The Regulation and Quality Improvement Authority

Monitoring of Article 116 of The Mental Health (Northern Ireland) Order 1986

2013/2014

national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

Table of Contents

1.0 Introduction

1.1 The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. The Mental Health & Learning Disability Team (MHLD) undertakes a range of responsibilities for people with mental ill health and those with a learning disability, in accordance with the Mental Health (Northern Ireland) Order, 1986 (MHO).

1.2 Monitoring of Patient Finances by RQIA in accordance with the Mental Health (Northern Ireland) Order, 1986

Article 116 of the MHO outlines specific expectations in relation to the trusts' handling of patients' property as follows:

(1) Subjects to paragraphs (4) and (5), where it appears to a trust that any patient in any hospital or in any accommodation administered by it under the Health and Social Services (Northern Ireland) Order 1972 is incapable, by reason of mental disorder, of managing and administering his property and affairs, the trust may receive and hold money and valuables on behalf of that patient.

(2) A receipt or discharge given by a trust for any such money or valuables shall be treated as a valid receipt.

(3) Where a trust holds money or valuables on behalf of a person in pursuance of paragraph (1), it may expend that money or dispose of those valuables for the benefit of that person and in the exercise of the powers conferred by this paragraph, the trust shall have regard to the sentimental value that any article may have for the patient, or would have but for his mental disorder.

(4) A trust shall not receive or hold under paragraph (1) on behalf of any one patient without the consent of the RQIA money or valuables exceeding in the aggregate such sum as the Department may from time to time determine.

(5) Paragraph (1) shall not apply where a controller has been appointed in Northern Ireland in relation to the property and affairs of the patient.

The MHO also defines a role for RQIA in relation to oversight of patients' property at Article 86 (2) (c) (iv) in "preventing or redressing loss or damage to [patients] property";

RQIA is required to monitor the arrangements put in place by trusts to safeguard patients' monies. Specifically under Article 116(4) of the MHO, trusts are not permitted to receive or hold balances in excess of an agreed sum without the consent of RQIA. This sum was set by the Department of Health, Social Services and Public Safety at no more than £20,000 for any single mental health or learning disability patient in September 2012.

1.3 Methodology used by RQIA to Monitor Compliance with Article 116

In the 2013/2014 inspection year, RQIA monitored compliance with Article 116 through a programme of financial inspections. Financial inspections were undertaken in 63 mental health and learning disability wards. The finance inspector sought to obtain assurances that trusts apply best practice in the management of patients' property and monies through:

- Compliance with DHSSPS Circular 57/2009 - Misappropriation of Residents' Monies – Implementation and Assurance of Controls in Statutory and Independent Homes. This applies to all Trust facilities including hospitals;
- Application of accounting policies as detailed in their Standing Financial Instructions (SFIs);
- Implementation of comprehensive local procedures; and,
- Application of Standard 15 of the Nursing Homes Minimum Standards (in so far as this can be applied to hospital patients).

The inspections involved the review of:

- Availability of appropriate written procedures for the Handling of Patients' Private Property and Cash;
- Staff access to and awareness of the procedures;
- Staff training in the application of the procedures;
- Review of processes relating to withdrawal of patient's monies;
- Review of patient property books;
- Review of cash record books; and,
- Patients' income and expenditure records.

The inspector met with the ward manager, deputy ward manager or nurse in charge on each ward to discuss the processes in place to safeguard patients' monies and property. A report of inspection findings and a Quality

Improvement Plan (QIP) detailing recommendations was issued to each Trust in March 2014. Individual Trust reports and QIPs are available at http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability/inspection_reports.cfm .

2.0 Summary of Inspection Findings

Table 1 - Number of recommendations made per trust

Trust	Number of wards inspected	% of inspections undertaken (n= 63)	Number of recommendations made	% of recommendations made (n=161)
Belfast	22	35%	39	24%
Northern	12	19%	41	25%
South Eastern	7	11%	15	9%
Southern	8	13%	18	11%
Western	14	22%	48	30%

Table 1 lists the number of wards inspected in each of the five trust areas, the percentage of the total number of inspections undertaken and the number of recommendations made. The number and overall percentage of wards inspected in the Belfast Health and Social Care Trust (BHSCT), South Eastern Health and Social Care Trust (SEHSCT) and Southern Health and Social Care Trust (SHSCT) areas appears to be proportionately reflected in the corresponding number and percentage of recommendations made for each respective Trust.

In the Western Health and Social Care Trust (WHSCT) area just over one fifth of inspections undertaken resulted in just under one third of the total number of recommendations made.

In the Northern Health and Social Care Trust (NHSCT) area just under one fifth of inspections undertaken resulted in just over a quarter of the total number of recommendations made.

In terms of the percentage of inspections undertaken, the number of recommendations made in the Western and Northern Trusts is proportionately higher than the number of recommendations made in the Belfast, South Eastern and Southern Trust areas. This is due to the concerns noted in a number of wards in both of these Trusts in relation to the lack of robust practices of recording, receipting, verification and reconciliation.

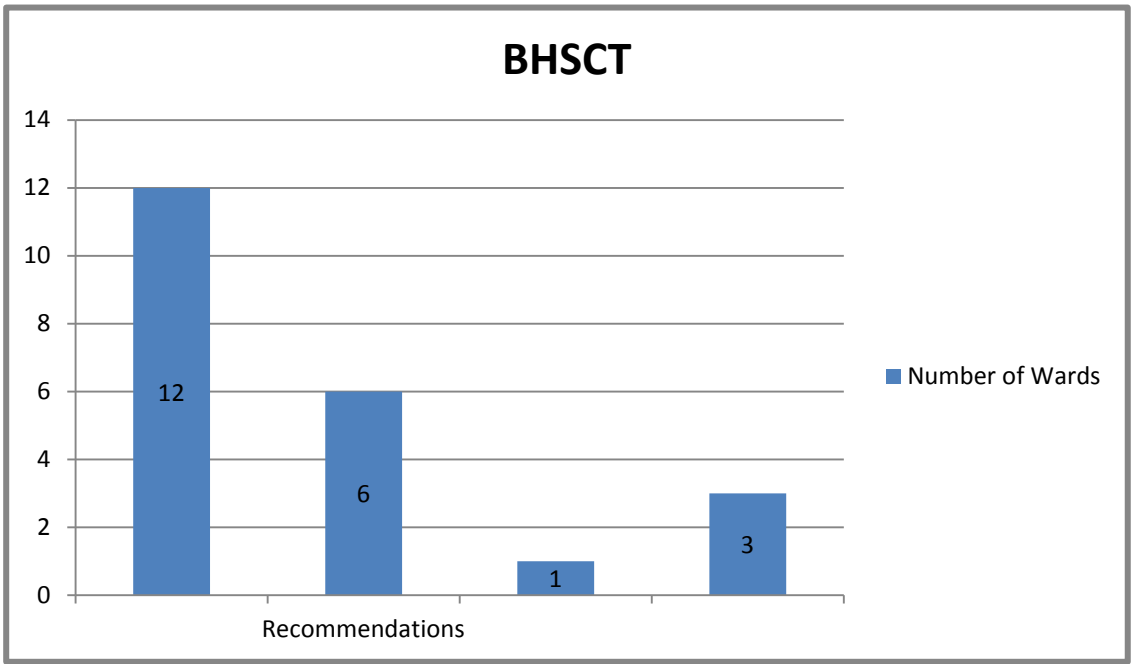
Table 2 - Number of recommendations made in specific programmes of care

