ENTRY AND EXIT FOR NON-SECURE MENTAL HEALTH AND LEARNING DISABILITY INPATIENT UNITS POLICY (M-022)

Version Number:	5.1
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Executive Lead (name & job title):	Dr Kwame Fofie, Medical Director
Name of approving body:	Mental Health Legislation Committee
Date full policy approved:	7 May 2020 (v5.0)
Date Ratified at Trust Board:	May 2020
Next Full Review date:	March 2026

Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*MHLSG - 15 March 2023*
Date EMT as approving body notified for information:	*March 2023*

Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

Patients who go missing from mental health wards present a continuing challenge to mental health services. They may place themselves and others at risk, their friends and family may experience stress and anxiety due to their loved ones being missing, and significant amounts of health service time and resources are spent in seeking to ensure their safety.

The National Mental Health Development Unit in its publication "Strategies to reduce missing patients" offers the following five practical strategies which can help to reduce the numbers of patients who go missing:

- Understanding the problem
- Developing entry/exit policies
- Providing meaningful engagement
- Structuring the day
- Engaging key stakeholders

This policy sets out the Trust's entry/exit approach for non-secure mental health and learning disability inpatient units for people who are both informal and formally detained under the Mental Health Act (1983) and may be vulnerable and at risk of harm.

2. SCOPE

This policy applies to all inpatient areas across the Trust and all staff working within those areas.

The Trust recognises that it is important to differentiate between those units designated as secure and those that have controlled egress. This policy covers all non-secure inpatient units. The general principles are relevant to all in patient areas however those units designated as low or medium secure have separate security polices reflecting their level of security.

3. POLICY STATEMENT

The Trust believes the safety of patients, staff and visitors is our utmost priority, and recognises its responsibilities and duty of care to ensure provision of safe and secure environments.

The Trust recognises that those patients admitted to Mental Health wards have complex, specific and individual needs. The locking of ward doors is intended to protect patients. This extends to protecting our patients and staff from others gaining access to the wards. Chapter 8 of the Code of Practice (2015) supports this.

The Trust also acknowledges that a balance must be achieved between open and easy access to inpatient units by visitors and the need to prevent unannounced visitors or unauthorised access of people who may want to enter a unit with criminal or other intent.

The primary means of ensuring patients do not leave inpatient units without the awareness of staff is through good communication, comprehensive risk assessment and the use of the Supportive Engagement Policy. Physical and procedural security is an additional control not an alternative.

The Trust acknowledges that a balance must be achieved between the right of informal patients to leave an inpatient unit on request and the responsibilities of the Trust towards patients who may be a risk to themselves or others if they leave through uncontrolled exits. The Trust also wishes to avoid the distress that a patient leaving a unit unexpectedly may cause to family/friends or carers.

In Rabone v Pennine Care NHS Trust (2012) UKSC 2 the Supreme Court ruled that a psychiatric in-patient who was known to be at real and immediate risk of suicide was owed a positive operational duty under article 2 of the ECHR by the NHS trust to take preventative measures to safeguard her life even though she was a voluntary patient who was not detained under the Mental Health Act 1983.

The Trust views any instances of a patient leaving either without authorisation or without staff knowing as an Adverse Incident, it also views failure to allow authorised patients or visitors to leave the unit when they request as an Adverse Incident. In all instances a Datix must be completed to reflect these incidents.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive will ensure that systems are in place and regularly monitored to ensure that all inpatient units offer the required level of security to prevent people entering them without permission, and that patients who are not detained are able to leave units unhindered when they request to do so.

Medical Director, Director of Nursing, Allied Health and Social Care Professionals, and Chief Operating Officer
The medical director, director of nursing, allied health and social care professionals, and the chief operating officer will ensure that the policy is followed by staff in all Divisions.

General Managers and Divisional Clinical Leads
Business units will ensure that all staff are aware of this policy and operate within it by ensuring that all units have a single point of entry and exit and that all fire exits etc. are appropriately alarmed. They will also ensure all patients have access to a safe outside area.

Matrons
The responsible matron for each unit will monitor this policy at regular intervals, in the context of regular visits as specified in Monitoring (Section 10).

