Policy for Door Locking within In-Patient and Residential Care Settings (MH/LD) / Locked Door Policy - Management if Patients are at Risk of Absconding (ICS)

To be read in conjunction with: Security Management Procedures

Summary:
This policy sets out how locked door procedures are to be managed within in-patient and residential care settings within the MH/LD division and the locked door policy (ICS) in order to comply with Health & Safety / Fire Safety legislation, Mental Health Act, Human Rights Act, DOLS and Mental Capacity Act.

Keywords (minimum of 5): (To assist policy search engine)
Locked Doors, In patient, Absconding, Health & Safety, Legislation, Mental Health Act, DOLS, Human Rights Act, MCA.

Target Audience:
All staff employed by Southern Health NHS Foundation Trust, specifically those employed in MH/LD in-patient units and ICS hospitals.

Next Review Date:
September 2020

Approved and Ratified by:
Estates Departmental Management Team

Date of meeting:
28/03/2013

Date issued:
April 2013

Author:
Nigel Dowland, Local Security Management Specialist.

Sponsor:
Helen McCormack, Medical Director.
Locked Door Policy

Author: Nigel Dowland, Local Security Management Specialist
Version: 1
April 2013

Version Control

Change Record

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Reviewers/contributors

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1. **Introduction**

1.1 Southern Health NHS Foundation Trust recognises its responsibilities and duty of care in ensuring that inpatient areas are safe and secure environments for the delivery of patient care.

1.2 The trust aims to ensure a balance between the human rights and safety of patients. The decision for controlling access in and out of wards should be justifiable and determined as the least restrictive option available.

1.3 There are occasions when open wards need to be locked to protect patients, staff or the visiting public. Where this need arises, wards will only be locked in accordance with the legal framework which permits such action and in accordance with individual patients risk assessments and care plans.

2. **Scope**

2.1 **Inclusions** - Because of the specific needs of the different areas of service provision, this policy will consider the different needs of the distinct types of service / clinical areas and includes:

   (i) Adult Mental Health (AMH)
   (ii) Older Persons Mental Health (OPMH)
   (iii) Learning Disabilities (LD)
   (iv) Leigh House
   (v) Community Hospitals

2.2 This policy applies to and will affect those patients who are unable to consent to being detained and will be required to remain on the ward, either due to their mental state (Service users detained under a section of the Mental Health Act), or because of the risk they may present to themselves or others, or because they lack capacity (Mental Capacity Act 2005) and are considered to be a vulnerable person at risk of absconding.

2.3 This policy applies to the practice of double handled doors and the use of combination locks which are considered to be a means of restricting access. Therefore, for the purpose of this policy, these will be considered as a means of locking the ward doors.

2.4 **Exclusions** - This policy does not apply to clinical areas where Home Office Regulations or security / Health & Safety considerations require that all entrances / exits must be locked at all times, including:

   (i) Areas officially designated as low or medium secure areas (Bluebird House, Ravenswood House, Evenlode etc.)
   (ii) Psychiatric Intensive Care Units / Intensive Care Areas
   (iii) Places of safety (Section 135/136 MHA suites)
2.5 In addition, the policy does not apply to the perinatal ward at Melbury Lodge or services provided by TQTtwentyone as TQTtwentyone provision is not healthcare. Non-clinical services should refer to the MCA and DOLS as should OPMH/ICS for non-detained patients.

3. Definitions/ Abbreviations

3.1 The following abbreviations, definitions and terms are used throughout this policy.

SHFT Southern Health Foundation Trust
MHA 1983 Mental Health Act 1983 (as amended in 2007)
MCA Mental Capacity Act 2005
AMH Adult Mental Health
OPMH Older Persons Mental Health
LD Learning Disabilities
NIC Nurse in Charge
MDT Multi-Disciplinary Team
DOLS Deprivation of Liberty Safeguard

4. Duties / Responsibilities

4.1 Directors of Operations – and Clinical Directors are responsible for ensuring that systems are in place to ensure compliance with this policy.

