Mental Health and Neurological Rehabilitation Unit
Locked Door Policy

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Purpose of Agreement	This policy sets out how, under particular circumstances, a person in charge of a clinical area may decide to prevent access to off ward areas by locking the door to a ward which ordinarily has a secure door in operation. This is within their sphere of responsibility in order to ensure the safety and well- being of one or more patients. This policy outlines the considerations and procedures, which are recommended within the Mental Health Act 1983, updated 2007 and the Code of Practice and must be followed when detention is necessary.
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Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
		3	Removed Oakdene	June 2021
1.7 + 5.5 + 9.2		6 + 10 + 11	Changed Psychiatric Observations to Therapeutic Observations	June 2021
2.3		6	Removed Oakdene	June 2021
3.4		7	Amended “the team” to “multidisciplinary team”	June 2021
4.1.2		9	Clarified role for Operations Director	June 2021
4.1.4		9	Added induction to training	June 2021
4.2.1		9	Replaced Assurance Committee with Clinical Executive Group	June 2021
5.3		10	Clarified evidence location for competency assessment	June 2021

Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
V1	March 2018	Richard Brown	Mental Health Governance	New policy
V1	May 2018	Richard Brown	Policy Approval Group	Small changes to policy title, document sponsor and executive summary made
V2	March 2021	Ben Martin-Lihou	Policy Steering Group and Clinical Executive Group	Small changes to policy wording, remove references to Oakdene

SUMMARY OF POLICY

This policy sets out how, under particular circumstances, a person in charge of a clinical area may decide to prevent access to off ward areas by locking the door to a ward which ordinarily has a secure door in operation. This is within their sphere of responsibility in order to ensure the safety and well- being of one or more patients. This policy outlines the considerations and procedures, which are recommended within the Mental Health Act 1983, updated 2007 and the Code of Practice and must be followed when locking a door is necessary

The policy outlines the processes and considerations that the nurse in charge of the shift must complete in order to justify the locking of a door to a ward and how these processes differ for both patients who are informal and those who are detained under the Mental Health Act. It outlines the recording responsibilities of the nurse in charge of the shift as well as the actions that are expected in contacting members of the Multi-Disciplinary Team to ensure a thorough and prompt assessment of the patient(s) for whom the door is locked.

This policy is only applicable for mental health and neurological rehabilitation inpatient wards which operate a secure (but not locked) entrance/exit door as part of their normal business within their clinical environment. Therefore the following wards are relevant to this policy:

- Hawthorns Ward – 20 bed Adult Mental Health Acute Unit
- Brooker Ward – 22 bed Older Persons Mental Health Organic and Functional Unit

Each of these wards has a standard operating procedure (SOP) in relation to their use of a secure door. This SOP is communicated with relevant members of staff by means of internal training and discussion at team meetings. These can be found in Appendix B

Table of Contents

1. INTRODUCTION & PURPOSE

1.1 This policy sets out how, under particular circumstances, a person in charge of a clinical area may decide to prevent access to off ward areas by locking the door to a ward which ordinarily has a secure door in operation. This is within their sphere of responsibility in order to ensure the safety and well- being of one or more patients. This policy outlines the considerations and procedures, which are recommended within the Mental Health Act 1983, updated 2007 and the Code of Practice (2015) and must be followed when locking a door is necessary

1.2 By following this policy, staff will ensure that they are acting responsibly, legally and with the patients' best interests in mind at times when it is necessary to lock the door on the unit

1.3 When making decisions as to the appropriate use of locking an entrance/exit door to the ward, practitioners must give due regard and consideration to the Code of Practice, particularly the five guiding principles:

- **Use of the least restrictive option and maximising of independence**

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient must not be detained. Wherever possible a patient's independence must be encouraged and supported with a focus on promoting recovery.

- **Empowerment and involvement**

Patients must be fully involved in decisions about care, support and treatment. The views of families, carers and others must be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals must explain the legal reasons for this.

- **Respect and dignity**

Patients, their families and carers must be treated with respect and dignity, listened to by professionals and their viewpoints accorded due and consistent consideration.

- **Purpose and effectiveness**

Decisions about care and treatment must be consistent and appropriate to the patient, with clear therapeutic aims, promote recovery and must be performed to current national guidelines and/or current, available best practice guidelines.

- **Efficiency and equity**

Providers, commissioners and other relevant organisations must work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant

services must work together to facilitate planned timely, safe and supportive discharge from detention.