Charge Nurses
Will ensure:

- Informal patients are aware of their right to leave on request.
- The request of a patient to leave the unit is dealt with as soon as possible and a risk assessment completed prior to each episode of leave.
- The information about leaving the unit is available on the unit and clearly displayed at point of exit.
- All instances where an authorised patient is not allowed to leave the unit promptly is reported as an Adverse incident.
- Patients who have barriers to communication due to a disability or not speaking English as a first language can be made aware of the provisions of this policy in other ways.
- Deprivation of liberty is checked when patients lack capacity and restrictions are placed on them. This must be recorded in the clinical notes.
- Plans of care detail specific requirements for individual patients to support access and exit from inpatient areas

Unit staff
Unit Staff will respond to all requests to leave the unit by patients and visitors promptly.

PALS/Complaints
To record and report on any instances where requests to leave the unit by patients or visitors has not been responded to promptly.

Local Security Management Specialist (LSMS)
They LSMS will offer support and advice regarding controlling entry to inpatient units. The Physical Security of Premises and Other Assets Policy P051 promotes security measures; firstly with general education, training and good management; secondly, to purchase equipment, such as alarms, safes, security doors etc.; thirdly, where appropriate by the employment of security staff and companies.

Estates
The Estates Department has a duty under the Health and Safety Act 1974 to provide a safe and secure environment for patients and to provide safe access and egress to and from units.

The Estates Department also has a duty to ensure that fire exits open in the event of a fire. Ensure that all outside patient areas are surrounded by a fence over 1.5 meters (5 feet) high with any posts or rails to the outside as opposed to the inside.

5. PROCEDURES

5.1. Keeping Patients and Carers Informed

Detained patients – if a patient is detained under the MHA they must have authorisation from their Responsible Clinician (RC) if they are to leave the hospital in which they are detained.

If the patient's presentation or risks have changed since leave was authorised, a patient's leave can be withheld or suspended. This decision can be made by the nursing staff. The reasons for withholding/suspending leave must be explained to the patient and, where appropriate, their carer and will be documented in the patient's record.

Informal patients – all informal patients will be assumed to have capacity to consent to admission. If capacity is doubted then consideration of the appropriateness of using the Mental Health Act or the Mental Capacity Act must be given.

Each informal patient will be given details about how time away from the hospital is negotiated and how decision making is informed by thorough risk assessment. An informal patient has the right to leave hospital at any time, does not require permission to do so, but may be asked to inform staff if they wish to do so.

If the patient's presentation or risks change and the patient wishes to leave the ward, consideration should be given as to whether holding powers under s5(2) or S5(4) of the MHA should be used to lawfully prevent the patient leaving the ward.

In the case of informal patients all staff working with the patient should ensure they are supportive of the patient's right to leave the ward, explaining their legal rights where necessary and ensuring any difficulties experienced by the patient are raised as a concern. The information provided and discussions with the patient should include details of how they can discharge themselves from the hospital and their compliance with the agreed care plan and how to request a review of this. Informal patients must not feel they are unable to agree with conditions set out in the care plan and these should not extend into unnecessary or disproportionate restrictions.

All patients will be made aware individually and through appropriate signage that:

- Unless they have been told otherwise (detained under the Mental Health Act/Capacity Act), they have the right to come and go from the unit freely.

- A patient information leaflet – *your rights as an informal patient* - must be given to each informal patient at the point of admission.
- If they wish to go out, they should ask a member of staff to open the door and that it will be done promptly unless there is a known and valid reason not to do so.

The Trust's Assessment of leave – section 131 and 17 Standard Operating Procedure applies and should be followed.

The above is supportive of Chapter 8 in the Code of Practice (2015).

Carers should receive an explanation of this policy as well as information around Deprivation of Liberty Safeguards. Carers and relatives can be informed of these at the ward reception meetings or equivalent meetings.

5.2. Entry

All units must have a single robust controlled point of entry where people who are not staff or patients cannot enter the building without being authorised to do so. A record of all those visiting the ward, to include staff from other areas of the Trust, will be kept in reception or the appropriate designated place for every ward. A separate record will be kept for all contractors entering/exiting the ward as per Estates Contractor Control Policy.

There are circumstances where visitors' access may be restricted, refused entry or asked to leave. The two principal grounds on which the above may occur are: clinical grounds and security grounds. Exclusion from visiting may be necessary following previous and/or current behaviours from a particular visitor. The Mental Health Code of Practice (2015) Chapter 11 lists the following as exclusion criteria:

- Incitement to abscond.
- Smuggling of illicit drugs or alcohol.
- Transfer of potential weapons.
- Unacceptable aggression
- Attempts by the media to gain unauthorised access.

