Secure Management of Patients’ Property

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Patient Admitted with Valuables and Property

Does Patient have Capacity under NCA 2005?

Yes

Patient Retains Valuables and Property

Patient Signs Disclaimer Form

Valuables stored in patients bedside safe

No

Patient hands in Valuables and Property for safe keeping

Staff to complete patient property book

Valuables transferred to cashier's office

Valuables stored in Ward safe

Yes

Patient sends valuables and property home

No

Does patient have NoK or person with LPA?

Yes

Property and valuables sent home with NoK or person with LPA

No

Patient Retains Valuables and Property
1. **Summary**

This policy is designed to ensure that appropriate measures are in place for the secure management of patients’ property, so that the risk of loss of, or damage to, the property is minimised. This is part of delivering a safe and secure environment of care in line with statutory and regulatory obligations.

2. **Introduction**

2.1. The policy sets out the provision for safekeeping and accounting for patient’s property in accordance with the NHS Protect guidance for the secure management of patients’ property (2012). It sets out the steps taken by the Trust to assure patients, carers and visitors to the hospital and its departments that all reasonable steps have been taken to ensure the safety and security of their property whilst they are under our care. Failure to comply with this policy may result in losses with the Trust required to make compensation payments. The Security Policy (2010) and Security Policy community (2008) sets out the measures, policies and procedures put in place to ensure a safe and secure environment throughout the Trust.

2.2. In cases of negligence the Trust is covered under the NHSLA public liability scheme (subject to a £3000 excess). In cases of negligence where the loss is below excess the service may have cover those losses.

2.3. In case of non-negligent losses there is a raised level of duty of care even for accidental loss, theft or damage as the Trust is encouraging patient’s to keep with them property and valuables as part of their treatment.

2.4. The Trust has a duty to provide safe custody for the personal property of any patient who has either formally handed it in for safe keeping or who is unconsciousness or confused and temporarily or permanently incapable of handling his/her own affairs.

2.5. The Trust’s approach to the secure management of patient property is:

   2.5.1. To provide an environment where the loss of or damage to patients’ property personal belongings is minimised.

   2.5.2. To minimise the Trust’s liability for lost or damaged property and ensure incidents or loss or damage are dealt with swiftly and effectively.

   2.5.3. To provide safeguards for service users from abuse (theft, misuse or misappropriation of money of property).

   2.5.4. To provide safeguards for staff against inappropriate and false accusation.

3. **Scope**

This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff. This policy should apply to all areas in which NHS care is provided and to all care settings.
4. **Roles and Responsibilities –**

**Statutory Responsibilities**

4.1. **NHS Protect** – NHS Protect is a Division of the NHS Business Service Authority and has responsibility for the management of security in the NHS in England. This includes creating a safe and secure environment in the NHS.

4.2. **Care Quality Commission**

4.2.1. The Care Quality Commission (CQC) was established under the Health and Social Care Act (2008) as the independent regulator for health and adult social care in England. The Act sets out essential standards which providers are required to meet to register with the CQC.

4.2.2. Under the Regulations providers ‘must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse’ (Regulation 11, paragraph 1). The relevant meaning of abuse includes theft, misuse or misappropriation of money or property.

4.2.3. Providers must ensure that ‘service users and others are protected against the risks associate with unsafe and unsuitable premises’ (Regulation 15).

4.2.4. In order to meet the requirements of regulation 15 providers should ensure measures are in place to protect the personal possessions of people who use services.

4.3. **NHS Litigation Authority (NHSLA)**

4.3.1. NHSLA handles civil liability claims through a variety of membership schemes of which the Trust is a member. Claims relating to patients’ personal belongings may be covered under the Liabilities to third parties Scheme and the Property Expenses Scheme, known collectively as the Risk Pooling Schemes for Trusts.

**Trust Responsibilities**

4.4. **Chief Executive** - has overall responsibility for the provision of a safe and secure environment for patients and their property while on NHS premises.

4.5. **Chief Nurse and Director of Governance** – has overall day to day responsibility for ensuring the implementation of the policy.

4.6. **Director of Finance** - is generally responsible for implementing the Trust’s financial policies, including those relating to patients’ monies and other property.

4.7. **Chief Cashier** – is responsible for providing a safe central storage facility for patient’s property taken into the Trust’s care, performing related functions and highlighting and reporting any potential risks.

4.8. **Local Security Management Specialist** (LSMS) – ensures the Trust maintains and promotes a safe and secure environment for the secure management of patient’s property and effectively responds to incidents and security breaches. The LSMS advises the Trust executives relating to security management. The LSMS ensures all in-house and contracted security staff are trained, made aware of security practices and procedures and have access to the policy.

4.9. **Local Counter Fraud Specialist** - responsible for conducting both proactive and reactive counter fraud work for the Trust. The LCM ensures that staff, patients and visitors alike
adopt a zero-tolerance attitude towards fraud to deters potential fraudsters and encourage the development of a counter-fraud culture within the Trust

4.10. Heads of Nursing and Midwifery, Departmental Managers and the Registered Manager Mary Seacole Nursing Home – are responsible for informing staff of their responsibilities and duties for the administration of patient’s property and ensuring the policy and procedures are implemented

4.11. Healthcare professionals - are responsible for ensuring that all patients’ property is documented following the correct procedure and in a timely way. They are also responsible for making patients and their representatives aware of the Trust’s policies and procedures with regard to patient’s property

4.12. Administrative staff – support by ensuring the correct patient property information documentation is available and liaising with the cashier’s office about property held by the Trust in safe custody

4.13. Bereavement Officer – liaises with bereaved relatives ensuring property is returned to the appropriate patient representative in a timely way

4.14. Patient Advice and Liaison Service – provides information about the complaints procedure assisting with claims for compensation and liaising with departments and wards when PALS enquires are made by relatives, carers or patients

4.15. All Trust staff - all required to uphold security arrangements at the Trusts and comply with financial procedures. Staff must be aware of the policy, their responsibility and accountability for the steps to be taken to safeguard patient’s property. Staff must consider security of patient property if the patient is incapable or unable to make a decision and take any property into safekeeping on their behalf.