4.2 Area Managers – and Clinical Service Directors are responsible for:

- Ensuring staff are aware, and operating within the requirements of this policy and;
- Ensuring regular review of local practice to monitor compliance. This includes at least six monthly formal reviews of physical measures in place to prevent service users from leaving the safety of the unit.
- Ensuring local processes are in place for the collection and collation of locked door forms

4.3 Person in charge of any shift / Nurse in charge

- The NIC / Shift Leader in charge of any shift is responsible and accountable for the care of patients and staff and the maintenance of a safe environment. It is then the responsibility of each NIC on subsequent shift to review and maintain the safety of the environment.
- The NIC / Shift Leader has discretion for all or part of that shift to lock the door of the ward / unit to protect service users or others and to maintain the safety of the ward / unit.
- Before the decision to lock the door is made, the NIC / Shift Leader should consider all other options available to maintain the safety / security without locking the door. This might include interventions such as verbal discussion / de-escalation / distraction, medication / increasing observation levels, or temporarily increasing staffing levels (subject to availability and authorisation)

4.4 Ward Managers

Ward managers are responsible for ensuring a weekly check of the locked door record book is carried out. Ward Managers should ensure that the locked door policy is included as part of local induction for all ward staff.
4.5 All Staff
All staff working in inpatient and residential settings must have read and understood this policy.

5. Locked Doors – General

5.1 Possible reasons requiring doors to be locked (in all services)
The doors to a ward may be locked if the following circumstances apply:

- Risk of harm to others or intent thereof
- Intent to leave without authorisation
- Risk of harm to self – inability to maintain own safety or suicidal ideation / verbalisation / attempts
- Absconding behaviour – where distraction and other interventions are futile
- Extreme vulnerability to risk from others related to mental health presentation
- To stop unauthorised entry e.g. members of the public entering the building
- Detention under the MHA & high absconding risk present
- Service user detained under Section 5(4) which permits the patients detention for up to 6 hours or until a doctor or approved clinician with a power to use s.5(2) arrives. N.B. it cannot be renewed
- Service user detained under s.5(2) to allow for an assessment for detention under the MHA
- A request for assessment under s.5(4) and 5(2) must happen immediately and the request must be documented in the clinical records

5.2 Action to be taken when locking doors by shift leader / NIC

5.2.1 Inform all staff on duty and ensure this information is handed over.

5.2.2 Inform all service users and visitors in the ward / unit why this action is taken and how long it is likely to last and display a notice to that effect at the ward entrance. Appendix A - example of notices.

5.2.3 Where it is clinically appropriate, the NIC should inform the service user(s) whose behaviour has led to the ward door being locked, of the reason for taking such action and ensure risk assessment and care plan are reviewed and updated.

5.2.4 Leigh House only – inform and update parent / guardian.

5.2.5 Review the observation levels for the individual service user(s) whose presentation necessitated the locking of the doors and for any other service user(s) whose presentation may be affected by the locking of the doors. This section should be read in conjunction with the SHFT Observation Policy (SH CP 37).

5.2.6 Consider and where appropriate, make amendments to the care plan and risk assessment.

5.2.7 When ward staff consider the implementation of locked door procedures within ward areas, they should ensure that at the same time, they also consider patient access to the ward garden (where applicable) as part of their assessment of patient need.
5.2.8 Inform all other service users and visitors that they may request to leave at any time, that they understand how to leave and who they should inform and ensure that someone is available to unlock the door.

5.2.9 If the door requires locking then the locked door record must be completed and the review process followed. Appendix B

5.3 **Locking doors within OPMH and LD areas**

5.3.1 Chapter 19.27 of the Code of Practice specifically refers to the use of combination locks and double handled doors and states these should only be used where there is a regular and significant risk of service users wandering off and / or being at risk of harm.

5.3.2 To conform with the Code of Practice, these measures must be reviewed at least every six months.

5.3.3 In OPMH wards that provide care for people with cognitive impairment and reduced mental capacity and who may also be physically frail, it is recognized that if patients were to leave the unit without appropriate supervision then there is a significant possibility that they would be placing themselves at risk of harm.

5.3.4 In order to help keep these vulnerable patients safe, most OPMH wards are permitted to use a system by which the main entry and exit doors are controlled either by an electric key code, a key fob operating system or a staff controlled buzzer system. This system will be in operation throughout the day and information detailing this approach to patient safety and security must be included within the ward information leaflets. Specific door signs should also be prominently displayed. These signs should provide information about how to enter and exit the ward for both patients (with capacity) and visitors and explain that patients who are not legally detained in hospital have the right to leave at any time. At all times, patients and relative should be informed of the ward safety and security arrangements.