Staff have a responsibility to verify the authenticity of people wishing to gain access to a ward and to restrict such access in order to maintain the safety and privacy of patients and staff.

Any decision to exclude a visitor should be fully documented and explained to the relevant patient. Any visitor being excluded should be given a rationale as to why they have not been granted access to the ward, ensuring patient confidentiality is maintained. This decision should be reviewed on a regular basis as clinically appropriate based on risk. Any exclusion must be reported to the Mental Health Act Clinical Manager, who collates monthly data regarding the exclusion of visitors.

5.3. Exit

All units should have only one door that is regularly used to permit patients to leave the unit. This door will remain permanently controlled by staff. How exit is managed will be agreed at ward level and may differ across services. This will be supported by local procedures. It is the responsibility of the Charge Nurse to ensure these procedures are in place and for the Modern Matron to ensure they are followed and compliance monitored. This procedure will be clearly explained to patients on admission and documented in their clinical notes. In the event of a fire all fire doors should automatically open that are designated to do so. On admission patients will be informed what their role will be in case of a fire and to listen to staff guidance in this situation.

Trust staff must remember their duty of care towards all potentially vulnerable patients who are using services and to reduce the instances of tailgating across inpatient areas. When staff are leaving inpatient facilities they must supportively question any patients wishing to leave and/or

ensure that staff on the ward are made aware of the patients intentions before they leave the building. If the patient says they have agreement to leave then this must be checked with the staff on duty, before allowing the person to leave the building (Blue Light Alert 2013-10). If a patient successfully tailgates a member of Trust staff from the building this must be reported to the nurse in charge immediately and if appropriate Missing Patient Procedure implemented. All instances of tailgating must be reported to the ward, whether successful or not, and a Datix completed to ensure appropriate strategies are put in place to support the patient.

Any patient wishing to leave the ward must be reviewed by a qualified nurse to ensure the appropriate documentation is in place, Section 17 leave for detained patients, and to assess the mental state of the individual.

5.4. Outside Areas

Within mental health and learning disability services all patients should have unrestricted access to safe outside areas without leaving the unit or its grounds.

All patient-accessible outside areas should be surrounded by a sturdy fence over 1.5 meters high (5 feet) and will be considered to be part of the unit. Any gates associated with the fence should be locked and nothing placed close to the fence which can be used to assist people climbing the fence.

It should be noted that even with a high fence these areas cannot be considered secure and the fence only acts as a deterrent. The primary means of ensuring patients do not abscond from outside areas is use of the Supportive Engagement Policy and engagement by staff, not the fence. A care plan that highlights indicators that may lead to absconding and looks at the interventions to reduce these risks, should be formulated by the clinical team were appropriate.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This policy is applicable to all people who are in receipt of mental health and learning disability services from the Trust and seeks to ensure that they receive safe, high quality care. People who have barriers to communication due to a disability or not speaking English as a first language will be made aware of the provisions of this policy in other ways.

7. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy .

8. MONITORING AND AUDIT

The responsible matron for each unit will monitor this policy at regular intervals, in the context of monthly visits as follows:

- Information about leaving the unit is available and visible on units.
- All units are operating a single point of entry and exit and that all fire exits are appropriately alarmed and linked into the fire alarm to fail safe, should they be designated to do so.
- All patients are able to access a safe outside area on request.
- The availability of resources for patients who have barriers to communication due to a disability or not speaking English as a first language.

As the policy states that all delays in allowing patients or visitors to leave units must be reported as Adverse Incidents and missing patients are also reported as Adverse Incidents and a Datix completed in all instances, the exceptions to this policy will be monitored through the Mental Health Legislation Steering Group and the quarterly reporting mechanisms to the Mental Health Legislation Committee.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

References/Evidence

Strategies to Reduce Missing Patients, National Mental Health Development Unit, April 2009.

Berkshire Healthcare NHS Foundation Trust, Door Locking Policy.

Mental Health Act Code Of Practice (2015).

Mental Capacity Act (2005).

Blue Light Alert 2013-10: Tailgating Security Awareness.

Social Care Institute for Excellence (SCIE) (2013). Deprivation of Liberty Safeguards: putting them into practice.

Supreme Court (2014). 'P v Cheshire West and Chester Council and another' and 'P and Q v Surrey County Council'.

Tees, Esk and Wear Valleys NHS Foundation Trust – Controlling Access to and Exit from Inpatient Areas.

10. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Risk Management Strategy

Supportive Engagement Policy

Physical Security of Premises and Other Assets Policy

Inpatient Leave Policy

Health and Safety Policy

Policy for the Development and management of policy and procedural documents

Estates contractor control policy

Assessment of leave – section 131 and 17 Standard Operating Procedure

Missing Patient and Section 18 AWOL SOP

Appendix 1: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Entry and Exit for non-secure mental health and learning disability inpatient units policy
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Act Clinical Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
This policy sets out the Trust's entry/exit approach for non-secure mental health and learning disability inpatient units for people who are both informal and formally detained under the Mental Health Act (1983) and may be vulnerable and at risk of harm. The Trust recognises that it is important to differentiate between those units designated as secure and those that have controlled egress. This policy covers all non-secure inpatient units. The general principles are relevant to all in patient areas however those units designated as low or medium secure have separate security polices reflecting their level of security.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	This Policy is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Medium**	People with speech or language difficulties may not be able to communicate their wish to leave as easily as others. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format
Sex	Men/Male Women/Female	**Low**	This Policy is consistent in its approach regardless of sex.
Marriage/Civil Partnership		**Low**	This Policy is consistent in its approach regardless of marital status.
Pregnancy/ Maternity		**Low**	This Policy is consistent in its approach regardless of maternal status.

Race	Colour Nationality Ethnic/national origins	**Medium**	This SOP is consistent in its approach regardless of race. It is acknowledged however that people who do not speak English may not be able to easily communicate their wish to leave. For any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	This Policy is consistent in its approach regardless of religion or belief.
Sexual Orientation	Lesbian Gay men Bisexual	**Low**	This Policy is consistent in its approach regardless of sexual orientation.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	This Policy is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The impact of people with speech or language difficulties possibly not being able to communicate their wish to leave as easily as others can be lessened by good nursing practice in ensuring they are given the necessary information by a means in which they can understand more easily. In order to reduce the impact of people who do not speak English not being able to easily communicate their wish to leave they should be provided with access to interpreters and leaflets in other languages.
EIA Reviewer: Michelle Nolan

Date completed: 13 March 2023	Signature: M Nolan

Appendix 2: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Entry and exit for non-secure mental health and learning disability inpatient units policy (p002)		
Document Purpose	This policy sets out the Trust's entry/exit policy for non-secure mental health and learning disability inpatient units for people who are both informal and formally detained under the Mental Health Act (1983).		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	01/04/20	Mental Health Legislation Steering Group (sent remotely as MHLSG cancelled due to Covid-19)	
	15.03.23	Mental Health Legislation Steering Group	
Approving Committee:	Mental Health Legislation Committee (MHLC)	Date of Approval:	07/05/20
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.		
Monitoring and Compliance:	The responsible Matron for each unit will monitor this policy at regular intervals, in the context of monthly visits as follows: • Confirming that all informal patients with capacity are aware of their right to leave and this is documented in the patient notes. • Information about leaving the unit is available and visible on units. • All units are operating a single point of entry and exit and that all fire exits are appropriately alarmed and linked into the fire alarm to fail safe, should they be designated to do so. • Patients who lack capacity and remain informal have a clear care plan and have had a best interests meeting that reflects this decision. • Ongoing review of restriction, restraint and care plans to ensure care and treatment does not move towards deprivation of liberty. • All patients are able to access a safe outside area on request. • The availability of resources for patients who have barriers to communication due to a disability or not speaking English as a first language. As the As the policy states that all delays in allowing patients or visitors to leave units must be reported as Adverse Incidents and missing patients are also reported as Adverse Incidents the exceptions to this policy will be monitored through the quarterly reporting mechanisms to the Governance Committee for Adverse Incidents, Complaints and PALS contacts.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
1.0	*Review*	*18/06/06*	*Egress Control from non-secure Inpatient Units policy approved TMT*
2.0	*Review*	*06/07/09*	*Ratified*
2.1	*Minor changes*	*August 2010*	*Changed from HMHT to HFT*
3.0	*Review*	*07/05/14*	*Reviewed following Supreme Court judgement 19th March 2014. Put into Trust format.*
4.0	*Review*	*21/08/17*	*Review of Policy, minor changes.*
5.0	*Review*	*07/05/20*	*Full Review*
5.1	*Review*	*13.03.23*	*Review (minor amendments). Approved at Approved at Mental Health Legislation Steering Group (15 March 2023)*