1.4 Whilst these principles relate to patients detained under the Mental Health Act (1983, amended 2007), they can equally be applied for informal patients

1.5 Locking the door on an otherwise secure door unit could contribute to unlawful deprivation of a patient's liberty. Therefore, appropriate action must be taken to ensure that this does not occur. Examples of appropriate action include consideration to detain the patient under the Mental Health Act (1983, amended 2007); ensure restrictions on those patients for whom the locked door does not apply are minimised and/or reduce any restrictions so that otherwise compliant patients, who lack capacity to consent to the admission, are not deprived of their liberty

1.6 This policy should be read in conjunction with Solent NHS Trusts Mental Health Act Policy and the Deprivation of Liberty Safeguards and Mental Capacity Act Policy which provide further guidance around entry and exit issues relating to inpatient units

1.7 The person in charge of the shift should refer to other Solent NHS Trust policies when locking a door on a secure door ward, including Therapeutic Observation and Engagement and Clinical Risk Assessment and Management

2. SCOPE & DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will demonstrate fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 This policy is only applicable for mental health inpatient wards which operate a secure (but not locked) entrance/exit door as part of their normal business within their clinical environment. Therefore the following wards are relevant to this policy:

- Hawthorns Ward – 20 bed Adult Mental Health Acute Unit
- Brooker Ward – 22 bed Older Persons Mental Health Organic and Functional Unit

Each of these wards has a standard operating procedure in relation to their use of a secure door. These can be found in Appendix B

2.4 Inpatient wards which have the entrance/exit doors to the unit permanently locked are not included in the scope of this policy. This applies to the following ward

- Maples Ward – 10 bed Adult Mental Health Psychiatric Intensive Care Unit
- The Kite Unit – 10 bed Neuropsychiatric Rehabilitation unit

Maples Ward and the Kite Unit have a standard operating procedure (SOP) in relation to their use of a locked door. This can be found in Appendix C

2.5 **Formal Patient:** A person who is admitted to a ward under the Mental Health Act, 1983 (amended 2007)

2.6 **Informal Patient:** A person who is admitted to a ward voluntarily

2.7 **Locked Door:** A locked door to an inpatient ward refers to the exit door to the ward being locked for one or more patients on the ward due to concerns regarding their safety and wellbeing or to maintain the safety of others. If the patient(s) requests the door to be opened, then this will be refused by the nurse in charge of the ward

2.8 **Secure Door:** A secure door is a door that acts as the entrance/exit to an inpatient ward which is secured closed but which can be opened upon request by patients and visitors to the unit. Its purpose is to prevent unauthorised access to and egress from the ward

3. PROCESS/REQUIREMENTS

3.1 A locked door should only apply to the patient(s) for which it has been locked. All other patients should be granted leave from the ward, subject to personalised risk assessment. To facilitate this, the poster in Appendix E must be clearly displayed on the locked door

3.2 The door must never be locked for the purpose of helping the ward staff manage staff shortages or increased clinical demands

3.3 The locked door must be reviewed on a regular basis (as outlined in the Locked Door Record in Appendix D) and efforts should be made to open the door at the earliest opportunity. If the door remains locked for longer than 7 days for one or more patients, an urgent review of the patients treatment plan should occur. The Matron for the unit (or their deputy) and the patients' medical team must be part of this review and it should occur during the next available working day

3.4 If a patient on a secure door ward has the door locked to maintain their safety and wellbeing, the multidisciplinary team must review the patients care as a matter of urgency to determine if it is appropriate for the patient to remain on the secure door unit and if not, plans are made to transfer them to a more secure setting

3.5 If the door is locked either as a result of (or in the process of) detaining a patient under Section 5(4) of the MHA (1983) and the following assessment re-grades the patient to informal status, then the door must be unlocked

<u>Process and actions to take when locking the door</u>

3.6 FORMALLY DETAINED PATIENTS – ACTION TO BE TAKEN

- Following a thorough assessment of risk and needs, the person in charge of an area may contain a formal (detained) patient by locking the exit door to the ward. He/she must ensure that:

- The patient who is detained and for whom the door is being locked must be informed why the door is being locked and this conversation documented in the patients record. This action should be proportionate to the risks it is seeking to prevent and consideration should have been given to less restrictive ways to manage the situation
- All staff working on the unit (including professional visitors/domestic staff) must be made aware of the door being locked and who the door is being locked for
- All other patients on the unit (informal or detained patients) will be able to access off-ward areas through staff intervention as if the door were open – pending a risk assessment by staff
- When the door is locked, the Lead Nurse or Modern Matron should be informed at the earliest opportunity and this information recorded in the patients record
- The appropriate documentation is completed. **(See Appendix A – 'Locked Door Record')**

