
Nurse Consultants (inpatient wards)
Deputy Associate Director for Crisis and Emergency Care Network
SHSC Head of Mental Health Legislation

9 Audit, Monitoring and Review

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 Dire4ctors	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	Policy Governance	Within a week of ratification	
Make Ward manager/Unit Managers aware of new policy via appropriate forums	Service/Clinical Director	Within 2 weeks of ratification	
Team to be made aware of the policy	Ward Manager/Unit Managers	Within 2 months of ratification	
Che4ck 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 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
4.0	One week after ratification	One week after ratification	June 2020	

Previous version of the policy should be removed from the Intranet/Internet and archived by Policy Governance Department.

12 Training and Other Resource Implications

All new starters to the Trust, including Bank and Agency staff, should be familiar with the policy at their local induction

13 Links to Other Policies, Standards (Associated Documents)

Mental Health Act (1983)
Section 17 Authorisation of Leave policy
Mental Capacity Act
Deprivation of Liberty Safeguarding Policy
Local Standard Operating Procedures
Blanket Restrictions Policy

14 Contact Details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Senior Operational Manager – Crisis and Emergency Care Network	Shirley Lawson	18173	shirley.lawson@shsc.nhs.uk
Senior Operational Manager, Crisis and Emergency Care Network	Mark Bell	63174	mark.bell@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Mark Bell 06/05/2020	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**no**	**no**	
Disability	**no**	**no**	
Gender Reassignment	**no**	**no**	
Pregnancy and Maternity	**no**	**no**	

Race	**no**	**no**	
Religion or Belief	**no**	**no**	
Sex	**no**	**no**	
Sexual Orientation	**no**	**no**	
Marriage or Civil Partnership	**no**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Mark Bell 06/05/2020