5.3.5 In accordance with the Mental Capacity Act, patients should be assessed as to their mental capacity on admission and this should be reviewed on a regular basis. Assessment should consider the patient’s ability to understand the reason for their admission to hospital and whether there is any concern regarding their acceptance to remain in hospital and on the ward.

5.3.6 In incidences where patients with cognitive impairment express a consistent and purposeful desire to leave the ward or who are variable in this desire, the MDT should ensure they are considered for assessment under the MHA as soon as possible and that the outcome of this assessment is documented clearly.

5.3.7 In the OPMH Service, the use of door controlled systems must be a proportionate response and the procedures by which these systems are operated are reviewed by the area Governance group to ensure best practice in accordance with the legal framework.

5.3.8 In functional OPMH wards that do not operate the system described above on a continual basis, then doors to the ward may be locked when it is assessed as necessary to do so. In these circumstances, existing electronic key code / key fob systems are initiated or physical locking of the door will take place through use of a key system.
6. **Training Requirements**

6.1 The location and circumstances will determine whether or not this action needs to be implemented. As such, all ward staff should be versed in this policy and understand when and when not to implement the locked door procedure. Training sessions are to be organised and delivered locally by Managers / Team Leaders.

6.2 **Legal Framework**

6.2.1 Article 5 of the European Court of Human Rights provides that no-one may be deprived of their liberty unless it is in accordance with a procedure prescribed by law. In the healthcare context in England and Wales, there are primarily three legal frameworks regulating a deprivation of liberty:

1. Mental Health Act 1983
2. Deprivation of Liberty Safeguards Authorisation under the MCA 2005
3. Court order under s.16 MCA 2005

6.2.2 In order for a person to be lawfully deprived of their liberty, it must be in accordance with one of the above legal frameworks. The MHA 1983 applies to both capable and incapable patients, whereas the DOLS authorisation and a Court Order under s.16 MCA 2005 only applies to persons lacking capacity. An informal patient, with capacity, can consent to the deprivation and therefore none of the legal frameworks above apply.

The key consideration is whether the service user is being managed in circumstances amounting to a deprivation of liberty. There is no statutory definition of a deprivation liberty and each case will need to be considered on its facts. Healthcare practitioners should refer to Chapter 2 of the code of practice to the DOLS when determining whether a service user is deprived of their liberty. Factors to consider include:

- Do staff exercise complete and effective control over care and movement of the service user for a significant period?
- Do staff exercise control over assessments, treatment, contact and residence?
- Has the hospital decided that the service user will only be cared for by others or allowed to live elsewhere if it thinks it appropriate?
- Has the hospital or care home refused a request for discharge by carers?
- Is the service user unable to maintain social contacts because of restrictions imposed?
- Has the service user lost autonomy by being under continuous supervision and control?
- Does the service user object to confinement? Consider the service user’s behaviour, wishes and feelings, views, beliefs and values.

6.2.3 In the context of an inpatient unit, there are two categories of service user:

1. Formal service users whose deprivation of liberty is in accordance with the MHA 1983
2. Informal service users – these fall into one of two categories:
   a. Have capacity and consent to remaining on the ward – there is therefore, no deprivation
   b. Lack capacity and are either:
i. Being managed in a manner which does not amount to a deprivation of liberty
ii. Are being deprived of their liberty but are subject to a DOLS authorisation (where appropriate)
iii. Are being deprived of their liberty but are subject to a court order under s.16 MCA 2005.

6.2.4 Where an informal service user who lacks capacity is being managed in circumstances amounting to a deprivation of liberty, the healthcare practitioner should consider:

1. Reviewing their care plan to manage in circumstances not amounting to a deprivation of liberty
2. Detaining the service user under the MHA 1983
3. Applying for a DOLS authorisation (where appropriate)
4. Applying to the court for an order under s.16 MCA 2005
5. Discharging the service user.

6.2.5 In order for a DOLS authorisation to be granted, the service user must meet the criteria set down in schedule 1A MCA 2005. In accordance with case law which applied the statutory framework, a service user will not be eligible for a DOLS authorisation if:

1. They are in hospital and
2. They are receiving treatment for a mental disorder and
3. They are objecting to being deprived of their liberty and
4. They meet the criteria for detention under the MHA 1983

6.2.6 In reality, most informal service users on an inpatient unit receiving treatment for a mental disorder will be ineligible for a DOLS authorisation. An exception to this would be informal service users with a learning disability which is not associated with abnormally aggressive or seriously irresponsible behaviour, as they would not be eligible for detention under the MHA 1983.