3.7 EMERGENCY DETENTION OF INFORMAL PATIENTS – ACTION TO BE TAKEN

- Following a thorough assessment of an informal patient's risks and needs, the person in charge of the shift may contain the patient by locking the exit door to a ward. The nurse in charge must ensure that:

  - The patients legal status must be reviewed **IMMEDIATELY** by the nursing and medical team
  - In the absence of a doctor, implementation of the nurses holding power – ***Section 5(4) Mental Health Act 1983 (amended 2007)*** – must be considered and used if the decision is made to prevent an informal patient from leaving the ward
  - The patient being detained is informed of the detention and the reason why
  - The patient being detained must be informed of their legal rights as required by s132 MHA 1983 (amended 2007)
  - All staff working on the unit (including professional visitors/domestic staff) must be made aware of the door being locked and who the door is being locked for
  - All other patients on the unit (informal or detained patients) will be able to access off ward areas as if the door were open – pending a risk assessment by staff
  - When the door is locked, the Lead Nurse or Modern Matron should be informed at the earliest opportunity
  - The appropriate documentation is completed. **(See Appendix D – 'Locked Door Record')**

3.8 PAPER AND ELECTRONIC RECORDING STANDARDS

3.8.1 If a door is locked to maintain the safety and wellbeing of a patient, the Locked Door Record sheet in Appendix D must be completed by the nurse in charge of the shift

3.8.2 An entry in the patient's record must be made to explain the reasons why the door has been locked for that person

3.8.3 As a minimum, every 24 hours the inpatient clinical team (nurse in charge of shifts alongside senior nurses and the medical staff) should review the necessity for the door to remain locked; dependent upon the needs and risks of the person for whom the door is locked. Within this review, consideration to transfer the patient to a more secure ward environment should be made and any restrictions should only continue whilst they remain proportionate to the risk they are seeking to prevent and consideration should be given to less restrictive ways of

managing the risk. This review must be clearly documented in the patients record which will include the name of the staff involved in the review and the decisions made

3.8.4 The Locked Door Record sheet should be stored/archived on the ward once completed

4. ROLES & RESPONSIBILITIES

4.1 Staff

4.1.1 The **Chief Executive** has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to

4.1.2 The **Operational Director for Mental Health Services** has the responsibility of ensuring that this policy is cascaded down to their Service Managers as appropriate for dissemination and implementation within their inpatient environments

4.1.3 **Operational Managers** are responsible for the dissemination and implementation and monitoring of this policy in the areas that they are accountable for.

4.1.4 **Modern Matrons/Lead Nurses** are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff receive appropriate training as part of their induction, support and guidance on this policy and will monitor for breaches and take action as appropriate to rectify this

4.1.5 **Inpatient staff** are responsible for being aware of and following the guidance within this policy at all times. They should also raise potential clinical problems that may arise from this policy with their line manager to enable a review of its contents and suitability. They are also responsible for ensuring new starters to the team and Bank and Agency staff are aware of this policy.

5. TRAINING

5.1 Staff working in inpatient wards where the nurse in charge of the ward may have cause to lock the entrance/exit door to the unit must have a sound knowledge base regarding the locked door. There is no formal training required to develop this knowledge base but instead it should be gained through induction to the role and ward and through ongoing supervision. The knowledge base should include:

- The clinical scenarios that may require a locked door to be used
- The need to clearly communicate the initiation of the locked door to patients and visitors on the ward
- The clinical management of the patient(s) for whom the locked door is required – including their legal status and what to do if the patient should attempt to leave the ward
- The recording processes required when the door is locked
- How to ensure that other patients for whom the locked door does not apply are still afforded leave from the unit as per their individual care plan
- Actions to take when the locked door ends to enable the ward to return to usual operating process
- How to raise concerns if any arise in relation to the use or impact of the locked door
- Consideration to be given to Safeguarding concerns

5.2 As well as the knowledge base above, Registered Mental Health Nurses who also undertake the role of nurse in charge of the unit, must also have a competency and knowledge based assessment in relation to the locked door as part of their induction to the role/ward. This will include:

- The legal implications of locking a door to prevent one or more patients leaving the unit
- For informal patients which require the door to be locked the interface and action this generates with regard to consideration of using either the Mental Health Act (1983, amended 2007) or Deprivation of Liberty Safeguards and can apply knowledge as to which process should be followed
- Can articulate and understand the role of the nurse in charge when locking a door with regard to:
    - Communication
    - Record Keeping
    - Interface with medical staff

Evidence of successful completion of the competency assessment will be filed with the Nurse's Induction Pack.