5. Managing patients’ property during admission and stay

5.1. Key terms and definitions used in the policy are:

5.1.1. Property: includes money and any other personal property

5.1.2. Valuables: any item of value not limited to monetary value such as cash, credit/debit cards, portable electronic devices and jewellery

5.1.3. Deposited property: property which the Trust has taken into care for safekeeping, either following an explicit agreement with the patient or because the patient is incapacitated or otherwise unable to look after it

5.1.4. Undeposited property: property patients retain with them on the Trust

5.2. Patient awareness of secure management of patient property

5.2.1. Disclaimer notices will be displayed throughout the Trust, including community clinics and health centres, in commonly used languages advising any visitors, carers and patients attending that the Trust is not liable for any lost or damaged property

5.2.2. As part of the elective admissions process patients should be given an information leaflet, in advance of admission, informing them that the Trust will not be held liable for the loss or damage to any property not handed in for safekeeping. Patients’ for day surgery procedures will receive a leaflet particularly tailored to their requirements
5.2.3. Patients booked to attend for an outpatient procedure or investigation should be advised not to bring any valuables with them. The same applies for patients attending Community Clinics and Health Centres.

5.2.4. On admission, patients should be made aware of the risks of retaining undeposited property and given a patient property information leaflet on how to look after their belongings and informing them that the Trust will not be held liable for the loss or damage to any property not handed in for safekeeping.

5.2.5. If a patient wishes to retain their personal property they must be asked to complete a disclaimer form (Appendix 1) and a copy must be retained in the patient’s healthcare records.

5.2.6. If the patient has monies or valuables that he/she wishes to retain they must be informed that the Trust will not be held liable for the loss of undeposited jewellery, cash and valuables and the patient must sign a disclaimer form.

5.2.7. Patients should be aware that they should have documentation relating to property. This will either be a completed page in the Patients’ Property Record Books or a disclaimer form.

5.2.8. Patients should be advised to take common precautions to prevent accidental loss such as labelling items or carrying cases for spectacle, hearing aids, with the patient’s name, for example.

5.2.9. Patients should be advised that they should not bring everyday items that have significant economic value such as laptops or e-readers as these items are likely targets for theft. Responsibility for safekeeping lies with the patient unless the items are handed in for safekeeping.

5.2.10. This policy and a copy of the information leaflet will be detailed on the Trust website.

5.3. Receipt and recording of deposited patient’s monies and property

5.3.1. The admitting nurse must check with the patient whether the patient has valuables or property either to be handed in for safekeeping or retained with a signed disclaimer completed.

5.3.2. Electronic Patient Record (EPR) has fields within the Initial Contact Assessment Form to indicate whether valuables have been taken into safekeeping and these must be completed and updated as necessary.

5.3.3. A full audit trail should be created by keeping detailed, formal, accurate records of a patient’s property and of relevant actions taken in relation to the property. In the case of compensation claims incomplete documentation can be decisive.

5.3.4. Once completed documents should not be altered in any way. If an error is made and amendments are required the text should be crossed out with a single line and initialled by the person making the entry.

5.3.5. The Patients’ Property Record Book is the only record that should be kept for deposited property and each department or ward should only use one book at a time. The book must be stored securely when not in use.
5.3.6. The Patients' Property Record Book are controlled stationery and any spoiled sheets should remain in the book endorsed “cancelled”. The books are retained for six years following the year of use in the cashier's office. New books can be obtained from the cashier's office.

5.3.7. When checking deposited property staff should list item-by-item and any additional information of relevance added e.g. where the items will be held. The record must include the patient’s full details including hospital number. The record in the Patients' Property Record Books should be signed by a registered nurse and the patient or, if the patient is incapacitated or refuses to sign, by two staff, one of whom must be a registered nurse. All valuables and cash should be placed in the security bag and sealed in the presence of the signatories. If the patient is able then one nurse and the patient can check and sign for receipt of property.

5.3.8. When completing the record staff should be careful to describe items accurately and not use ambiguous terms. The terms “gold”, “silver”, “diamond” must not be used. Instead, the description should read “yellow metal”, “white metal”, “white stone”.

5.3.9. Cash should be counted in front of the patient or their representative (where possible) and detailed in the Patients’ Property Record Books. Staff should never accept sealed envelopes of cash for safekeeping without confirming the contents. This also serves against dishonest claims for cash amounts not handed in.

5.3.10. Cash should be put into a sealed blue patient’s cash/valuables bag and stored securely as soon as reasonably practicable. As an added precaution the amount handed in for safekeeping should be documented in the patient’s healthcare record.

5.3.11. Ideally large sums of money – £100 and over- should not be stored locally and every precaution should be taken against loss or theft during the transfer to the cashier's office. Staff should advise patients about repayment. The patient has an option to have their cash returned or they can be issued with a cheque.

5.3.12. Mary Seacole Nursing Home finances are managed by the welfare officer in the Cashier’s Office, Homerton East Wing, City and Hackney Centre for Mental Health, Homerton Row, Hackney, London, E9 6SR. The cashier’s office only holds cash and valuable for deceased patient’s when the Trust is responsible for the funeral.

5.3.13. Once the Patients’ Property Record Book is completed the three copies should be distributed as follows:

- The white copy to be given to patient (or representative)
- Blue copy stays with property
- Pink remains in the book

5.3.14. If it is not possible to hand the copy to the patient or representative it should be filed in the healthcare record.

5.3.15. The Cashier’s office has a main safe where patients’ valuables can be held.

5.3.16. Where property is to be held for safekeeping in the cashier’s office the patient’s valuable bag and completed Patients’ Property Record Book should be taken to the cashiers/property office. All three pages should be intact in the book when it is brought.
with the valuables to the cashier’s office to be signed by the cashier before the white copy is given to the patient.

5.4. Variations to deposited property and full or partial withdrawals

5.4.1. If a list of items in safe custody changes for any reason, such as if additional items are added, a new entry should be created in the Patients’ Property Record Book. If an existing entry is amended this could give rise to disputes on the legitimacy of the amendments and compromise the whole record and the audit trail.

5.4.2. When a patient asks to withdraw all or part of their property from safekeeping, staff should remind them of the risks of keeping property with them and advise them to send property home if possible.