Type	Number of wards inspected	% of inspections undertaken	Number of recommendations made
Mental Health	36	57%	91
Learning Disability	14	22%	37
Older People	13	21%	33

Table 2 reflects a proportionate distribution of the number of recommendations made corresponding to the percentage of inspections undertaken in across wards in the three relevant programmes of care; wards for people with mental ill health, wards for people with learning disabilty and wards for older people with mental ill health.

2.1 Belfast Health and Social Care Trust

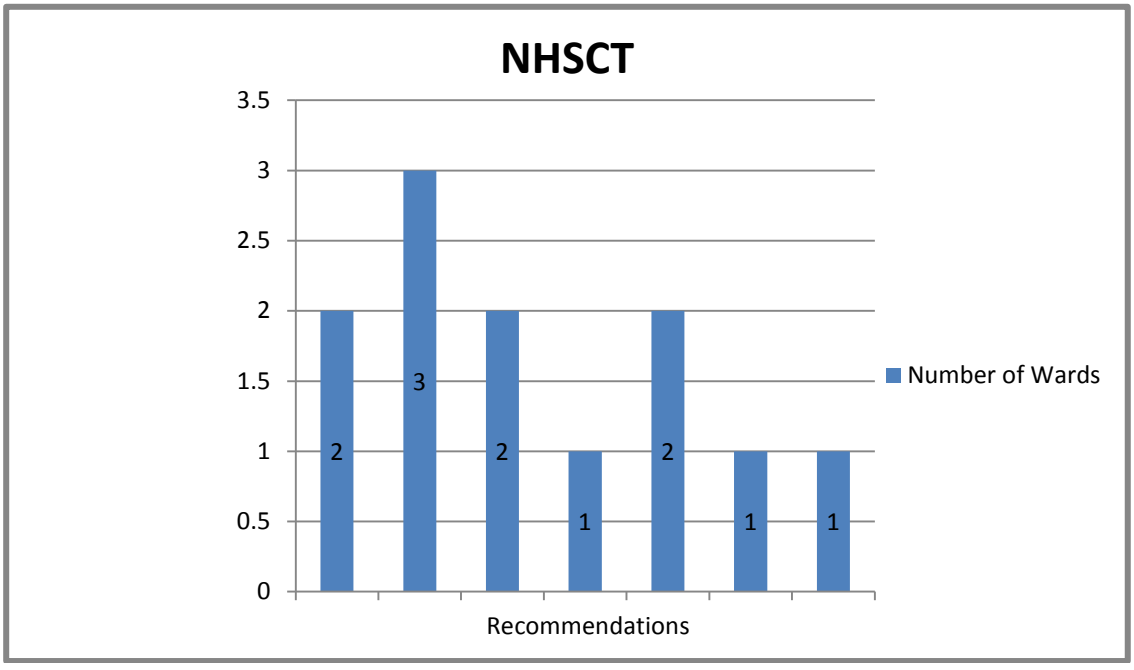
The inspector visited 22 wards across three hospital sites in the BHSCT. A total of 39 recommendations were made. There were examples of good practice noted in individual wards in relation to receipting and verification of purchases, and twice daily checking of safe contents.



There were no concerns noted in relation to discrepancies of balances of monies in patients' accounts. However, several concerns were noted in relation to staff implementation of policies and procedures and accuracy of record keeping, across all hospital sites. These included 24 recommendations across 21 wards in relation to ward processes for keeping patients' monies safe in terms of where monies are kept by staff on each ward. The recommendations also related to the management of risk in access to these monies. Five recommendations were made for four wards in relation to the updating of policies and procedures to guide and support staff practice. Other areas to be addressed included seven recommendations across three wards relating to the management of group expenditure and how this is equally and fairly managed for individual patients, and the charging arrangements for transport and therapeutic activities. The BHSCT is the only Trust where recommendations were made in relation to group expenditure and charging patients for items required for therapeutic and recreational activities.

2.2 Northern Health and Social Care Trust

The inspector visited 12 wards across two hospital sites in the NHSCT. A total of 41 recommendations were made for 10 wards. It was good to note that no recommendations were made following inspections of two wards. There were examples of good practice noted in individual wards in relation to accurate receipting of money and property, and lodging of money and valuables in the cash office.