5.3 All staff (Solent NHS Trust, Bank and Agency staff) therefore must complete local induction which should include the use of this policy for clinical areas where it may be used

5.4 All staff should read and be familiar with the contents of other Trust policies which have a direct association with this policy. This includes the Deprivation of Liberty Safeguards and Mental Capacity Act Policy, Psychiatric Observations and Engagement Policy, the Mental Health Act Policy and the Policy for Security and Management of Violence and Aggression

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The Impact Assessment can be seen in Appendix A

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The success criteria for this policy would be that secure entrance/exit doors on inpatient wards are only locked when there is clear clinical justification to do so based upon the immediate need to contain one or more patients from leaving the ward due to concerns regarding their safety or wellbeing

7.2 In order to monitor the effectiveness of this policy to ascertain if it successfully achieves its aims, each occasion whereby a ward has implemented a locked door policy will be reviewed at the service level, monthly Mental Health Act Monitoring meeting. This meeting is chaired by the Head of Access & Unplanned Care or Mental Health Act/Mental Capacity Act Lead and the Lead Nurse or Modern Matron for the ward in question is required to present the incidence(s) of a locked door being used at the meeting. This review will consist of:

- The clinical reasoning as to why the locked door was implemented is recorded on both the monitoring form as well as in the patients record
- The length of time the locked door was in place and evidence that it was rescinded at the earliest possible occasion
- Evidence that the patient(s) was informed why the door had been locked

- Evidence of notable or poor practice to enable learning to be achieved and shared across the service – including review of any incident reports raised as a result of a locked door being implemented
- Direct patient or carer feedback as a result of a locked door being implemented

7.3 On any occasion whereby the requirements of this policy are not followed, this must be immediately reported to the staff members manager (out of hours on call manager if appropriate) and a risk event form must be completed

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 References

- Department of Health (2007) *Mental Health Act, 1983, amended 2007.* HMSO. London.
- Department of Health (2015) *New Mental Health Act Code of Practice.* HMSO. London

9.2 Links to other Solent Policies

- Clinical Risk Assessment and Management Policy
- Deprivation of Liberty Safeguards and Mental Capacity Act Policy
- Mental Health Act Policy
- Policy for Security and Management of Violence and Aggression
- Therapeutic Observations and Engagement Policy

Appendix: A **Equality Impact Assessment**

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Mental Health Services	
Title of Change:	Mental Health and Neurological Rehabilitation Unit Locked Door Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Review of Solent Policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	

Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	No	There were no stakeholder consultations for this update. Staff consultations have taken place for previous versions of this policy. Locking a ward door is determined by the needs and risks of the individual, to show parity between different groups and fairness to all inpatients. Inpatients can share views on their experience and to help manage behaviours in the future.
Have you taken into consideration any regulations, professional standards?	Yes	Mental Health Act (1983, amended 2007) Code of Practice

Step 3: Review, Risk and Action Plans			
How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	A clear operational policy and applying the guidance and practice within it to all inpatients at all times, ensures that no group could be unlawfully treated more favourably or unfavourably than another. To ensure training standards are maintained, reviews of all physical interventions are undertaken, and national standards are maintained. It promotes recovery, the use of least restrictive practice and enhances the patient experience. Annual audit to be completed, providing thematic data to identify protected characteristics that may be disproportionately affected, and take appropriate action as needed.		
Who will be responsible for monitoring and regular review of the document / policy?	Head of Quality & Professions, Mental Health Service		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	Ben Martin-Lihou	*Date:*	12/03/2021

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix: B

Standard Operating Procedure
Hawthorns Ward Entrance Door – Secured Door Process

1. Location of Operation

Hawthorns Ward is a 20 bed Acute Mental Health Ward at Orchards Unit, St James Hospital, Portsmouth. This Standard Operating Procedure applies only to Hawthorns Ward. This document, replaces all other versions and will be reviewed every three years unless clinical concerns dictate an earlier review

2. Procedure

The entrance door to Hawthorns Ward will be secured by the electromagnetic lock as the usual and default mode of ward operation. This will prevent unauthorised access to and egress from the ward by this route. Patients and visitors who are authorised to enter or leave the ward will be enabled to do so by a ward staff member opening the door with the electromagnetic release fob. The door will be secured in this way at all times unless the entrance door is **locked** in accordance with "Locked Door Policy", or because of times of operation

3. Rationale

This Standard Operating procedure has been introduced to support local implementation of the principles within the Solent NHS Trust Locked Door Policy and the guidance within the Mental Health Code of Practice. The Secured Door process enables the balance to be maintained between staff oversight and awareness of people entering and exiting the ward and ensuring that patient movement and freedom is not adversely affected.

4. Interaction with Locked Door Policy

When the "Locked Door Policy" is in operation this Standard Operating Procedure is suspended.