5.4.3. Once the cashier has signed the Patients’ Property Record Book then the Trust is responsible for the property and it is entered in the Patients’ Property Register. When cash is returned to the patient by the cashier the patient signs to confirm safe return and a staff member from the ward acts as a witness.

5.4.4. A new record will be created for the patient’s property retained in safekeeping.

5.4.5. For property retained in the cashier’s office ward staff should contact the office.

5.5. Recording of undeposited property

5.5.1. Patients will wish to retain certain types of property with them, particularly items that are necessary for the normal activities of daily living such as spectacles, books or clothing.

5.5.2. While not accepting loss of, or damage to, patients’ property not handed in for safekeeping the Trust must take reasonable steps to reduce the risk of loss or damage. Wards and departments must provide appropriate storage facilities such as a bedside cabinet.

5.5.3. Staff should keep a detailed record using the patient property disclaimer form. This also provides evidence to defend against claims of negligence made by patients or their representatives at a later time.

5.5.4. Where patients lack capacity to make decisions the Trust has an obligation to look after their property and should take any undeposited property into safekeeping.

5.5.5. A detailed item-by-item list should be recorded and described accurately using unambiguous terms.

5.5.6. The patient should be asked to sign the disclaimer along with a member of staff. If the patient declines, or is unable to sign, a note should be made on the disclaimer form and two members of staff should sign the form.

5.6. Transfer

5.6.1. When patients are transferred, either within the organisation or to another NHS facility or to a private, voluntary or local authority care provider, their property must be covered in the handover between the transferring unit and the receiving unit as a matter of routine.
5.6.2. Transfers to another NHS facility or to a private, voluntary or local authority care provider should be treated in the same way as a discharge home in regard to property and valuables

5.6.3. If the patient is incapacitated and the patient has no identified next-of-kin the Cashier’s office will retain the valuables in safekeeping

5.6.4. If the patient has been transferred from another ward or department within the Trust the nurses from both areas should check the patient’s property according to the current Patients’ Property Record Book entry and agree with the patient (if the patient’s clinical condition allows) that all items have been transferred – deposited correctly

5.6.5. If the property is undeposited both areas will check that a disclaimer form is still a valid and complete list.

5.6.6. The transferring area will document in their Patients’ Property Record Book that the patient has been transferred.

5.6.7. The receiving nurse documents that the patient and his/her property have been received

5.6.8. Not all patients are transferred with an escort nurse. Both the transferring and receiving staff are required to have a witness or patient signature. This is to confirm that the patient has left one area with all his/her property and that the property is re-checked as correct on arrival in the new area

5.6.9. Following the transfer, if the documentation is found to be incomplete, it is the transferring areas responsibility to ensure that the entire patient’s known property has been handed over and to sign as such

5.6.10. Staff transferring the cash may consider a security escort in particular from Mary Seacole Nursing Home to Homerton East Wing, City and Hackney Centre for Mental Health

5.7. Temporary custody of patient’s property

5.7.1. If patients are temporarily away from the ward/department – in theatre or x-ray- they should be informed that they can hand in for safekeeping any undeposited property and should be encouraged to do so. It is the Trust’s responsibility to secure their property.

5.7.2. Where property is taken into temporary custody the same procedure should be followed as when items are handed over for safekeeping with the difference that items should be stored locally, in the ward safe or bedside safe, if secure options are available.

5.8. Discharge

5.8.1. Undeposited property should be checked against the patient’s disclaimer form on the discharging ward
5.8.2. If applicable staff should advise patients of the trust process for returning deposited amounts of cash over £100. Return can be in the form of a cheque or cash depending on the patient’s wishes.

5.8.3. On discharge all property handed in for safekeeping should be returned as soon as practicable. If the patient is incapacitated it will be returned to the patient’s representative as documented in the healthcare record. The patient can give verbal instructions as to who the property should be handed over to and this must be documented on the property sheet.

5.8.4. Other than this case staff should not hand over property to anyone other than the patient without the patient’s written consent.

5.8.5. Deposited property held in the ward safe should be checked and returned against the Patients’ Property Record Book in the presence of the patient or representative, who will sign that this has been done on both the ward copy in the property register and the patient’s white copy.

5.8.6. The cashier’s office will check the contents of the property bag against the property register in the presence of the patient. If the patient is unable to come to the cashier’s office the cashier will go to the ward to hand back the property and the patient will be asked to sign the property register that the property returned in good order.

5.8.7. When property is returned that has been kept for safekeeping on the ward, to the patient or representative, staff should ask the patient to check against the white patient copy. Staff should check the returned property in the presence of the patient or representative who should be asked to sign in the property register that this has been done and the property returned in good order.

5.9. Patients who lack capacity to make a decision about their property

5.9.1. When patients lack capacity to make a decision about their property staff may have to make that decision in their best interests.

5.9.2. Where staff have a reasonable belief that the patient lacks capacity they should consider whether everything has been done to support the patient to make the decision.

5.9.3. Patients are assessed as lacking capacity by following the requirements of the Mental Capacity Act (MCA) (2005) and this must be documented. Staff must follow the requirements of the MCA (2005) as outlined in the Safeguarding Vulnerable Adults Policy (2012) and the Mental Capacity Act and Deprivation of Liberties Policy (2013). Staff must be aware that though the patient lacks capacity on one occasion that does not mean that they lack capacity to make another decision in the future.

5.9.4. Staff must be aware that though the patient lacks capacity on one occasion that does not mean that they lack capacity to make another decision in the future.

5.9.5. Staff should involve patients as much as possible in any decisions about their property and every effort should be made to consider their wishes and feelings.

5.9.6. The MCA (2005) does not protect staff for liability for negligence. If staff place a patient’s property into safe keeping in line with the MCA (2005) but there is negligence in handling the property, the staff will remain liable for any loss or damage that occurs.
5.9.7. Holders of a ‘property and affairs’ lasting power of attorney (LPA) or their deputy appointed by the Court of Protection should be involved in relevant decisions concerning the patient’s property where a patient has been assessed as lacking capacity.