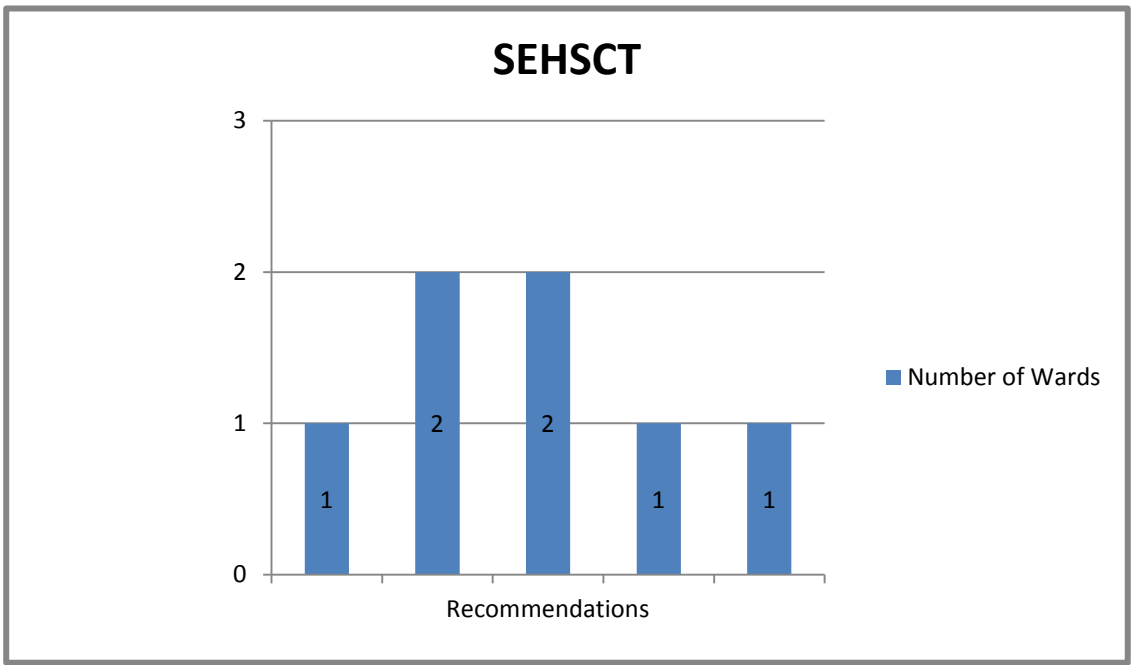


There were no concerns noted in relation to discrepancies of balances of monies in patients' accounts. Particular concerns were noted in relation to staff training and implementation of policies and procedures, and accuracy of record keeping, across both hospital sites. This resulted in 27 recommendations for nine wards, including recommendations in relation to

ward processes for keeping patients' monies safe in terms of where monies are kept by staff on each ward. These recommendations also related to receipting of transactions and the management of risk in access to patients' monies. Other areas to be addressed included review of the interface between the ward and the cash office, the access by numerous individuals to patients' accounts and the updating of policies, procedures and training, to guide and support staff practice.

2.3 South Eastern Health and Social Care Trust

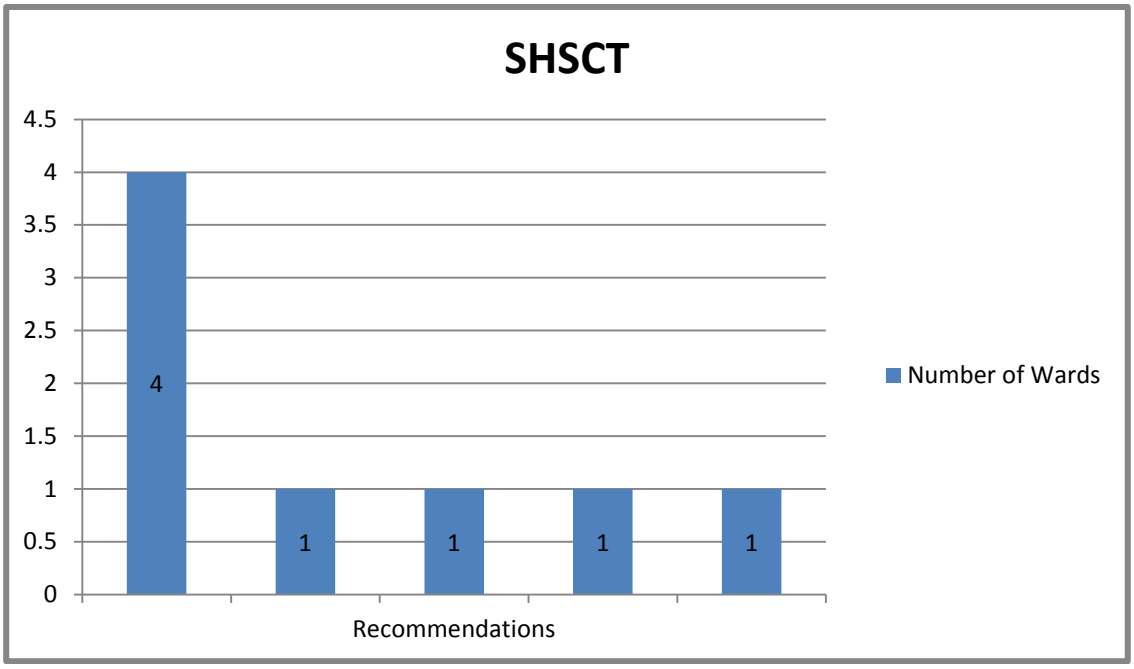
The inspector visited seven wards across four hospital sites in the SEHSCT. A total of 15 recommendations were made for six wards. It was good to note that no recommendations were made following inspections of one ward. There were no recommendations made for wards in the SEHSCT in relation to interfaces with the cash office, which was an area for recommendation for three of the five other trusts.



There were no concerns noted in relation to discrepancies of balances of monies in patients' accounts. However, concerns were noted in relation to staff implementation of policies and procedures and accuracy of record keeping, across three hospital sites. This included ward processes for keeping patients' monies safe in terms of where monies are kept by staff on each ward, receipting of transactions, resulting in seven recommendations in two wards. These recommendations also related to the management of risk in access to patients' monies resulting in four recommendations for four wards. Other areas to be addressed included the updating of policies, procedures and training, including approval and authorisation of expenditure for larger items, to guide and support staff practice.

2.4 Southern Health and Social Care Trust

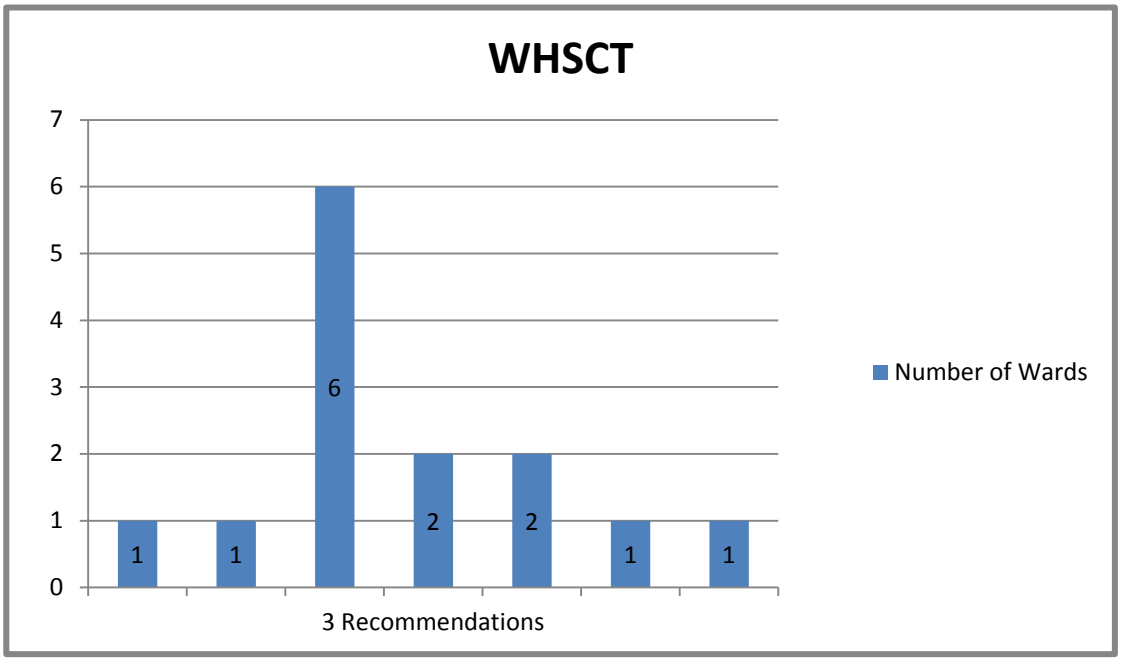
The inspector visited eight wards across three hospital sites in the SHSCT. A total of 18 recommendations were made for all wards. There were examples of good practice noted in individual wards in relation to completion of property books and receipting of monies left on the ward for individual patient expenditure and a robust discharge system in place whereby the patient had acknowledged the return of their money. There were no recommendations made for wards in the SHSCT in relation to interfaces with the cash office, which was an area for recommendation for three of the five other trusts.