6.2.7 The Code of Practice – MHA 1983 states:

16.38 Locking doors, placing staff on reception to control entry to particular areas, and the use of electronic swipe cards, electronic key fobs and other technological innovations of this sort are all methods that hospitals should consider to manage entry to and exit from clinical areas to ensure the safety of their patients and others.

16.39 If hospitals are to manage entry to and exit from the ward effectively, they will need to have a policy for doing so. A written policy that sets out precisely what the ward arrangements are and how patients can exit from the ward, if they are legally free to leave, should be made available to all patients on the ward. The policy should be explained to patients on their admission and to their visitors. In addition to producing the policy in English, hospitals may need to consider translating it into other languages if these are in common use in the local area.

16.40 If managing entry and exit by means of locked external doors (or other physical barriers) is considered to be an appropriate way to maintain safety, the practice adopted must be reviewed regularly. This will ensure that there are clear benefits for patients and that it is not being used for the convenience of staff. It should never be necessary to lock patients and others in wards simply because of inadequate staffing levels. In conjunction with clinical staff, managers should
regularly review and evaluate the mix of patients (there may be, for example, some patients who ought to be in a more secure environment), staffing levels and the skills mix and training needs of staff.

19.9 there are circumstances where hospital managers may restrict visitors, refuse them entry or require them to leave. Managers should have a policy on the circumstances in which visits to patients may be restricted, to which both clinical staff and patients may refer.

21.36 patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward.

7. Monitoring Compliance

7.1 As a minimum, the following will be monitored to ensure compliance:

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<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
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<td>Ward Manager</td>
<td>Matron Walk Round Tool</td>
<td>Bi-Monthly</td>
<td>Q&amp;S</td>
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<td>Training compliance including induction</td>
<td>Ward Manager</td>
<td>Audit / Spot check audit</td>
<td>Semi-Annually</td>
<td>Q&amp;S</td>
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8. Policy Review

8.1 This policy will be reviewed a minimum of every four years, however this policy is to be reviewed 12-18 months after initial publication or in the event of any changes in legislation which may have an impact on procedures.

9. Associated Documents

- MHA Code of Practice
- Clinical Risk Assessment and Risk Management Policies and Procedures
- Risk Management System
- Risk Management policy
- Incident Reporting Policy
- Health & Safety Policy
- Security Management Procedures

10. Supporting References

- Mental Health Act 1983 (as revised 2007)
- Mental Health Act Code of Practice 1999 (as revised 2008)
- Mental Capacity Act 2005 and Deprivation of liberty safeguarding (2007)
● CQC – Essential Standards for Quality (2009)
● Health & Safety at Work Act 1974
● The Regulatory Reform (Fire Safety) Order 2005
Ward Security

Entering and Leaving the Ward

Please note that for security and safety reasons, the doors to this ward operate on a key fob/key pad system.

Visitors are asked to please ring the doorbell to gain entry to the ward and inform a member of staff when they wish to leave.

If you have any questions or concerns regarding this notice, please contact a member of the ward team.
Ward Security

Entering and Leaving the Ward

Please note that for security and safety reasons, occasionally it may be necessary for the doors to this ward to be locked.

If the doors are locked, visitors are asked to please ring the doorbell to gain entry to the ward and inform a member of staff when they wish to leave.

If you have any questions or concerns regarding this notice, please contact a member of the ward team.
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Locked Door Policy
Author: Nigel Dowland, Local Security Management Specialist
Version: 1
April 2013

**LOCKED DOOR RECORD**

Entry to be made below:

1. When door is locked
2. By incoming shift leader / NIC following each subsequent handover
3. When door is unlocked

Ward / area……………………………………………………………… Month ……………………….. Year………

(Format… of …… Forms)

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<th>Decision and reason</th>
<th>Staff name and signature</th>
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Locked Door Policy
Author: Nigel Dowland, Local Security Management Specialist
Version: 1
April 2013
Appendix C - Equality Impact Analysis Screening Tool

Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team.