5.9.8. If a patient’s LPA holder or deputy is not available staff should follow the Trust procedures for safeguarding property.

5.9.9. Procedure for the safekeeping and return of property is as described in 5.3 and 5.10.

5.9.10. Where patients are admitted and accompanied by a next-of-kin property, at the discretion of staff, may be taken home by the next-of-kin but valuable retained in safekeeping.

5.9.11. Where patients are discharged and lack capacity any deposited property should be given to the attorney or deputy. In practice this will often be a relative or friend.

5.10. Return of property held in safekeeping

5.10.1. When a patient wants some or all of their property returned from the ward safe a member of staff and the patient must sign all copies of the Property register form stating what has been returned and when.

5.10.2. When a patient needs their property returning from the cashiers/property office, the ward staff should first inform the cashier’s office.

5.10.3. Where a patient has been assessed as lacking capacity property should be returned to the patient if appropriate or the holders of the LPA or their deputy.

5.11. Out of hours

5.11.1. Gaining access to the Cashiers/Property Office for patient’s property should be for emergencies only. Please note property deposited in the night safe or any cash cannot be returned until the office is open. Office hours: Mon-Fri 9.00 – 17.00.

5.11.2. To gain access to the Cashiers/Property Office outside normal hours, both the Clinical Site Manager and Security Supervisor need to meet at the office. The Clinical Site Manager holds the internal door key, and the Security Supervisor has access to the burglar alarm code (this is kept in a sealed envelope in a locked cabinet in the security office). Each time the safe is opened it must be reported on DATIX. Both parties must only enter the office together thus ensuring a high level of security.

5.12. Deceased patients

5.12.1. The Trust has a duty to look after property until such time as it can be handed over to the appropriate person.

5.12.2. When a patient dies all property/valuables that is not already in safe custody, must be documented by two staff, (at least one being a qualified nurse) in the patients’ property register.
5.12.3. Both staff should sign the Patients’ Property Record Book. The ward clerk should then take all property/valuables to the cashier’s office before 10am the next working day.

5.12.4. The bereavement officer will bring the patient’s representative to the cashier’s office and the cashier will hand over the deceased patient’s property. Mary Seacole Nursing Home will follow the procedures as set out in the Mary Seacole Nursing Home section

5.12.5. When a bereaved next-of-kin, holder of LPA or Deputy appointed by the Court of Protection comes unaccompanied to the bereavement office the cashier will confirm that property or valuables should be handed to him/her by asking them to establish their identity and check against the healthcare record. Appropriate documentation may be a will or passport.

5.12.6. All items (e.g. wedding ring) must normally be removed from the body. If any jewellery is not removed, this must be documented in the patient’s property register and on the Death Notice.

5.12.7. Valuables should be placed in the patient’s valuables bag and sealed. All property should be placed in the grey plastic bags, tied and labelled. If more than one bag is used, this should be clearly shown in the Patients Property register.

5.12.8. When the deceased patient’s property is being transferred to the cashier’s office any patient medications should first be labelled and returned to pharmacy.

5.12.9. Any soiled items that are kept must be double bagged, labelled as ‘soiled’ and follow infection control procedures.

5.12.10. Any property found in relation to discharged or deceased patients should be transferred to the cashier’s office without delay.

5.12.11. If at any stage there is doubt as to the patient representative’s entitlement to the property items must be retained in safe custody pending further enquiries.

5.13. Release of property/valuables to patients’ representative or other Health Professionals

5.13.1. Property should only be given to the person listed as next-of-kin, holders of LPA or Deputy appointed by the Court of Protection. When property is held in the cashier’s office the cashier will take responsibility for the handing over the property. On the ward/department responsibility lies with the manager or designated person in charge. The patient’s representative must produce appropriate documentation showing entitlement such as the registered LPA document.

5.13.2. If the patient’s relatives or representatives wishes to take property home and a disclaimer form has not been signed, then consent needs to be obtained from the patient.

5.13.3. Any items removed by the next-of-kin/representative should be documented in the patient’s property register and the next-of-kin/representative and patient should sign that the property has been received.

5.13.4. When a health professional requires any property such as house keys for a home visit then consent must first be obtained from the patient or the patient’s
representative. If the property is held in the cashier’s office the cashier will release the property

5.14. Missing or damaged property

5.14.1. When a patient reports deposited property as missing or damaged staff should launch an immediate enquiry, inform security and complete a DATIX incident report form

5.14.2. It is the Trust’s responsibility to inform the police

5.14.3. Patients may want to contact the police directly and they should be assisted to do so if required

5.14.4. If a patient’s deposited property is reported damaged the staff responsible for its storage should make enquires as soon as reasonably practicable to ascertain causes. Patients should be advised of any damage as soon as is practicable

5.14.5. If undeposited property is reported damaged staff should make enquires and alert security and the police if criminal damage is suspected. Staff should inform the patient the Trust will not accept liability for the damage

5.14.6. Patients or their representative can lodge a complaint. Staff should make patients aware of PALS and the correct procedure to follow

5.15. Unclaimed and lost property

5.15.1. Unclaimed property relates to those items left behind by patients or their relatives following the patient’s discharge, transfer or death

5.15.2. Every effort should be made to return unclaimed property to the owner or representative as soon as practicable. This is particularly important in the case of valuable items

5.15.3. Where property retained for safekeeping that has not been returned (e.g. unclaimed, forgotten or patient deceased) records of such attempts must be kept

5.15.4. All items not already in safekeeping should be taken into care. Staff responsible for the storage should write to the patient or patient’s representative asking them to contact the Trust to arrange collection. All reasonable steps to make further contact should be taken if the first attempt fails. If not collected within two weeks from the ward property should be taken to the cashier’s office

5.15.5. Soiled items are an exception and can be disposed of immediately

5.15.6. Valuable items should be transferred as soon as is practicable to the cashier’s office and documented according to the policy guidance

5.15.7. Valuable items must be kept for six years based on the provision of the Limitation Act 1980 as this is considered reasonable. After this time advice should be sought before disposal

5.15.8. If it proves impossible to identify or contact the rightful owner, the property should be kept in safe custody until a decision is made regarding disposal

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5.15.9. Unclaimed property of low value left in hospital by patients that is not claimed within four weeks can be assumed to have been abandoned and may be disposed of. The cashier’s office will deal with this. If there is doubt about the value expert advice should be sought.