There were no concerns noted in relation to discrepancies of balances of monies in patients' accounts. However, concerns were noted in relation to policies, procedures, guidance and training for staff. Additionally concerns were noted in relation to processes for keeping patients' monies safe in terms of where monies are kept by staff on wards, resulting in four recommendations for four wards. These recommendations also related to receipting of transactions and the management of risk in access to patients' monies, resulting in nine recommendations for six wards. Another area to be reviewed included the receipting of removal of items by relatives on admission.

2.5 Western Health and Social Care Trust

The inspector visited 14 wards across five hospital sites in the WHSCT. A total of 48 recommendations were made for 13 wards. It was good to note that no recommendations were made following the inspection of one ward. Some areas of robust processes consistent with best practice were also noted. There were examples of good practice noted in individual wards in relation to completion of property books and receipting of monies left on the ward for individual patient expenditure.



There were no concerns noted in relation to discrepancies of balances of monies in patients' accounts. However, there were individual wards where the lack of robust practices of recording, receipting, verification and reconciliation, and implementation of systems and processes presented a realistic risk of misappropriation of patients' monies. There were 20 recommendations made (42% of recommendations made for this trust area) in relation to systems and processes for 13 wards (93% of wards inspected in this trust area). The WHSCT is the only trust where recommendations were made in relation to systems and processes in this number. Review of policies, procedures, staff guidance and staff training also required to be addressed.

2.6 Common Themes

A number of common themes emerged across trust areas. Although these themes resulted in a number of recommendations made in three or more trust areas, the percentage of recommendations made were significantly higher for individual trusts in three of the commonly themed areas. These are as follows:

2.7 Keys, Safes and Associated Records

- Total number of recommendations made **48**
- Total number of Trust areas where recommendations were made **5**

Recommendations related to:

- access to keys and safes
- associated records for any person who obtains the keys.

There were 48 recommendations made for 43 wards (68%) across all trusts. This equates to 30% of the total number of recommendations made.

The highest number of recommendations in this area were made in the BHSCT where 50% of the total number of recommendations in relation to access to keys and safes and associated record keeping were made .
It should be noted that more wards were inspected in the BHSCT than other trust areas (35%),

2.7.1 Record Keeping Processes and Processes in relation to Receipting of Transactions

- Total number of recommendations made **43**
- Total number of Trust areas where recommendations were made **5**

Recommendations related to:

- review of record keeping processes and processes in relation to receipting of transactions between the ward and the patient, the ward and a relative and the ward and the cash office

There were 43 recommendations made for 24 wards across all trusts. This equates to 27% of the total number of recommendations made.

The highest number of recommendations were made in the NHSCT. This equates to 92% of wards inspected in the NHSCT and 40% of the total number of recommendations made in relation to record keeping processes and processes in relation to receipting of transactions.

Recommendations in relation to record keeping processes and processes in relation to receipting of transactions were made for 75% of wards in the SHSCT and 44% of wards in the WHSCT.

2.7.2 Interface with the Cash Office

- Total number of recommendations made **15**
- Total number of Trust areas where recommendations were made **3**

Recommendations related to:

- interfacing with the cash office
- ensuring that the cash office provided individual patient statements to facilitate verification of transactions.

There were 15 recommendations made for 12 wards across three trusts. This equates to 9% of the total number of recommendations made.

The hightest number of recommendations were made in the NHSCT; 11 recommendations were made, representing 73% of the total number of recommendatons in this area.

2.7.3 Implementation of/updating of Policy and Procedure

- Total number of recommendations made **15**
- Total number of Trust areas where recommendations were made **4**

Recommendations related to:

- implementation of/updating of policy and procedure for the management of patients' monies and property.

There were 15 recommendations made for 15 wards across four trusts. This equates to 9% of the total number of recommendations made.

The number of recommendations made were spread evenly across the Belfast, South Eastern, Southern and Western Health and Social Care Trusts.

2.7.4 Staff Training

- Total number of recommendations made **5**
- Total number of Trust areas where recommendations were made **4**

Recommendations related to:

- Staff training in the procedures governing the management of patients' monies and property.

Five recommendations were made. Although the number of recommendations made represents only 7% of the total number of recommendations made, these recommendations were made in four of the five trust areas, the exception being the NHSCT.

3.0 Conclusions from Inspection Findings

Inspection findings would indicate that patients' monies and property in the Mental Health and Learning Disability wards inspected had generally been managed appropriately and were being properly safeguarded. It was good to note some areas of robust processes consistent with best practice, and these practices are to be commended. However, in other wards the lack of robust practices of recording, receipting, verification and reconciliation presented a realistic risk of misappropriation of patients' monies. A number of control issues were identified and relevant recommendations have been made to address these issues in all trust areas. Trusts were advised that these recommendations should be implemented immediately to mitigate risks.

4.0 Next Steps

RQIA will evaluate the implementation of recommendations on individual wards as part of a planned programme of inspections in 2014/20105. RQIA will continue to monitor the management of patient finances as part of its statutory functions in accordance with the Mental Health (Northern Ireland)

Order 1986. This will include reviewing Trusts' Standing Financial Instructions, policies and procedures, and management of Trust held funds for individual patients' monies and valuables with balances greater than £20,000.