<table>
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<tr>
<th>Name of policy/service/project/plan:</th>
<th>Policy For Door Locking Within In-Patient and Residential Care Settings (MH/LD) / Locked Door Policy - Management if Patients are at Risk of Absconding (ICS)</th>
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<td>Department:</td>
<td>Health, Safety and Security</td>
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<tr>
<td>Lead officer for assessment:</td>
<td>Nigel Dowland: Security Advisor Ricky Somal: Equality and Diversity Lead</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>April 2013</td>
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1. Identify the aims of the policy and how it is implemented.

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<th>Answers / Notes</th>
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<td>Briefly describe purpose of the policy including:</td>
<td>This policy sets out the procedure for searching to maintain the dignity and welfare of patients and visitors during potentially provocative procedures.</td>
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<tr>
<td>- How the policy is delivered and by whom</td>
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<tr>
<td>- Intended outcomes</td>
<td>Southern Health NHS Foundation Trust (SHFT) is required to provide a safe and secure environment in which patients, staff and visitors may safely engage in a therapeutic regime. This policy has been written with reference to the Mental Health Act (1983 as amended 2007); The Mental Health Act Code of Practice (1999 as amended 2008) and the Human Rights Act (1998).</td>
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2. Consideration of available data, research and information.

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and...
voluntary/community organisations

- Analysis of records of enquiries about your service, or complaints or compliments about them
- Recommendations of external inspections or audit reports

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<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 What is the equalities profile of the team delivering the service/policy?</td>
<td>The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td>2.2 What equalities training have staff received?</td>
<td>All Trust staff have a requirement to undertake Equality and Diversity training as part of Organisational Induction (Respect and Values) and E-Assessment</td>
</tr>
<tr>
<td>2.3 What is the equalities profile of service users?</td>
<td>The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis</td>
</tr>
<tr>
<td>2.4 What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
<td>The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include: 1. Better health outcomes for all 2. Improved patient access and experience 3. Empowered, engaged and included staff 4. Inclusive leadership</td>
</tr>
</tbody>
</table>

HUMAN RIGHT ACT ISSUES
The following must be considered:

Staff when deciding to lock doors must be able to justify the decision as being for the protection of health and safety of a service user or the public.

The person in charge should also consider whether the health and safety of the service user or the public can reasonably be protected by any other means which will have a less intrusive effect upon the service user concerned and the other service users on the ward.

The fact that these issues have been considered should be recorded by the person in charge when setting out their reasons for deciding to lock doors.

If doors were locked because of inadequate staff resources without there being any consideration as to whether it is reasonable to provide further staff, this may leave the Trust open to challenge under Articles 5 or 8 of the Convention.

Staff must give due regard to Article 5 of the Human Rights Act (1998) and
ensure that doors are only locked when a situation is risky enough to warrant this actions and that the duration of the period that the door is locked is no longer than is necessary

The locking of a door must not be used as an alternative to considering whether a service user may need to become subject to the Mental Health Act 1983 and detained.

<table>
<thead>
<tr>
<th>2.5</th>
<th>What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations</td>
</tr>
</tbody>
</table>

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:
<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Applied to all protected groups: The policy (5.1.5) states that searches should be conducted in such a way as to ensure maximum privacy and dignity for the patient</td>
<td>No adverse impacts identified at this stage of screening</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Southern Health responds positively to requests for reasonable adjustments and also provides interpreting and translation services through Access to Communications. This can be accessed via the Equality, Diversity and Human Rights Policy</td>
<td>Within Mental Health Units typically there is evidence that individuals who have a sensory or physical disability are more likely to have a poor experience of being admitted to hospital than non disabled individuals.</td>
</tr>
<tr>
<td><strong>Gender Reassignment</strong></td>
<td>No adverse impacts identified at this stage</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Adverse Impacts</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No adverse impacts identified at this stage of screening</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No adverse impacts identified at this stage of screening</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Southern Health responds positively to requests for reasonable adjustments and also provides interpreting and translation services through Access to Communications. This can be accessed via the Equality, Diversity and Human Rights Policy. A service user whose first language is not English may not understand the implementation of this policy. There may be an adverse impact of this policy for refugee / asylum seekers who may have been victims of torture.</td>
<td>Interpreting and translation services provided by Access to Communications. Equality, Diversity and Human Rights Policy</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>No adverse impacts identified at this stage of screening</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>No adverse impacts identified at this stage of screening</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>No adverse impacts identified at this stage of screening</td>
<td></td>
</tr>
</tbody>
</table>