5.16. Ward safes

5.16.1. Wards which have a ward safe must keep the keys with the ward ‘drug keys’ and always in possession of the ward nursing staff

5.16.2. Ward safes should be checked weekly, and a record of checks maintained, to ensure that valuables are not retained for long periods and unclaimed items are taken to the cashiers/property office. If there is a likelihood of valuables required to be held in safekeeping for more than two days then they should be transferred to the cashier’s office. Records of these checks (Appendix 2) are to be maintained and must be able to be produced for audit purposes.

5.16.3. Ward and department managers are required to implement local procedures to ensure checks are made with regards to completed Patients’ Property Record Book forms or disclaimers. This check should be undertaken by the ward/department manager or an allocated member of staff.

5.17. Patients going to theatres

5.17.1. At pre-admission, the nurse is responsible for informing the patient that no valuables, money or credit cards be brought into the unit as the Trust is not responsible for their safekeeping. Patients who have valuables should be advised to give them to their representative

5.17.2. All patients at pre-admission will be given a day surgery leaflet with instructions about valuables, money and credit cards

5.17.3. Patients should have all valuables documented and locked in the ward safe as detailed for ward admissions before going to theatre. When the patient returns from theatre and has recovered sufficiently, the valuables can be handed over and the patient must sign the relevant part of the patients’ property register to clarify their safe return. The patient may wish their items to be retained until discharge

5.17.4. Some patients may wish to leave their valuables in the ward safe until discharge

➢ If a patient has cash of more than £100 this should be sent to the cashiers office in a sealed blue patient’s valuables bag
➢ If the item is too large to fit in the ward safe, for example a laptop, the patient will be asked either to sign a disclaimer, arrange for it to be taken home, or sent to the property office.

5.18. Day Surgery

5.18.1. On the morning of admission, each patient will be given a garment bag for their clothes and shoes. It will be emphasised at this point by the nurse that valuables will not be safe in these bags as they do not have individual locks
5.18.2. All patients’ bags will have the patient’s name and hospital number on them. This is the responsibility of the nurse admitting the patient. All garment bags will remain with the patient until he/she goes to theatre or Endoscopy.

5.18.3. Once the patient has gone for their surgery or procedure, the nurse or healthcare support worker will be responsible for taking the garment bag to the Step-down Area. The garment bag will be securely stored in the designated area. Patients will receive their garments back when they are ready for discharge.

5.18.4. Patients and relatives are not permitted to get their garment bags from the designated area. It is the responsibility of the patient to open and remove their belongings. A member of staff returns the empty bag to the designated area.

5.19. Accident & Emergency

Procedures in the policy are applicable for A & E with the following additional considerations and actions.

5.19.1. A & E have a property bin rather than a safe and as such all retained property of value will be transferred to the cashier’s office. If the cashier’s office is closed then valuables should be deposited in the night safe via security. The property is placed in plastic bags provided. Soiled clothing, if not taken by relatives should be wrapped separately and identified as being soiled before being placed with the rest of the property.

5.19.2. The property bin is used to store non-valuable property overnight that has been listed, and is then taken to the Cashier’s office the next working day for safekeeping. The department manager is to ensure this is checked regularly.

5.19.3. In the case of deceased patients:

5.19.3.1. For reasons of establishing legal next-of-kin, property and valuables must not be handed over. The next-of-kin or patient’s representative must be directed to the cashier’s office to collect property. However, the Senior Nurse may authorise the release of certain items of patient’s property, within their discretion, if, for example, house keys are required by a bone fide next-of-kin/LPA/police.

5.19.3.2. Please note on the property form if the patient is a brought in dead or died in casualty.

5.19.3.3. Any property required by the police must first be listed in the property register. Two nurses must still sign the property register and it must be signed by the police officer removing the property, together with their number and station. The nurse-in-charge or deputy must countersign the officer’s signature. This procedure is extremely important because if the police enter the removed property in evidence staff will be required to make a statement, for continuity of evidence.

5.19.3.4. If the property is required for forensic testing it is important that the nurse when removing the clothing, lays it on plastic bags, separately. If evidence bags are available, each item of clothing will be placed in a separate bag. Do not seal the bag. The police do this after listing and signing for the property.
5.19.3.5. Any perishable items, which have been brought in to the department, can be destroyed at the discretion of the nurse in charge. This procedure must be written in the nursing notes.

5.19.3.6. All medications from deceased patients should be bagged and labelled accordingly then sent to pharmacy, via the pharmacy tin.

5.19.3.7. In the case of lost property: any property found in the department for which the owner cannot be identified should be bagged and marked lost property and handed to the cashier’s office. The items should be listed, attached to the bag and it must be documented in the A&E communication diary.

5.20. Radiology

5.20.1. Radiology operates differently to other clinical areas and therefore has specific instructions. In-patients attending radiology are be covered by previous sections.

5.20.2. All patients who need to change into a gown will be provided with a basket to store their property. This basket will be kept with the patient at all times.

5.20.3. Patients that remove jewellery for an investigation are encouraged to keep those items with them.

5.20.4. During MRI scanning the basket can be left with Radiographers in the scanning control room.

5.20.5. MRI patients that wish to can place valuables in a locker and should keep the key. However during scanning the key will need to be left with Radiographers. The lockers are small and are kept within MRI recovery but out of sight. This room is only accessible to MRI staff or patients that are waiting to go in for their scan.

5.20.6. If patients are not able to do so, primarily in MRI, and no family members are able to keep property for them for the duration of the investigation then staff are to follow the policy guidance for receipt and recording of patient’s monies and property.

5.21. Long stay Patients:

Mary Seacole Nursing Home (MSNH); Homerton Transitional Rehabilitation Unit (HTRU), MSNH; Regional Neurological Rehabilitation Unit (RNRU)

5.22. It is a fundamental part of the service that residents/long stay patients are given the opportunity to maintain and develop skill in the management of their monies wherever possible. However, for the avoidance of ambiguity and doubt, all staff must adhere to the following.

