Somerset Partnership NHS
NHS Foundation Trust

LOCKED DOORS AND DOOR CONTROL POLICY

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Relevant Staff Group/s:	Mental Health staff in inpatient areas, MH wards only.

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DOCUMENT CONTROL

Reference Number BJ/Nov/13/LD&DCP	**Version** 3	**Status** Final	**Author** MH Legal Strategies Lead
Amendments	Rewritten to reflect changed staff roles and service monitoring structures		
Document objectives: To inform hospital staff of when ward doors might be locked and how patients, detained and informal, should be made aware of the policy.			
Intended recipients: Trust-wide, staff caring for detained and informal patients in mental health inpatient areas.			
Committee/Group Consulted: Mental Health Act Group. Improving the Quality of In-patient Services Best Practice Group. Clinical Governance Group.			
Monitoring arrangements and indicators: The Trust will receive comments from patients, visitors, staff and the CQC and review our policy and practices against those comments. Overall monitoring will be by the Regulation Governance Group.			
Training/resource implications: The Trust will ensure that all necessary staff (qualified, unqualified, other clinical staff, bank and agency staff) are appropriately trained in line with the organisation's training needs analysis.			
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1. INTRODUCTION

1.1 The provision of a safe environment and the personal safety of both informal and detained patients and staff are of the utmost importance to the Trust.

1.2 The Trust recognises its responsibilities and duty of care in ensuring that in-patient wards are safe and secure environments for the delivery of patient care. In addition, there is a requirement to provide protection for patients in our care and staff from the public. If managing entry and exit to the ward, by patients or visitors, by means of locked external doors is considered by the ward manager or nurse in charge to be an appropriate way to maintain safety, then the practice is acceptable.

1.3 The intention when locking the ward door should be to protect patients, in particular those who are at risk of suicide, self-harm, accidents or inflicting harm on others unless they are prevented from leaving the ward.

1.4 While it may be possible to lock the ward door, alternative strategies to manage patient welfare and safety should always be considered. These might include having a member of staff always in the vicinity of the door, who is able to monitor who comes in or goes out.

1.5 It should be borne in mind that the nature of engagement with patients and of therapeutic interventions, and the structure and quality of life on the ward, are important factors in encouraging patients to remain on the ward and in minimizing a culture of containment.

2. PURPOSE & SCOPE

2.1 The aim of this policy is to ensure the safety of all patients and staff on our wards, whilst providing a safe internal environment in which care and treatment can be delivered. This includes ensuring the safety of patients lacking capacity who are at risk of wandering out of the ward area and who, without supervision, may be in danger of accident or harm.

2.2 This policy applies to all Trust staff directly involved with mental health inpatient care and is intended to clarify the clinical / legal position of having our ward doors locked.

2.3 The Trust acknowledges and respects the diverse needs of its patients and staff will respect these at all times when implementing this policy. This may necessitate the use of a professional interpreter and the translation of written information (see Professional Interpreting and Translation Services Policy). Staff will at all times be mindful of the person's protected characteristics and cultural differences which will be taken fully into account when implementing this policy to ensure the described procedure is conducted in as sensitive manner as possible which respects their privacy and dignity.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Trust Board** has a duty to care for all patients on wards in the Trust.

3.2 The **Chief Operating Officer** is responsible for this policy covering the locking of ward doors but will delegate authority for the operational implementation and ongoing management of this policy to the Mental Health Legal Strategies Lead.

3.3 The **Mental Health Legal Strategies** Lead is the author of this policy, who will review this policy at least every three years.

3.4 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.

3.5 **All staff** caring for detained and informal patients in in-patient areas should be familiar with the procedures detailed in the document and other related policies.

3.6 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies.

4. Explanation of Terms Used

4.1 **RiO** - the Electronic Patient Record system supplied by CSE Healthcare in use within the Trust.

4.2 All other explanations of terms used are included in the text of the policy and are not separately stated here.

5. THE DECISION TO LOCK THE WARD DOOR

5.1 If the nurse in charge or ward manager believes the ward door should be locked in the interests of patient safety (this could be for the safety of one or more patients), then they can exercise their duty of care by authorizing the locking of the ward door.

5.2 Psychiatric intensive care, low secure and wards treating patients with dementia or other significant cognitive problems must always have their main door locked.

5.3 When wards other than those mentioned in 5.2 (above) are locked, the ward manager should regularly review the locking of the ward to ensure it is being done to secure patient safety and not for any other reason.

6. CONTROLLING PATIENT ACCESS TO AND EXIT FROM THE WARD

6.1 Detained patients should be informed immediately they are detained that they will not be allowed to leave the ward except when section 17 leave arrangements authorize the patient being away from the ward. The information should be provided in a language the patient understands. If necessary, an interpreter should be used.