Appendix 1 Wards Inspected

Belfast Trust

No	Trusts	Hospital	Wards	Date of Visit
1	BHSCT	Mater Hospital	Ward J - Mater	30/12/2013
2	BHSCT	Mater Hospital	Ward K - Mater	30/12/2013
3	BHSCT	Mater Hospital	Ward L - Mater	30/12/2013
4	BHSCT	Knockbracken	Shannon Clinic Ward 1	30/12/2013
5	BHSCT	Knockbracken	Shannon Clinic Ward 3	30/12/2013
6	BHSCT	Knockbracken	Shannon Clinic Ward 2	30/12/2013
7	BHSCT	Knockbracken	Valencia	30/12/2013
8	BHSCT	Knockbracken	Clare Ward	30/12/2013
9	BHSCT	Knockbracken	Avoca Ward	30/12/2013
10	BHSCT	Knockbracken	Innisfree	30/12/2013
11	BHSCT	Knockbracken	Dorothy Gardiner	30/12/2013
12	BHSCT	Knockbracken	Rathlin	30/12/2013
13	BHSCT	Muckamore Abbey	Cranfield Female	31/12/2013
14	BHSCT	Muckamore Abbey	Cranfield ICU	31/12/2013
15	BHSCT	Muckamore Abbey	Killead	31/12/2013
16	BHSCT	Muckamore Abbey	Cranfield Male	31/12/2013
17	BHSCT	Muckamore Abbey	Six Mile	31/12/2013
18	BHSCT	Muckamore Abbey	Erne	31/12/2013
19	BHSCT	Muckamore Abbey	Moylena	31/12/2013
20	BHSCT	Muckamore Abbey	Greenan	31/12/2013
21	BHSCT	Muckamore Abbey	Donegore	31/12/2013
22	BHSCT	Muckamore Abbey	Oldstone	31/12/2013

Northern Trust

No	Trust	Hospital	Ward	Date of Visit
1	NHSCT	Holywell Hospital	Tobernaveen Centre	02/01/2014
2	NHSCT	Holywell Hospital	Tobernaveen Lower	02/01/2014
3	NHSCT	Holywell Hospital	Tobernaveen Upper	02/01/2014
4	NHSCT	Holywell Hospital	Carrick 1	02/01/2014
5	NHSCT	Holywell Hospital	Carrick 3	02/01/2014
6	NHSCT	Holywell Hospital	Carrick 4	02/01/2014
7	NHSCT	Holywell Hospital	Lissan 1	02/01/2014
8	NHSCT	Holywell Hospital	Tardree 1	02/01/2014
9	NHSCT	Holywell Hospital	Inver 1	02/01/2014
10	NHSCT	Holywell Hospital	Inver 3	02/01/2014
11	NHSCT	Holywell Hospital	Inver 4	02/01/2014
12	NHSCT	Causeway Hospital	Ross Thompson unit	08/02/2014

South Eastern Trust

No	Trust	Hospital	Ward	Date of Visit
1	SEHSCT	Ulster Hospital	Ward 27 - Ulster	03/01/2014
2	SEHSCT	Downshire Hospital	Ward 27 - Downshire	03/01/2014
3	SEHSCT	Downshire Hospital	Ward 28	03/01/2014
4	SEHSCT	Downe Hospital	Dementia Ward	03/01/2014
5	SEHSCT	Downe Hospital	Downe Acute	03/01/2014
6	SEHSCT	Lagan Valley Hospital	Ward 11	03/01/2014
7	SEHSCT	Lagan Valley Hospital	Ward 12	03/01/2014

Southern Trust

No	Trust	Hospital	Ward	Date of Visit
1	SHSCT	Craigavon Area	Silverwood	06/01/2014
2	SHSCT	Craigavon Area	Bronte	06/01/2014
3	SHSCT	Craigavon Area	Cloughmore	06/01/2014
4	SHSCT	Craigavon Area	Willow	06/01/2014
5	SHSCT	St. Luke's Hospital	Gillis Memory Centre	06/01/2014
6	SHSCT	St. Luke's Hospital	Haven Close	06/01/2014
7	SHSCT	St. Luke's Hospital	Ward 3	06/01/2014
8	SHSCT	Longstone	Longstone Assessment	06/01/2014

Western Trust

No	Trust	Hospital	Ward	Date of Visit
1	WHSCT	T&F	Beech	07/01/2014
2	WHSCT	T&F	Ash	07/01/2014
3	WHSCT	T&F	Oak A	07/01/2014
4	WHSCT	T&F	Oak B	07/01/2014
5	WHSCT	T&F	Lime	07/01/2014
6	WHSCT	T&F	Elm	07/01/2014

7	WHSCT	Gransha Hospital	Cedar Ward	08/01/2014
8	WHSCT	Grangewood Hospital	Evish -	08/01/2014
9	WHSCT	Grangewood Hospital	Carrick	08/01/2014
10	WHSCT	Lakeview Hospital	Strule Lodge	08/01/2014
11	WHSCT	Lakeview Hospital	Brooke Lodge	08/01/2014
12	WHSCT	Waterside Hospital	Ward 1	08/01/2014
13	WHSCT	Waterside Hospital	Ward 3	08/01/2014
14	WHSCT	Shantallow	Slievemore Nursing Unit	08/01/2014

HSC Public Health Agency

HSC Health and Social Care Board

REGIONAL GUIDELINES FOR THE SEARCH OF PATIENTS, THEIR BELONGINGS AND THE ENVIRONMENT OF CARE WITHIN ADULT MENTAL HEALTH/ LEARNING DISABILITY INPATIENT SETTINGS

February 2014

Improving your health and wellbeing

CONTENTS

15.0	**Appendices**	
	Appendix 1: Flowchart 1 – The Search Procedure for Patients	20
	Appendix 2: Flowchart 2 – Search with Patient's Informed Consent	21
	Appendix 3: Flowchart 3 – Search without Patient's Consent	22
	Appendix 4: Flowchart 4 – The Search Procedure for Visitors	23
	Appendix 5: Flowchart 5 – Search of Visitors	24
	Appendix 6: Pat Down Search Procedure	25
	Appendix 7: Pat down body search (Male)	27
	Appendix 8: Pat down body search (Female)	30

This guidance has been developed in a collaborative manner and sought to engage input from relevant stakeholders.

Contributors include:

- The five HSC Trust Mental Health Directorates;
- The Mental Health Service Users Groups within the five Trusts;
- The Bamford Monitoring Group (this group is made up of service users, carers and Patient Client and Council staff);
- Health & Social Care Board;
- Public Health Agency;
- BSO Legal Services.

An Equality and Human Rights Screening Assessment has been completed and the document updated on the basis of feedback received.

Full consideration has been given regarding the requirements of the Human Rights Act (1998) and the potential for ‘unjustifiable breaches’.

Staff responsible for implementation and practice under this guidance and any Trust policy and procedure developed as a result, must ensure that where searches are conducted that any action taken is reasonable and proportionate to the given circumstance in which it is conducted.