5.22.1. Staff caring for or working in MSNH, HTRU or on RNRU must not be:

- Involved in writing wills or bequests of people who use services;
- Able to use property of people who use services for personal use;
- Able to borrow money from, or lend money to, people who use services;
- Able to sell or dispose of goods belonging to people who use services for their own gain.
5.23. Managing the monies of long-stay patients

5.23.1. If it is agreed that a resident/long stay patient is able to safely manage his/her own affairs then this must be agreed and respected and the appropriate level of support provided by staff. This should be monitored and the level of support adjusted as necessary.

5.23.2. Where patients hand over money for safekeeping, or otherwise accumulate monies above £200 and maintain this balance over a period of three months, an appropriate sum should be reserved for their day to day needs and the rest deposited in a bank account.

5.23.3. If the patient is willing and able they should be encouraged to open a savings account in this/her own name. If the patient lacks capacity or is unwilling to open an account in his/her own name their deposited money should be paid into a separate bank account opened in the name of the NHS organisation to manage patient monies.

5.23.4. All documents should be kept in safe custody and may be reviewed by the Trusts internal auditors as required.

5.23.5. All requests for withdrawal should be made in writing using a money request form.


5.23.7. When residents/long stay patients lack capacity to make a decision about their property staff must follow the requirements of the Mental Capacity Act (2005) as outlined in the Safeguarding Vulnerable Adults Policy (2012) Mental Capacity Act and Deprivation of Liberties Policy (2013).

5.24. HTRU: Managing and safeguarding residents’ property

5.24.1. The HTRU unit is a 7 bedded unit based at MSNH. The aim of the unit is to support people with acquired brain injury to develop greater independence before returning to live in the community. The unit is accessed through the main entrance doors to MSNH, which have keypad access, and a further door into the HTRU unit, also with keypad access.

5.24.2. HTRU residents who have capacity are encouraged, as part of their rehabilitation, to keep their own bank cards and manage their own bills. HTRU residents whom are assessed as being able to maintain their safety on occasions are encouraged to use personal equipment such as phones and IPADS which may become their future memory/communication aids.

5.24.3. HTRU staff must keep an itemised list of each patient’s valuables and property.

5.24.4. HTRU residents must be informed that they should keep personal property and valuables in the lockers in the dining room or in the locked drawers in their rooms. Residents have their own keys (master copies held securely by staff). Residents are supported by staff to be responsible for keeping their personal property secure.

5.24.5. HTRU residents are encouraged to access the community regularly either on their own, with staff or with friends and family, this includes visiting home at the weekend.

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Residents are encouraged to use their own money when taking part in activities such as shopping or going to the gym and therefore need easy access to funds

5.24.6. Residents who choose to retain personal property must be asked to complete a disclaimer form (Appendix1) and a copy must be retained in the resident’s healthcare record

5.24.7. If a resident lacks capacity for his/her property and valuables they should be held for safekeeping in the main safe in MSNH and the Trust procedures for safeguarding a patient’s property followed.

5.24.8. Residents may be supported by the HTRU team, to retain small items of property and small amounts of money that enables them to access the community and re-gain their independence under support and guidance. If residents have capacity to look after all their property and valuables - a disclaimer form should be completed. If residents do not have capacity HTRU staff will discuss, where possible, with the next-of-kin/carer the risks and benefits of retaining valuables however responsibility for the safekeeping remains with the HTRU staff

5.24.9. Where RNRU patients are encouraged to bring in property or valuables as part of rehabilitation therapy the guidelines in the paragraph above will apply.

5.25. MSNH: Managing and safeguarding residents’ property

5.25.1. Staff at MSNH will follow the general policy guidance for receipt and recording of patient’s monies, property and valuables for resident’s who have property and valuables

5.25.2. A full inventory must be made of a resident’s/a long stay patient’s property. This must be updated regularly and amended if further items are purchased /obtained

5.25.3. At bank cards and passbooks must be securely stored and recorded as such on each MSNH resident’s inventory. Monthly checks of the contents of the safe should be made by two staff (at least one registered) against the inventories and expenditure sheet

5.25.4. Any transactions involving resident’s monies must be recorded on the individual expenditure sheet and signed and countersigned by two members of staff (at least one registered or the administrator of MSNH). All receipts should be kept and are attached to the resident’s expenditure sheet. Balances must be checked each time a transaction occurs by two registered nurses and logged on the expenditure sheet and handover book

5.25.5. Where residents are not able to manage the day to day use of their own money the MSNH staff are accountable for all transactions undertaken on behalf of the residents. They are accountable for ensuring that such money has been used in the best interest of the resident.

5.26. MSNH deceased resident’s property

5.26.1. When a resident dies, two staff, (at least one being a qualified nurse) must document all property/valuables in the patients’ property register
5.26.2. All items (e.g. wedding ring) must normally be removed from the body. If any jewellery is not removed, this must be documented in the Patients’ Property Record Book and on the Death Notice.

5.26.3. Valuables should be placed in the patient’s valuables bag and sealed. All property should be placed in the grey plastic bags, tied and labelled. If more than one bag is used, this should be clearly shown in the Patients’ Property Record Book.

5.26.4. Both staff should sign the Patients’ Property Record Book. The valuables should be kept in a safe for the patient’s representative to collect.

5.26.5. Where there is no known next of kin, the manager should inform the cashier’s office at Homerton East Wing City and Hackney Centre for Mental Health then take all valuables to them as soon as possible. All other properties will be disposed of accordingly in MSNH.

5.26.6. When the deceased patient’s property is being transferred to the cashiers / property office then medications should first be accounted for and disposed of according to local protocol.

5.26.7. Any soiled items must be double bagged, labelled as ‘soiled’ and follow infection control procedures for disposal.

5.26.8. The patient’s representative, LPA or deputy are encouraged to remove all of the patients’ properties from MSNH as soon as possible in accordance with Policy section ‘Deceased patients’. Any property not removed should follow the steps outlined in the policy.

5.27. Community Settings including visiting patients in their own home

5.27.1. Trust staff working at a community sites (health centre, GP practice, children’s centre or school) and visiting patients’ homes should not be involved in the direct care of a patient’s property, valuables or monies.