5. Decision Rights and Process

The Multidisciplinary Team (MDT) will review the decision to maintain the secured entrance doors each day at the MDT meeting. The door may be unsecured if the most senior nurse present on the unit and the two most senior Psychiatrists present at the MDT on that day agree that:

- There are no patients present on the ward who would present a cause for concern if their absence from the ward was not accounted for.

This decision can only be made at the MDT meeting and only following discussion of all patients. The Nurse in Charge of the ward can decide to reinstate a secured door at any time in response to changing clinical needs.

6. Procedure subsequent to un-securing the Entrance Doors

If the MDT decides to leave the entrance door unsecured on any day; then a member of staff will be allocated to check and record all access and egress of patients from the ward. The doors may not be secured however only for the reason that insufficient staff are available to undertake this task.

7. Standard Operating Procedure Review

This Standard Operating Procedure will be reviewed formally by the Head of Quality & Professions and the Modern Matron for the unit

Date of next Review: No later than June 2024

Standard Operating Procedure
Brooker Ward Entrance Door – Secured Door Process

1. Location of Operation

Brooker Ward is a 22 bed Older Persons Mental Health Ward at Limes Unit, St James Hospital, Portsmouth. The ward provides care and treatment for older people who have both organic and functional types of mental illness. This Standard Operating Procedure applies only to Brooker Ward, replaces all other versions and will be reviewed twice yearly unless clinical concerns dictate an earlier review

2. Procedure

The entrance door to Brooker Ward will be secured by the electromagnetic lock as the usual and default mode of ward operation. This will prevent unauthorised access to and egress from the ward by this route. Patients and visitors who are authorised to enter or leave the ward will be enabled to do so by a ward staff member opening the door with the electromagnetic release fob. The door will be secured in this way at all times unless the entrance door is **locked** in accordance with "Locked Door Policy", or because of times of operation

3. Rationale

This Standard Operating procedure has been introduced to support local implementation of the principles within the Solent NHS Trust Locked Door Policy and the guidance within the Mental Health Code of Practice. The Secured Door process enables the balance to be maintained between staff oversight and awareness of people entering and exiting the ward and ensuring that patient movement and freedom is not adversely affected.

4. Interaction with Locked Door Policy

When the "Locked Door Policy" is in operation this Standard Operating Procedure is suspended.

5. Decision Rights and Process

The Multidisciplinary Team (MDT) will review the decision to maintain the secured entrance doors each day. The door may be unsecured if the most senior nurse present on the unit and the most senior Psychiatrist agree that:

- There are no patients present on the ward who would present a cause for concern if their absence from the ward was not accounted for.

This decision can only be made by the MDT who will discuss the need (or not) for the continued use of the secured door at the daily handover meeting. The decision must account for the possible impact it may have for all patients on the ward. The Nurse in Charge of the ward can decide to reinstate a secured door at any time in response to changing clinical needs.

6. Procedure subsequent to un-securing the Entrance Doors

If the MDT decides to leave the entrance door unsecured on any day; then a member of staff will be allocated to check and record all access and egress of patients from the ward. The doors may not be secured however only for the reason that insufficient staff are available to undertake this task.

7. Standard Operating Procedure Review

This Standard Operating Procedure will be reviewed formally by the Head of Quality & Professions and the Modern Matron for the unit

Date of next Review: No later than June 2024

Appendix: C

The Kite Unit

Entrance Door "Locked Door Process"

March 2021

1. INTRODUCTION

The Kite Unit is a 10 bedded Neuro-Psychiatric Rehabilitation Service for people who have an Acquired Brain Injury (ABI) who as a result of their ABI, experience a cognitive impairment, mental health and behavioural issues, which due to their intensity and frequency, require admission for assessment and treatment to an inpatient service.

The Kite Unit is based at Western Community Hospital Southampton

This document is effective from March 2021

2. PURPOSE

This Standard Operating Procedure sets out the management of access to and from the unit.

Kite will have a mixture of patients with differing needs at any one time.

- Patients who have capacity to consent to admission to hospital; and consent to remain on the ward
- Patients who lack capacity to consent, who are deprived of their liberty and are detained under The Deprivation of Liberty Safeguards (DOLS)
- Patients detained under the Mental Health Act 1983

However the common factor uniting all patients at the unit, is that they have an Acquired Brian Injury, who due to their brain injury, often experience impairments including; confusion, disorientation, memory loss, poor processing, disinhibition, impulsivity, loss of insight, an over estimation of abilities, receptive and expressive communication disabilities, con current medical comorbidities, sensory and physical disabilities and/or may also have a serious mental illness.

