Policy:

Managing Access and Exit Policy 24 hour-bedded areas

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Policy Owner	Director of Nursing, Professions & Quality - Salli Midgley
Policy Author	Matron, Acute and Community Service

Document type	Policy
Document version number	V5
Date of approval by PGG	26/06/2023
Date of ratification	12/07/2023
Ratified by	Quality Assurance Committee (QAC)
Date of issue	30/06/2023
Date for review	June 2025

Summary of policy

The policy gives guidance and expected standards regarding the management of access to and exit (egress) from all 24 hour bedded areas

Target audience	Senior managers, Ward managers, Unit managers, all staff providing care and treatment in 24 hour- bedded areas

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

Storage

Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (v.4 2020). Any copies of the previous policy held separately should be destroyed and replaced with this version.

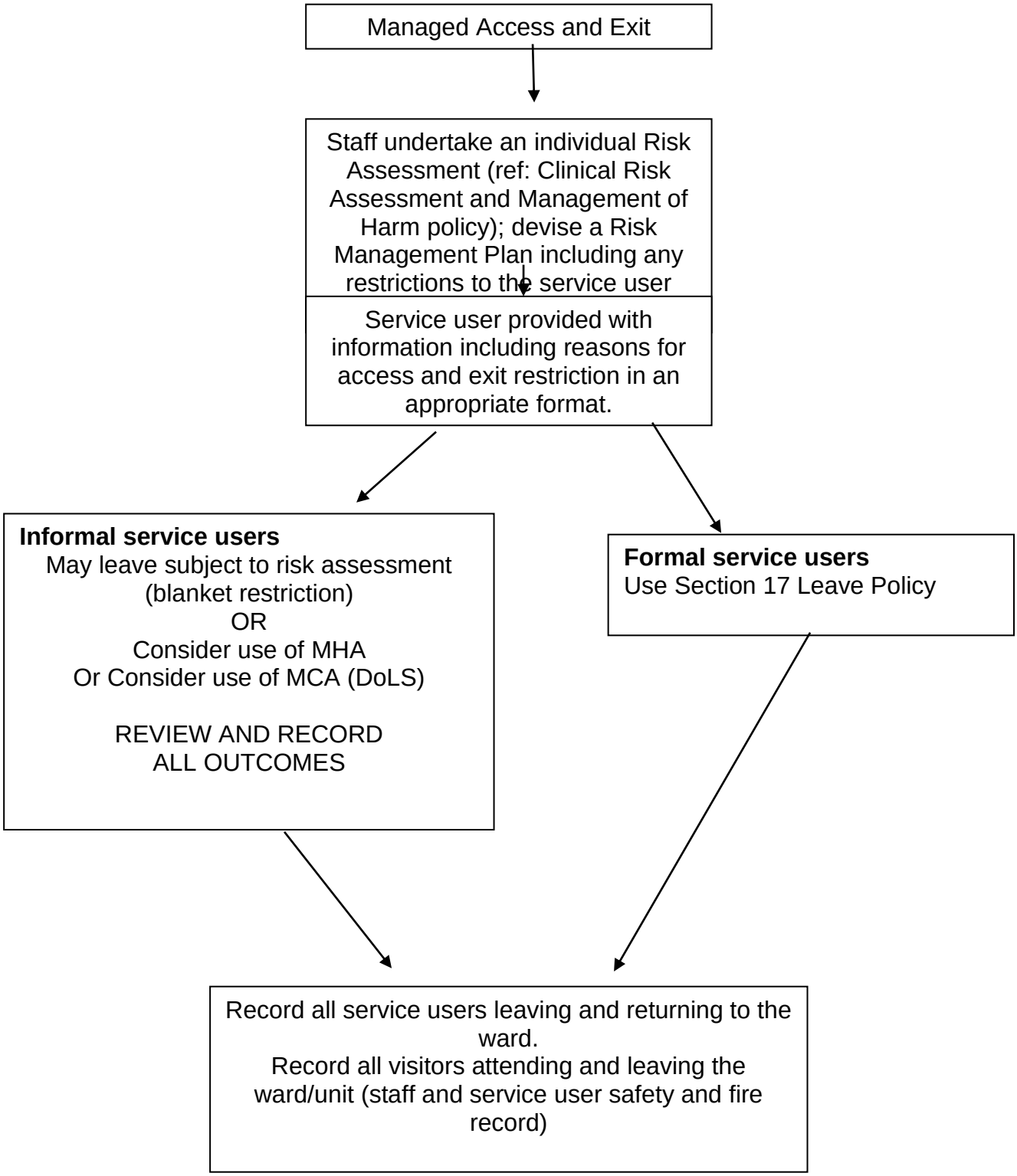
Version Control and Amendment Log

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 local Standard Operating procedures for internal locked doors
5.0	Review	June 2023	This policy has been transferred into the latest Policy on Policies format. Role titles have been amended. Wards, units and residential areas have been subsumed under the term ’24 hour bedded units’. Staff are directed to the Clinical Risk Assessment & Management of Harm policy for best practice in the development of a risk assessment & management plan (DRAM). Staff are directed to the Absent Without Leave and Missing Patient policy, where unauthorised leave is taken Reference to the Drowning and Scalding Policy has been removed as this is no longer a policy. Monitoring Compliance has been revised.