1.0 Introduction

1.1 Purpose of Guidelines

The overarching purpose of these guidelines is to ensure the safety and promote the protection of patients, staff and visitors by ensuring that dangerous items or hazardous substances are not brought into the in-patient setting, including illicit substances, prescribed / over the counter medications, dangerous items and alcohol or any other hazardous or potentially hazardous item or substance (hereafter these items will be referred to as 'dangerous items and/or hazardous substances').

The guidelines will support staff to complete searches where there is a clear concern around patient, staff or visitors' safety. Professional judgement will remain a key factor in any decisions made.

These guidelines apply equally to both Voluntary and Detained patients with the overarching premise focusing on safety.

It should be noted that searches of patients will only be carried out in **'exceptional'** circumstances in accordance with the guidelines noted within this document.

This document will be read in conjunction with the following Trust policies as applicable to individual Trusts:-

- Adverse Incident Policy;
- Promoting Quality Care Risk Assessment (PQC);
- Medicines Code;
- Prevention and Management of Aggression and Violence Policy;
- Therapeutic Engagement and Observation Policy;
- Substances in Inpatient Settings within Medium Security;

- Child Protection Regional Policy and Procedures;
- Mental Health Order NI (1986);
- Policy on admission/discharge;
- NMC code of professional conduct;
- Protection of Vulnerable Adults;
- Complaints policy; and;
- Restrictive Practices, DOLS Guidance.

(This list is not exclusive)

1.1.1. Within the Mental Health (NI) Order 1986 Code of Practice there is a requirement for managers of hospitals and nursing homes, admitting patients under the Order, to have a policy in place for searching patients and their belongings. Within the code of practice this is captured in the following way:-

"The purpose of these guidelines is to meet two objectives, which may at least in part, be in conflict. Firstly the creation and maintenance of a therapeutic environment in which treatment may safely take place; and secondly the maintenance of the security of the establishment and the safety of patients, staff and the general public.

The guidance may be extended to routine and random searching, but only in exceptional circumstances, for example, where the dangerous or violent criminal propensities of patients, creates a self-evident and pressing need for additional security."
(Mental Health (NI) Order 1986 Code of Practice

1.1.2. It is the priority of each Trust to provide a safe therapeutic environment, reduce the risk of injury (to patients, staff and visitors) and prevent untoward incidents caused by any use of illicit substances/alcohol or dangerous items; this is achieved through staff having access to clear guidance and support in

instances where action needs to be taken due to suspected or actual possession of dangerous items and/or harmful substances.

Patients and visitors should be made aware of any items that should not be brought into a unit. This information should be available in standard written format as well as accessible formats to accommodate those with low literacy, communication barriers or sensory disability. On entering the unit the patient should be asked if they are in possession of any of these items and if so, to hand them over to staff.

1.2 Definitions & types of searches undertaken

A search is any scrutiny of personal possessions or of an individual that exceeds the expected norms of any clinical environment. The expected norm is specific to the care group.

A personal search is a systematic mechanical (body scanner), visual or “pat-down” inspection of a patient which ordinarily takes place with consent, but may be undertaken in some instances without consent. A personal search takes place with outer clothing removed i.e. coats/jackets/jumpers/shoes/socks.

Where a body scanner is used an explanation will be given to the patient in relation to how the scanner works and the procedure followed.

A search of personal property is considered to be anything exceeding usual routine checks of property during the admission process or return of a patient to the ward.

A unit search is a systematic search of the environment, to seek out a missing object, potential stolen goods or hazardous or potentially hazardous items or substances that may jeopardise

individual safety or the integrity of the unit. Patient movement may be restricted during the search.

1.3 Scope of Guidelines

These guidelines will be implemented across all Trust Adult In-patient Mental Health and Learning Disability units, with the exception of Shannon Unit which has a specific Search Policy relevant to that service.

Particular deliberation should be given to patients who are unable to give informed consent.

The guidance applies to patients who are admitted for assessment and treatment either in a voluntarily capacity or detained under the Mental Health (NI) Order 1986.

Searching visitors is not usual practice. However, this policy may apply to a search of visitors who may be suspected of having brought harmful items into the clinical environment. On that basis they will be asked to consent to a search (see Section 3.10).

Secure and Forensic Services have a specific protocol; the protocol has the same purpose, definitions and principles however the scope of this protocol extends beyond this policy in order to meet clinical need. Ref: Protocol 2.15: For Searching Patients' Property for Dangerous items, Unsafe Items, Alcohol and Illicit Substance in Inpatient Settings within Medium Security (Shannon Unit BHSCT).

1.4 Principles

All patients have the right to receive care in a safe environment. However, some patients may bring items into the in-patient environment which may be harmful to themselves or others.

The decision to search a patient and / or their belongings is an unusual occurrence and can only take place if there are reasonable grounds to believe that a search is necessary. This must be discussed beforehand within the team and the reason for the decision clearly documented. The risk of compromising the patient's dignity must be balanced by the risks involved if no action is taken.

Before any search is undertaken full consideration must be given to issues relating to the patient's race, gender, sexual orientation, spiritual belief, disability and age to ensure as far as possible privacy, dignity and personal choice is protected. All risks should be considered prior to any search being carried out.

Indicators that might lead to the decision to undertake a search would include:

- A patient with a known **relevant** history of carrying and/or hiding an offensive item/harmful substance;
- A patient expressing the view that she/he intends to injure her/himself or another person with an implement;
- Information received from other patients, staff or visitors that the patient has a dangerous item in their possession;
- A patient who is acting in a threatening and unpredictable manner; and
- There is reason to believe that the patient is in possession of items that are potentially dangerous to their own health and safety or that of others – for example, drugs, alcohol or hazardous items.

(This list is not exhaustive)

2.0 Duties

2.1 Director of Mental Health/Learning Disability Responsibilities:

To ensure provision and distribution of comprehensive, up-to-date guidelines, reflecting best practice which is fit for purpose.

2.2 Mental Health/Learning Disability Services Manager Responsibilities:

To ensure a clear statement regarding searches is included in the Trust Operational Policy and that these guidelines are referenced therein.

To ensure the Operational Policy includes the requirement to alert the policy sponsor of any difficulties in implementing the policy.

To ensure the guidelines are consistently implemented across all inpatient units.

To work with the ward sister/ charge nurse in monitoring the frequency of the policy being put into action and compliance with Section 75 monitoring data, bearing in mind that any change in frequency of use may indicate either; a misinterpretation or misuse of the policy or a more serious service issue (i.e. increased number of hazardous items being introduced to the unit).

2.3 Ward Sister/Charge Nurse Responsibilities:

To ensure staff are consistent in their application of the guidance and clear about their individual responsibilities.