5.27.2. In particular, staff caring for or working in community settings must not be:

- Involved in writing wills or bequests of people who use services;
- Able to use property of people who use services for personal use;
- Able to borrow money from, or lend money to, people who use services;
- Able to sell or dispose of goods belonging to people who use services for their own gain.

5.27.3. Staff visiting patients in their own home should be aware of the Safeguarding Vulnerable Adults Policy (2012) and Mental Capacity Act and Deprivation of Liberties Policy (2013) and, if required, refer patients to Social Services for the management of their property. In an emergency staff should refer to the Social Services Duty Team. In this situation a DATIX must be completed.

5.27.4. Community staff should inform their manager and the Safeguarding Adult team if there are any issues with the management of patient property.
5.27.5. The overriding principle is to protect the patient from financial abuse of any kind, to protect staff from accusations of impropriety and to ensure that the patient’s needs are met.

5.27.6. Appropriate security arrangements ust be in place and disclaimer notices displayed in community sites which are leased by the Trust or shared premises. Where premises are shared disclaimers notices should be displayed in areas used by the Trust. Expensive items such as baby buggies may be left unattended and disclaimer notices will limit the Trust’s liability where reasonable actions (Unfair Contract Terms Act, 1977) have been taken to prevent loss and appropriate security arrangements are in place.

6. Training and awareness

6.1. All staff attend the Trust corporate induction which includes security training.

6.2. Staff training on safeguarding patient’s property be included at local induction with ongoing training as identified by the ward/departamental manager.

6.3. All staff are required to be aware of Trust policies which are available on the intranet.

6.4. Staff will be informed by the Quality and Risk department that the policy has been updated.

7. Review

This policy will be reviewed in 3 years’ time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

8. Monitoring/Audit

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/Audit</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Monitoring reported to which groups/committees, inc responsibility for reviewing action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis of issues pertaining to patients’ property</td>
<td>Monitor incidents and complaints</td>
<td>Twice a year</td>
<td>Audit Committee</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Audit Inpatients’ documentation – disclaimer slips completed and EPR</td>
<td>Audit</td>
<td>Twice a year</td>
<td>Ward managers and senior lead nurses</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Audit of patient’s property register</td>
<td>Audit</td>
<td>Twice a year</td>
<td>Chief cashier</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Long-stay patients: audit of safekeeping procedures for patient’s valuables</td>
<td>Audit</td>
<td>Twice a year</td>
<td>Lead Nurse MSNH/RNRU</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Measurable Policy Objective</td>
<td>Monitoring/Audit</td>
<td>Frequency of monitoring</td>
<td>Responsibility for performing the monitoring</td>
<td>Monitoring reported to which groups/committees, inc responsibility for reviewing action plans</td>
</tr>
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</tr>
<tr>
<td>Trust-wide survey the display of the disclaimer notice in the ‘Group 1/Major sites’.</td>
<td>Audit</td>
<td>Annual</td>
<td>Senior and lead nurses, department heads</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>An analysis of incidents, claims and complaints to ensure that there are no reports relating to wills, bequests, using property etc.</td>
<td>Monitor incidents, claims and complaints</td>
<td>Annual</td>
<td>Head of Adult Safeguarding</td>
<td>Safeguarding Vulnerable Adults Committee</td>
</tr>
</tbody>
</table>

9. **Sources of Evidence; References / Bibliography**

Guidance for NHS organisations on the secure management of patient’s property’, July 2012, NHS protect

Guidance about compliance: Essential Standards of Quality and Safety, Care Quality Commission, March 2010

Health and Social Care Act 2008 (Regulated Activities) 2010


Limitation Act (1980)

Mental Capacity Act and Deprivation of Liberties Policy (2013)

Patients’ Monies and Belongings (2011) Healthcare Financial Management Association

Safeguarding Vulnerable Adults Policy (2012)

Standing Financial Instructions Policy (2012)

Unfair Contract Terms Act (1977)
PATIENTS MONIES, VALUABLES & PROPERTY
DISCLAIMER FORM

Homerton University Hospital NHS Foundation Trust cannot accept liability for patients’ monies, valuables or property that are not deposited for safekeeping.

Homerton University Hospital NHS Foundation Trust will not accept any illegal or unlawful items into safekeeping and should such items be presented staff will inform Security.

This form is to be used for patients who choose to retain any personal items and as such accept personal responsibility for their safekeeping.

I understand that facilities exist within Homerton Hospital for me to deposit any item of personal property for safekeeping and I have been advised to do so.

I confirm that I have chosen not to make use of this facility.

As a result I acknowledge that property I have brought with me into Homerton Hospital remains entirely my own responsibility, and that Homerton University Hospital NHS Foundation Trust staff or its agents shall not be liable for any loss or damage, however caused.

Patient name:………………………………………………………

Hospital number:……………………………………………………

Patient signature:…………………………………………………

Date:………………………………………………………………

This section to be completed by staff:

I confirm that I have given the above patient a full explanation of the property safekeeping facilities within the Trust and that he/she has made an informed decision to retain their personal property.

Staff name:………………………………………………………

Staff role:…………………………… Ward / department:………………

Date:………………………………………………………………
Appendix 2

WARD SAFE CHECK FORM

- Ward safes are to be checked weekly to ensure that valuables are not retained for long periods.
- If there is a likelihood of valuables required to be held in safekeeping for more than 2 days then they should be transferred to the Cashiers Office.
- Any property found to be in relation to discharged or deceased patients should be transferred to the Cashiers Office without delay.
- Property retained for safekeeping that is not returned (e.g. unclaimed, forgotten or patient deceased) should be attempted to be returned and records of such attempts kept.