Due to these impairments, the patients have limited risk awareness or a reduced ability to develop risk management strategies, often presenting with a high risk of falls, an increased risk of getting lost or increased risks associated with accidental or deliberate self-harm and/or aggression or violence towards others. In addition to the risk to themselves, due to their vulnerability or disinhibited behaviours, the patients may also be at a higher risk of exploitation or assault by members of the public.

Given the unpredictable behaviour exhibited by the patients admitted to the Kite Unit, the likelihood and severity of these risks occurring without appropriate risk management strategies in place are very probable.

Therefore this Standard Operating procedure has been introduced to protect the safety of the patients by restricting their access off the unit and to ensure both staff and patient safety by restricting "others" access, i.e. members of the public. It aims to minimise the effects of the locked door on all patients and act as a guide to staff.

The Code of Practice for the Mental Health Act acknowledges that the use of electronic swipe cards or other such measures can be an effective way to ensure patient safety and security (Code of Practice ch 16.38). However, it advises that if these methods are used they should not be done due to staff shortages and advises the following regular checks and balances;

The restrictions should be reviewed to ensure they continue to bring benefits to patients (Code of Practice, ch 16.40)

There should be a protocol in place that is easily available and explained to patients and their carers (Code of Practice ch16.39)

And the restrictions should not take away from the importance of engagement with patients, and the structure and quality of the environment (Code of Practice ch16.37).

3. SCOPE

The content of this SOP applies to all staff, patients, contractors and visitors within the Kite Unit.

4. PROCESS

How access to and from unit is managed.

The entrance door to the Kite Unit is a **locked** door. The internal entrance door has a two door entry system with an airlock dividing them. Both doors are secured by an electronic swipe lock, the usual default mode of operation is that the door is locked. Patients and visitors who are authorised to enter or leave the ward will be enabled to do so by a ward staff member opening the door.

The patient external entrance door into the court yard, is secured by a key and lock, Patients who are authorised to enter or leave via this route, will be enabled to do so by a staff member opening the door with a master key.

Both entry /exit doors will be secured in this way at all times.

Solent NHS Trust and the staff on the Kite Unit acknowledge and understand that the locked door amounts to a blanket ban as it applies to all patients, all of the time and does not take into account individual clinical differences. However, due to the risk profile of patients on the Kite Unit, there are clear cogent reasons why this is the case.

5. PATIENT AND RELATIVE INFORMATION

An explanation will be given to all patients, this information will be provided in the appropriate accessible format.

A poster will be displayed in the reception area with an explanation of the restrictions.

An information leaflet is given to relatives, carers and visitors as part of the pre-admission process.

6. DECISIONS AND RIGHTS

A risk assessment is completed on each patient prior to and on admission and this is reviewed at the Multi-Disciplinary Team (MDT) meeting

At present all patients have a leave risk assessment and care plan in place, this sets out how they access leave off the unit and the outside space.

All informal patients, if appropriate and visitors are informed of their right to come and go as they please, and the high staffing levels on the unit ensure staff are available to respond promptly to such requests

The patient will be kept informed, as much as their level of understanding allows, of the restrictions, with regard to leaving the ward, that are in place.

The patient and their relatives will also be kept informed of the safeguards that apply to the regime and will be referred to advocacy where appropriate. With regard to sharing information with carers, the normal issues of confidentiality apply

The door to the enclosed garden is left open during daylight hours and patients are free to come and go unless individual patient risk assessment indicates this is not safe to do so. In this case individual patients may access the garden with staff support and supervision.

7. INTERACTION WITH LOCKED DOOR POLICY

One risk management strategy supporting patient safety is the existing Solent locked door policy, however due to the needs of the patients as listed above, the entrance door has never been left unlocked. Having the entrance door locked, although is for safety, as a risk management strategy, is in practice, a blanket locked door policy.

However, that said we do as good practice, follow the locked door policy.

8. RECORDING

Each patient will have a leave risk assessment and care plan

The locked door protocol information sheet and record of locked door form will be completed in accordance with time frames as set out in the locked door policy.

9. ROLES AND RESPONSIBILITY

All staff should be familiar with this protocol and follow it in the management of any restrictions to a patient's movement.

Nurses in charge are responsible for ensuring that no patient is deprived of their liberty without it being appropriately authorised.

Consultants are responsible for monitoring the legal status of their patients and ensuring it is appropriate.

The ward manager and Matron are responsible for reviewing the appropriateness of the ward being a locked ward.