To ensure all nurses have the relevant up-to-date skills to implement the guidance as per Trust Continuing Professional Development Programme.

To inform the Mental Health/ Learning Disability Services Manager on each occasion the guidance is implemented and the outcome.

To ensure an Incident Report is completed when a search has been undertaken.

To ensure the appropriate recording and reporting is completed using correct documentation as required by the Regional Guidance and Trust Operational Policy.

2.4 Clinical Team Responsibilities:

To ensure adherence to appropriate policies and procedures throughout the decision making process.

When making the decision to search a patient their Primary/ Key nurse or nominated deputy should be consulted where practicable. In exceptional circumstances, where it is believed that speed is of the utmost importance the decision may be made by the nurse in charge. The search, its rationale and outcomes will be discussed with the clinical team as soon as is reasonably practicable.

To ensure a full explanation is given to the patient, and where appropriate carer, as to why the decision to conduct a search has been taken.

To nominate a clinician to ensure consistency and clarity for the patient and where appropriate carer.

To ensure the rationale for and detail of the outcome of a search is recorded in the clinical notes and that the patients care plan and other relevant documentation is updated as appropriate.

3.0 Procedure for Searching

3.1 Once a decision has been reached to search the patient, he/ she will be closely observed until the search can be conducted. Every stage of the rationale, decision making process, clinical discussions, consent seeking and actions or searches undertaken must be fully documented in the patient's notes.

NB: Appendices 1, 2 and 3 contain flowcharts to guide the searching procedure.

3.2 In **all** cases, the consent of a patient will be sought before a search is attempted and the patient will be informed of the rationale for the search.

Special consideration will be given to those under the age of 18 (see section 5.2) and those who do not have capacity to consent (see section 5). Consideration will always be given to communication pathways, for example where the person is deaf, or does not have English as a first language. Access to information regarding the right to patient advocacy services will be provided.

An open dialogue will be maintained with the patient and carer, (where carer is present). Once the clinical rationale is outlined the patient will be encouraged to surrender any potentially harmful items they are suspected to have. When an item or items are surrendered the decision to implement a search will be reviewed.

3.3 Consideration will be given to the team's capacity to safely manage the search. The requirement for PSNI involvement should only be considered in exceptional circumstances and needs to be negotiated with the PSNI in terms of whether the PSNI need to be involved to prevent harm to the patient or others or a breach of the peace from occurring.

3.4 If the patient consents then the specified search will be carried out with due regard for the privacy and dignity of the individual.

3.5 If the patient is assessed as being unable to give consent please refer to section 5.

3.6 If the patient refuses to consent, the decision to carry out the search must be communicated to Senior Line Management with a full rationale of the reason for the search.

3.7 Any search that must be carried out without consent must be conducted with the minimum force necessary; the intrusiveness of a personal search must be reasonable and proportionate in response to the reason for the search **(NICE 2005).** All nurses involved in a search must have the appropriate training.

3.8 In the case of a search of patient's belongings, the owner of the property will be encouraged to be present. In rare circumstances a clinical assessment may indicate that it is not safe for a patient to be present.

When a patient's belongings are being searched the following should be checked:

- Individual bags;
- Items in lockers; the inside, top and underneath of the locker itself;
- Wardrobes and all personal effects including towels, flannels and toiletries; and
- Bedding, including pillows, pillowcases and all surfaces and edgings of mattresses.

(This list is not exhaustive)

3.9 In the case of personal searches users should be asked to remove all their outer clothing (e.g. jacket, shoes and jumper). A visual inspection will then be completed. Following a visual inspection, a search wand may be used. A "pat-down" may be performed only if significant concern remains. Items of removed clothing should be examined, including all pockets (see Appendix 6, 7 and 8).

3.10 Searching of Visitors

All visitors should be made aware of items which they should not take into the unit and that they may be searched if there is any suspicion that they are carrying banned or potentially hazardous items. This information should be provided in accessible formats.

Visitors may be asked to agree to a search of their property/ belongings and/ or a personal or pat down search if there is reasonable suspicion that they are in possession of potentially harmful substances or items. This will also be the case where there have been previous episodes where they have attempted to bring banned or potentially hazardous substances/items onto the unit.

Searches of visitors should be conducted with dignity and in a private area.

Where a visitor declines a search, staff have no right to insist upon one. However, a visitor may be asked to leave the premises on the basis that there is sufficient concern in terms of risk and safety.

If a visitor refuses to have a search carried out, they may be refused entry to the unit at that point in time and also may be refused entry in the future.

If necessary the PSNI should be called.

An incident form should be completed.

4.0 Personnel permitted to undertake searches

4.1 If a search of the patient or their belongings is to take place then at least two members of staff will conduct it, one will be of the same gender as the patient and one will be a Registered Nurse (RN).

Every effort will be taken to ensure the religion, belief and personal preference of the patient is respected when conducting a search. This may influence who conducts the search with specific reference to gender and as far as practicable consideration will be given to the items of clothing to be removed in the context of traditional dress.

4.2 There may be some situations where additional help or police assistance will be required. Police officers may be asked to attend Trust premises to prevent a breach of the peace, ensure the safety of all involved and to take any necessary actions on the outcome of the search; this must be negotiated with the PSNI.

5.0 Capacity to consent

5.1 If it has been determined that a patient will be searched but they have been assessed as lacking capacity to give their consent, consultation with a responsible person, relative, or an Independent Advocate should take place prior to a search being conducted unless it is considered there is immediate risk or it is not reasonably practicable in the circumstances.

The **appropriate adult** should be available to support the individual during a search unless it is not reasonably practicable in the circumstances. Full consideration must be given to the person's rights at all times.

Details of the capacity assessment specific to the decision about a search should be recorded on the appropriate documentation.

5.2 Where a patient under the age of 18 years is being cared for on an Adult Unit and the need for a search arises, the local Trust policy in relation to searching children/ adolescents should be adhered to.

6.0 Outcomes of the search

6.1 In circumstances where illicit substances or dangerous items have been found, they should be sealed in a transparent bag, clearly labelled with the name of the item, when and where it was found, the date and time and by whom. The item should be stored safely, preferably in a locked cupboard, until it can be handed over to police. The police should be called, who will then take possession of the item. If illicit substances are found staff can refer to the Trusts respective Pharmacy Codes for guidance.

6.2 The outcomes of the search must be fully recorded in the patient's notes and where illegal items are found this should be signed and countersigned in the patient's notes by two members of staff.

7.0 Post-Incident Management

7.1 The searching of patients or their property will be regarded as an incident and reported as such using the Trust's incident reporting processes. A general review of the incident may require the involvement of the Trusts Risk Manager or Lead Officer responsible for reviewing untoward incidents.