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 24-hour care settings including for 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 **service users and visitors should be informed on arrival** of the procedure for exiting a ward.

SHSC has a duty to provide care in 24 hour bedded units that is safe and protected. By having managed access and exit, we can ensure and maintain a safe and therapeutic environment.

Ensuring service user 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 expected standards regarding the management of access and exit to all 24 hour-bedded areas.

Some internal rooms/areas 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 or unit.

This policy provides information on the management of the informal patient.

The policy provides guidance on the provision of information to service users, carers/families, and all visitors.

4 Definitions

Service user – describes patients, clients and residents, in all 24 hour-bedded areas.

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, Heads of Service, General Managers, Heads of Nursing, Service Managers, Matrons

- 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 /Unit 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:

- 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 24 hour bedded units will have restricted access and exit through either locked doors or a managed entrance/exit.

In all areas 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 an up-to-date detailed risk assessment and management (DRAM) plan recorded in their electronic record (ref: Clinical Risk Assessment and Management of Harm policy) which will include whether restrictions will be placed on their ability to leave the ward/unit. This will also depend on whether they are detained or not – if detained, then section 17 leave is the only lawful authority for them to be absent from the hospital/unit, if not detained they are free to leave, subject to SHSC Blanket Restrictions Policy as it relates to risk assessment. Any

service user who leaves the unit without appropriate authorisation will be considered absent, and the Absent Without Leave Missing Person policy will be followed.

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's/unit's service user population.

7.1.3 There will be clear signage at the entrance and exits explaining the procedure for how to access and exit 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 leave.

7.1.4 All wards/ 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 area.

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 needs 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 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 5 of this policy was reviewed in consultation with:

All managers of 24 hour bedded services.
Heads of Nursing
Matrons
General Managers
Service Managers
Nurse Consultant for restrictive practice
Head of Mental Health Legislation
Inpatient Managers Governance meeting

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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
Wards/units provide a signing in and out system e.g. book, for all visitors	Monitor provision and use of signing in system	Ward/unit manager	Monthly and ad hoc	Matron and ward/ unit governance team	Matron, ward/unit manager	Matron/service manager and General manager
Wards/units provide posters at entrances and exits to and from their areas stating the procedures for access and exit	Ensure posters remain in place	Ward/unit manager	Monthly and ad hoc	Matron/service manager	Ward/unit manager and Matron/service manager	Matron/service manager and General manager
Monitor all instances of service users leaving the unit without appropriate authorisation including AWOL or without risk assessment	Review Incident reports	Ward/unit Manager	Monthly and ad hoc	Ward/unit manager with local governance team	Ward/unit manager with local governance team	Matron/service Manager and General Manager

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 e.g. delays in access to or exit from wards/units, 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 Managers/Unit Managers aware of reviewed policy via relevant forums	General Manager/Matron	Within 2 weeks of ratification	
Teams to be made aware of the policy	Ward Manager/Unit Managers	Within 2 weeks of ratification	
Check staff awareness through Supervision	Ward/Unit Manager	At first supervision following issue and thereafter ongoing	

11 Dissemination, Storage and Archiving (Control)

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

Dissemination – To be disseminated to all services that operate 24 hour bed based services. Reference to the policy to be included in the next available Communications Digest

Storage – Trust Intranet or central storage for all Trust Policies within one week of ratification.

The previous policy will be removed from the Trust intranet by the Clinical Governance team. Team managers are responsible for ensuring that it is also removed from any policy and procedure manuals or files stored in their offices and destroyed.

Archiving - The Clinical Governance team will keep a paper and an electronic version of the previous policy for archive purposes. Please contact them if a copy is needed

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
Visitors' 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 advise regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Matron–Acute and Community Services (acute inpatients)	Shirley Lawson	18173	shirley.lawson@shsc.nhs.uk

Appendix 1

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: Shirley Lawson 31/05/2023	**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:
no changes made.

Impact Assessment Completed by:
Name /Date Shirley Lawson 31/05/2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	√
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	√
5.	Has the policy been discussed and agreed by the local governance groups?	√
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	No recommendations received for review
	Template Compliance	
7.	Has the version control/storage section been updated?	√
8.	Is the policy title clear and unambiguous?	√
9.	Is the policy in Arial font 12?	√
10.	Have page numbers been inserted?	√
11.	Has the policy been quality checked for spelling errors, links, accuracy?	√
	Policy Content	

12.	Is the purpose of the policy clear?	√
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	√
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	No lessons learned identified for review
15.	Where appropriate, does the policy contain a list of definitions of terms used?	√
16.	Does the policy include any references to other associated policies and key documents?	√
17.	Has the EIA Form been completed (Appendix 1)?	√
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	√
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	√
20.	Is there a plan to i. review ii. audit compliance with the document?	√
21.	Is the review date identified, and is it appropriate and justifiable?	√