<table>
<thead>
<tr>
<th>Ward</th>
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</thead>
<tbody>
<tr>
<td>Date</td>
<td>Number of patients whose items are stored.</td>
<td>Can these be transferred to the cashier's office? Yes / No.</td>
<td>If yes has message been left for ward clerk?</td>
<td>Staff signature</td>
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</tbody>
</table>

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Appendix 3

Electronic Patient Record
Appendix 4

Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

<table>
<thead>
<tr>
<th>Policy/Service Name:</th>
<th>Secure Management of Patients’ Property</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Margaret Howat</td>
</tr>
<tr>
<td>Role:</td>
<td>Head of Patient Experience</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Corporate</td>
</tr>
<tr>
<td>Date</td>
<td>2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equalities Impact Assessment Question</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the attached policy/service fit into the trusts overall aims?</td>
<td></td>
<td></td>
<td>To ensure that Trust carries out its duty of care for patients which extends to keeping patient’s property safe</td>
</tr>
<tr>
<td>2. How will the policy/service be implemented?</td>
<td></td>
<td></td>
<td>This version is an update of an older version. Staff made aware through Team Brief, email and intranet</td>
</tr>
<tr>
<td>3. What outcomes are intended by implementing the policy/delivering the service?</td>
<td></td>
<td></td>
<td>To ensure that patients monies, valuables and property are kept securely, leading to a better experience of care for patients and limited or excluded liability for loss or damage of property for the Trust</td>
</tr>
<tr>
<td>4. How will the above outcomes be measured?</td>
<td></td>
<td></td>
<td>See monitoring section</td>
</tr>
<tr>
<td>5. Who are they key stakeholders in respect of this policy/service and how have they been involved?</td>
<td></td>
<td></td>
<td>All staff</td>
</tr>
<tr>
<td>6. Does this policy/service impact on other policies or services and is that impact understood?</td>
<td>X</td>
<td></td>
<td>Links to Safeguarding Vulnerable Adults Policy Mental Capacity Act and Deprivation of Liberties Policy (2013), and Procedures and Security Policy</td>
</tr>
<tr>
<td>7. Does this policy/service impact on other agencies and is that impact understood?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is there any data on the policy or service that will help inform the EqIA?</td>
<td>X</td>
<td></td>
<td>National Guidance refers to requirement to meet patients’ needs under Mental Capacity Act (2005)</td>
</tr>
<tr>
<td>9. Are there information gaps, and how will they be addressed/what additional information is required?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equalities Impact Assessment Question</td>
<td>Yes</td>
<td>No</td>
<td>Comment</td>
</tr>
<tr>
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</tr>
<tr>
<td>10. Does the policy or service development have an adverse impact on any particular group?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Where an adverse impact has been identified can changes be made to minimise it?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Is the policy directly or indirectly discriminatory, and can the latter be justified?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EQUALITIES IMPACT ASSESSMENT FOR POLICIES AND PROCEDURES**

1. If any of the questions are answered ‘yes’, then the proposed policy is likely to be relevant to the Trust’s responsibilities under the equalities duties. Please provide the ratifying Committee with information (the ‘form’) on why ‘yes’ answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of Workforce & Education to develop a more detailed assessment of the Policy’s impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

2. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.
### Appendix 5

**Policy Submission Form**

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

<table>
<thead>
<tr>
<th></th>
<th>Details of policy</th>
<th>Secure Management of Patients’ Property</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>1.1 Title of Policy:</strong></td>
<td><strong>Secure Management of Patients’ Property</strong></td>
</tr>
<tr>
<td></td>
<td><strong>1.2 Lead Executive Director</strong></td>
<td>Sheila Adam, Chief Nurse and Director of Governance</td>
</tr>
<tr>
<td></td>
<td><strong>1.3 Author/Title</strong></td>
<td>Margaret Howat, Head of Patient Experience</td>
</tr>
<tr>
<td></td>
<td><strong>1.4 Lead Sub Committee</strong></td>
<td>Audit Committee</td>
</tr>
<tr>
<td></td>
<td><strong>1.5 Reason for Policy</strong></td>
<td>To outline the roles and responsibilities for the secure management of patients’ property</td>
</tr>
<tr>
<td></td>
<td><strong>1.6 Who does policy affect?</strong></td>
<td>All staff and patients</td>
</tr>
<tr>
<td></td>
<td><strong>1.7 Are national guidelines/codes of practice incorporated?</strong></td>
<td>‘Guidance for NHS organisations on the secure management of patient’s property’</td>
</tr>
<tr>
<td></td>
<td><strong>1.8 Has an Equality Impact Assessment been carried out?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td><strong>2.1 Where was Policy information obtained from?</strong></td>
<td>Outdated policy, staff, national guidance</td>
</tr>
<tr>
<td>3.</td>
<td><strong>3.1 Is there a requirement for a new or revised management structure if the policy is implemented?</strong></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td><strong>3.2 If YES attach a copy to this form</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3.3 If NO explain why</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>4.</td>
<td><strong>4.1 Was there internal/external consultation?</strong></td>
<td>Internal</td>
</tr>
<tr>
<td></td>
<td><strong>4.2 List groups/Persons involved</strong></td>
<td>Chief Nurse and Director of Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Healthcare Compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Safeguarding Vulnerable Adults</td>
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<td></td>
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<td>Heads of Nursing and Midwifery</td>
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<td>Director of Estates, Facilities and Capital Projects</td>
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<td>Director of Finance</td>
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<tr>
<td></td>
<td></td>
<td>Senior and Lead Nurses and Midwives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heads of Departments</td>
</tr>
<tr>
<td>4.3</td>
<td>Have internal/external comments been duly considered?</td>
<td>Yes</td>
</tr>
<tr>
<td>4.4</td>
<td>Date approved by relevant Subcommittee</td>
<td>October 2013</td>
</tr>
<tr>
<td>4.5</td>
<td>Signature of Subcommittee chair</td>
<td></td>
</tr>
</tbody>
</table>

5 **Implementation**

| 5.1 | How and to whom will the policy be distributed? | Trust Internet available to all staff |
| 5.2 | If there are implementation requirements such as training please detail? | No |
| 5.3 | What is the cost of implementation and how will this be funded? | N/A |

6 **Monitoring**

| 6.1 | List the key performance indicators e.g. core standards | |
| 6.2 | How will this be monitored and/or audited? | As monitoring section |
| 6.3 | Frequency of monitoring/audit | As monitoring section |

Date policy approved by Trust Policy Group:  
29.10.13

Signature of Trust Board Group chair:  
[Signature]

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