All comments, complaints and compliments will be dealt with by the PALS and complaints service. Any comment, complaint or compliment should first be made directly to the Ward Manager. If a

resolution cannot be sought then it should be escalated to PALS and complaints department. A leaflet outlining the procedures is available on the ward

10. TRAINING

All staff will be familiar with the protocol as part of the in-house induction
All staff will attend Mental Capacity Act (including DOLs) and Mental Health Act training as part of the required core competencies.

11. EQUALITY AND DIVERSITY

The practice of locking a door whilst aimed at maintaining safety of patients, and permissible by law to achieve this, must also take into consideration the human rights of the individual patient.

In accordance with the European Convention on Human Rights every individual has the right to respect for his/her private life (ECHR Article 8) and the right to liberty and security of person (ECHR Article 5). This issue must be considered when reviewing the appropriateness of the locked door.

12. SUCCESS CRITERIA AND MONITORING EFFECTIVENESS

When this protocol is reviewed consideration will be given to feedback from the patient forum, other service user feedback any serious untoward incidents and any complaints.

13. REVIEW

This Standard Operating Procedure has been reviewed formally within the following forums:

The Neuro governance and assurance operational meeting
The Kite governance and operational meeting

And will be regularly reviewed as an agenda item at the Kite Unit monthly team meetings

This SOP will be reviewed annually, or earlier required.

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after twelve months.

REFERENCES AND LINKS TO OTHER DOCUMENTS

European Convention of Human Rights (ECHR) Council of Europe

Department of Health. 1983. "Mental Health Act (1983)". HMSO. London.

Department of health 2005. "Mental Capacity Act 2005" HMSO London

Department of Health. 2008. "Mental Health Act Code of Practice". HMSO. London.

Department of Health 2008. "The Deprivation of Liberty Safeguards Code of Practice" TSO. London

Solent NHS
NHS Trust

Maple Ward

Entrance Door "Locked Door Process"

March 2021

1. INTRODUCTION

Maple Ward is a 10 bedded Psychiatric Intensive Care Unit for people who have an acute mental health need which due to their intensity and frequency, require admission for assessment and treatment in a restrictive environment.

Maple Ward is based in The Orchards, St James Hospital, Portsmouth

This document is effective from March 2021

2. PURPOSE

This Standard Operating Procedure sets out the management of access to and from the unit.

Maple Ward will have a mixture of patients with differing acute mental health and associated needs at any one time, however all patients will be detained under the mental health act 1983.

Due to their mental health presentation, the patients have limited risk awareness or a reduced ability to develop risk management strategies, presenting with very high risk associated with accidental or deliberate self-harm and/or aggression or violence towards others. In addition to the risk to themselves, due to their vulnerability or disinhibited behaviours, the patients may also be at a higher risk of exploitation or assault by members of the public.

Given the unpredictable behaviour exhibited by the patients admitted to Maple Ward, the likelihood and severity of these risks occurring without appropriate risk management strategies in place are very probable.

Therefore this Standard Operating Procedure has been introduced to protect the safety of the patients by restricting their access off the unit and to ensure both staff and patient safety by restricting "others" access, i.e. members of the public. It aims to minimise the effects of the locked door on all patients and act as a guide to staff.

The Code of Practice for the Mental Health Act acknowledges that the use of electronic swipe cards or other such measures can be an effective way to ensure patient safety and security (Code of Practice ch 16.38). However, it advises that if these methods are used they should not be done due to staff shortages and advises the following regular checks and balances;

The restrictions should be reviewed to ensure they continue to bring benefits to patients (Code of Practice, ch 16.40)

There should be a protocol in place that is easily available and explained to patients and their carers (Code of Practice ch16.39)

And the restrictions should not take away from the importance of engagement with patients, and the structure and quality of the environment (Code of Practice ch16.37).

3. SCOPE

The content of this SOP applies to all staff, patients, contractors and visitors within Maple Ward.

4. PROCESS

How access to and from unit is managed.

The entrance door to Maple Ward is a **locked** door. The internal entrance door has a two door entry system with an airlock dividing them. Both doors are secured by an electromagnetic lock, the usual default mode of operation is that the door is locked. Patients and visitors who are authorised to enter or leave the ward will be enabled to do so by a ward staff member opening the door.

All entry /exit doors will be secured at all times.

Solent NHS Trust and the staff on Maple Ward acknowledge and understand that the locked door amounts to a blanket ban as it applies to all patients, all of the time and does not take into account individual clinical differences. However, due to the risk profile of patients on the Maple Ward, there are clear cogent reasons why this is the case.

5. PATIENT AND RELATIVE INFORMATION

An explanation will be given to all patients, this information will be provided in the appropriate accessible format.

A poster will be displayed in the reception area with an explanation of the restrictions.