6.2 Patients who lack capacity but are not detained can be refused exit from the ward. To comply with our duty of care and requirements of the Mental Capacity Act, the prevention of their exit from the ward should be linked to a capacity test and best interest assessment, which should be recorded on RiO.

6.3 Informal patients who are admitted to a ward where entry and exit is being controlled should be made aware that this does not deprive the individual of their Human Rights Act, article 5, right to liberty. They are free to leave at any time. The nurse in charge should ensure informal patients are made aware of their right to leave the ward. The information should be provided in a language the patient understands. If necessary, an interpreter should be used.

6.4 Access to the ward by a patient who has been admitted to the ward should be allowed at any time.

7. CONTROLLING VISITOR ACCESS TO AND EXIT FROM THE WARD

7.1 All visitors needing access to the ward should be able to alert staff by means of a bell, buzzer and/or intercom. Visitors should be allowed access to the ward at any reasonable time.

7.2 Visitors can be denied access to the ward if their visit it not being undertaken at a reasonable time, is not thought to be in the best interests of the patient or is being made to take advantage of vulnerable patients. All decisions to deny access to the ward can only be made by the nurse in charge, ward manager or senior manager. The reasons should be recorded on RiO and, where appropriate, the patient informed.

7.3 Immediate help must be given to visitors to exit the ward when the ward door is locked.

8. SIGNAGE

8.1 Each ward that is locked must display a laminated A4 poster on or near the door that provides information on why the door is locked and the procedure for having the door unlocked to allow exit from the ward (see appendix 1). This poster is in English. Patients will already have been given this information, but where non-English speaking visitors are on the ward, the manager should ensure they are informed in their own language.

9. TRAINING REQUIREMENTS

9.1 All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

10. EQUALITY IMPACT ASSESSMENT

10.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

11. COUNTER FRAUD

11.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 Monitoring arrangements for compliance and effectiveness

The Trust will monitor adherence to the procedural guidelines. Overall monitoring will be by the Regulation Governance Group.

Responsibilities for conducting the monitoring

12.2 The Chair of the Regulation Governance Group will ensure feedback reports from the Mental Health Act Group are timetabled within the Regulation Governance Group reporting schedule and present on appropriate agenda, annually, using the Group Reporting Template.

The Mental Health Act Group will monitor compliance and effectiveness of the policy.

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12.3 Methodology to be used for monitoring

Regular discussions of the following will be recorded within the MHA Group minutes

- Complaints monitoring
- Incident reporting and monitoring
- New significant risks to be reported to the Regulation Governance Group by the MHA Group

12.4 Frequency of monitoring

- An annual report from the Mental Health Legal Strategies Lead to the Mental Health Act Group
- Annual reporting by the MHA group to the Regulation Governance Group

12.5 Process for reviewing results and ensuring improvements in performance occur.

Information received will be discussed at the MHA Group which will identify good practice, any shortfalls, action points and lessons learnt. Any change in policy will be presented to the Regulation Governance Group which will be responsible for ensuring improvements, where necessary, are implemented.

13. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

The standards and outcomes which inform this procedural document are as follows:

Section	Outcome	
Information and involvement	1	Respecting and involving people who use services
	2	Consent to care and treatment
Personalised care, treatment and support	4	Care and welfare of people who use services
Quality and management	17	Complaints
	20	Notification of other incidents

14. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References

Mental Health Act 1983 Code of Practice – Chapter 16 – The Stationery Office 2008

Cross reference to other procedural documents

Consent & Capacity to Consent Treatment

Detained Patients AWOL policy

Development & Management of Organisation-wide Procedural Documents Policy and Guidance

Learning Development and Mandatory Training Policy

Professional Interpreting and Translation Services Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Section 17 Leave policy

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet (on the home page, click on Information, then Local Guidance).

15. APPENDICES

15.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix 1 – Poster for ward explaining reasons for locked doors

APPENDIX 1

NAME OF WARD

Unless you have been told otherwise, you have the right to freely come and go from the ward.

The provision of a safe environment and your personal safety is of the utmost importance to staff on the ward.

As part of our duty of care we ensure that *Name of Ward* is a safe and secure environment for the delivery of patient care. The ward door is locked to promote that safety and security.

IF YOU ARE A PATIENT OR VISITOR and wish to leave the ward, you should ask a member of staff to open the door and they will open it immediately, unless there is a valid reason not to do so.

IF YOU ARE A PATIENT and are leaving the ward unaccompanied by staff, you must let a member of staff know where you are going and approximately when you expect to return. If you are required to stay on the ward you will be given a reason and a member of staff will discuss this with you privately.