An information leaflet is given to relatives, carers and visitors as part of the pre-admission process.

6. DECISIONS AND RIGHTS

A risk assessment is completed on each patient prior to and on admission and this is reviewed at the Multi-Disciplinary Team (MDT) meeting

At present all patients have a leave risk assessment and care plan in place, this sets out how they access leave off the unit and the outside space.

The patient will be kept informed, as much as their level of understanding allows, of the restrictions, with regard to leaving the ward, that are in place.

The patient and their relatives will also be kept informed of the safeguards that apply to the regime and will be referred to advocacy where appropriate. With regard to sharing information with carers, the normal issues of confidentiality apply

7. INTERACTION WITH LOCKED DOOR POLICY

One risk management strategy supporting patient safety is the existing Solent locked door policy, however due to the needs of the patients as listed above, the entrance door will never be unlocked. Having the entrance door locked, although is for safety, as a risk management strategy, is in practice, a blanket locked door policy.

8. RECORDING

Patients may have leave authorised, as per Section 17 Mental Health Act (1983, amended 2007) and this is recorded in accordance with the Section 17 Leave Policy.

9. ROLES AND RESPONSIBILITY

All staff should be familiar with this protocol and follow it in the management of any restrictions to a patient's movement.

Nurses in charge are responsible for ensuring that no patient is deprived of their liberty without it being appropriately authorised.

Consultants are responsible for monitoring the legal status of their patients and ensuring it is appropriate.

The Lead Nurse and Matron are responsible for reviewing the appropriateness of the ward being a locked ward.

All comments, complaints and compliments will be dealt with by the PALS and complaints service. Any comment, complaint or compliment should first be made directly to the Lead Nurse. If a resolution cannot be sought then it should be escalated to PALS and complaints department. A leaflet outlining the procedures is available on the ward

10. TRAINING

All staff will be familiar with the protocol as part of the in-house induction
All staff will attend Mental Capacity Act (including DOLs) and Mental Health Act training as part of the required core competencies.

11. EQUALITY AND DIVERSITY

The practice of locking a door whilst aimed at maintaining safety of patients, and permissible by law to achieve this, must also take into consideration the human rights of the individual patient.

In accordance with the European Convention on Human Rights every individual has the right to respect for his/her private life (ECHR Article 8) and the right to liberty and security of person (ECHR Article 5). This issue must be considered when reviewing the appropriateness of the locked door.

12. SUCCESS CRITERIA AND MONITORING EFFECTIVENESS

When this protocol is reviewed consideration will be given to feedback from the patient forum, other service user feedback any serious untoward incidents and any complaints.

13. REVIEW

This Standard Operating Procedure has been reviewed formally within the following forums:

Clinical Governance Meeting, Mental Health Service

This SOP will be reviewed at least every three years, or earlier if required.

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after three years.

REFERENCES AND LINKS TO OTHER DOCUMENTS

European Convention of Human Rights (ECHR) Council of Europe

Department of Health. 1983. "Mental Health Act (1983)". HMSO. London.

Department of health 2005. "Mental Capacity Act 2005" HMSO London

Department of Health. 2008. "Mental Health Act Code of Practice". HMSO. London.

Department of Health 2008. "The Deprivation of Liberty Safeguards Code of Practice" TSO. London

Appendix D: Locked Door Record

LOCKED DOOR RECORD WARD:				
(1) NAME **(Of patient(s) being detained. Please indicate if formally detained under the Mental Health Act 1983)**	**(2) PREVENTING ACCESS TO** **(To whom or what the named people are being prevented access)**	**(3) REASON (For the restriction)**	**(4) DURATION** **(Intended duration of restriction in hours/minutes. Maximum 24 hrs or 7 days following 7 consecutive periods of 24 hrs**	**(5) REVIEW** **(Date/Time)**
Signature of Nurse In Charge:		**Please Print Name:**	**Date:**	**Time:**
COPIES OF THIS FORM SHOULD BE FORWARDED TO THE MENTAL HEALTH ACT CO-ORDINATOR, STORED IN A FILING CABINET WITHIN THE WARD AND ALSO DISPLAYED IN A PROMINENT PLACE IN THE WARD OFFICE AND ALL STAFF MADE AWARE				

Appendix E: Locked Door Poster

Solent NHS Trust

THIS DOOR IS CURRENTLY LOCKED

Due to safety concerns for one or more of our patients, we have had to lock this door. This restriction will not apply to most of our patients and these people will be able to leave the ward as usual. We hope that this is a temporary measure and will aim to have the door open again in the near future.

If you wish to leave the ward, please speak to a member of staff who will be able to assist you

We apologise for any inconvenience caused