7.2 A clinical review of the patient will always be undertaken at the earliest opportunity following the search and, if the outcome of the search has altered the patient's clinical management then the care plan will be revised to reflect this.

7.3 With or without consent, this procedure is intrusive and staff, patients and carers involved will need time to reflect on the process and may need to have access to appropriate debriefing. The debrief should enable the individual to talk about the experience with the aim to reduce the likelihood of stress and psychological trauma associated with the incident.

If the patient expresses concerns that they were not treated with dignity and respect, they should be informed of the complaints procedure.

8.0 Development, consultation & ratification

These guidelines have been reviewed and developed in consultation with all interested parties including Clinical Staff, Service Users, General and Senior Management, and take into account national guidance (NICE 2005). Legal input has been sought from BSO and the document updated as appropriate.

9.0 Equality and Human Rights Screening Assessment

An Equality and Human Rights screening assessment has been undertaken prior to the dissemination of the guidance to ensure that it is compliant with the Human Rights Act and has no recommendations in relation to any adverse impact upon any individuals or groups.
http://www.hscbusiness.hscni.net/services/2453.htm

10.0 Monitoring Compliance

Mental Health/ Learning Disability Service Managers will have the responsibility to measure, monitor and evaluate compliance with the policy and procedure including taking an overview of the volume and frequency of searches.

Monitoring will be undertaken each time the policy is invoked. The Mental Health Service Manager/ Learning Disability Manager will report directly to the Assistant Director of Mental Health any deviance from the policy and procedure and where appropriate make further recommendations.

The Mental Health/ Learning Disability Service Manager will report directly to the policy sponsor any need to amend the policy in light of changing service need.

Identification of trends will be part of the monitoring process; if differential patterns emerge this will be explored further.

11.0 Document Review

This document will be reviewed in April 2015.

12.0 Dissemination & Implementation of the Guidelines

The guidelines will be circulated electronically to all Directors of Mental Health, Mental Health/ Learning Disability Service Managers and will be discussed at the Mental Health/ Learning Disability Service Manager's meeting. The document will be available on the intranet for all staff and services.

For existing staff, implementation will take place at a local level, team by team. Training needs will vary between practitioners and will be assessed by the Ward Sister/ Charge Nurse on an individual basis. The policy will be part of the local induction for all registered and non-registered nursing staff joining any inpatient team. Training will include use of the Search Wand and should be incorporated within MAPA updates.

13.0 Document Control including archive Arrangements

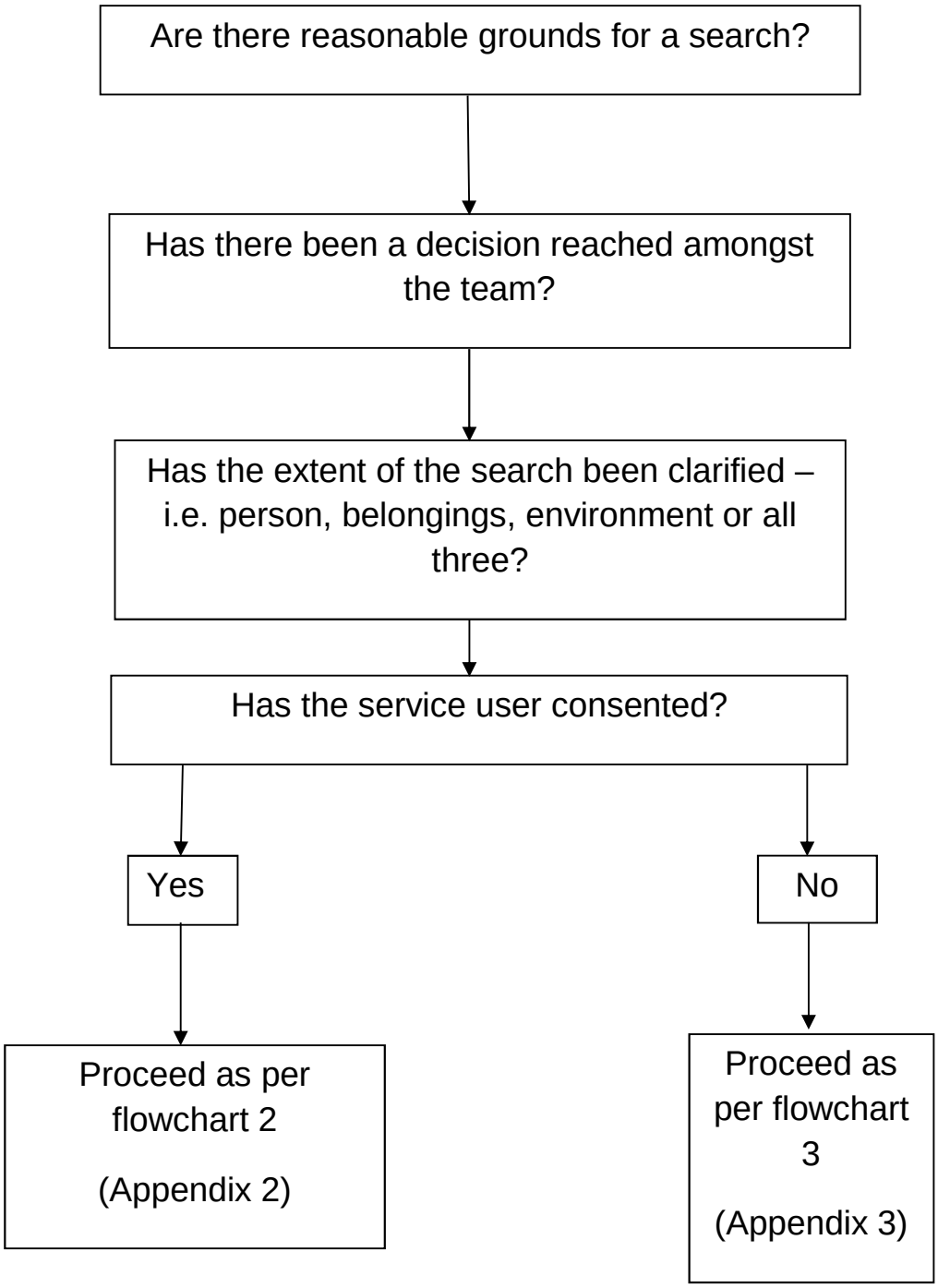
This document will be stored and archived in accordance with the Trust wide policy for the development and management of procedural documents.

14.0 Bibliography

- National Institute for Health and Clinical Excellence (2005) Violence - The short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments;
- DHSSPSNI Mental Health (NI) Order 1986 and the Orders - Code of Practice; and;
- Human Rights Act 1998.

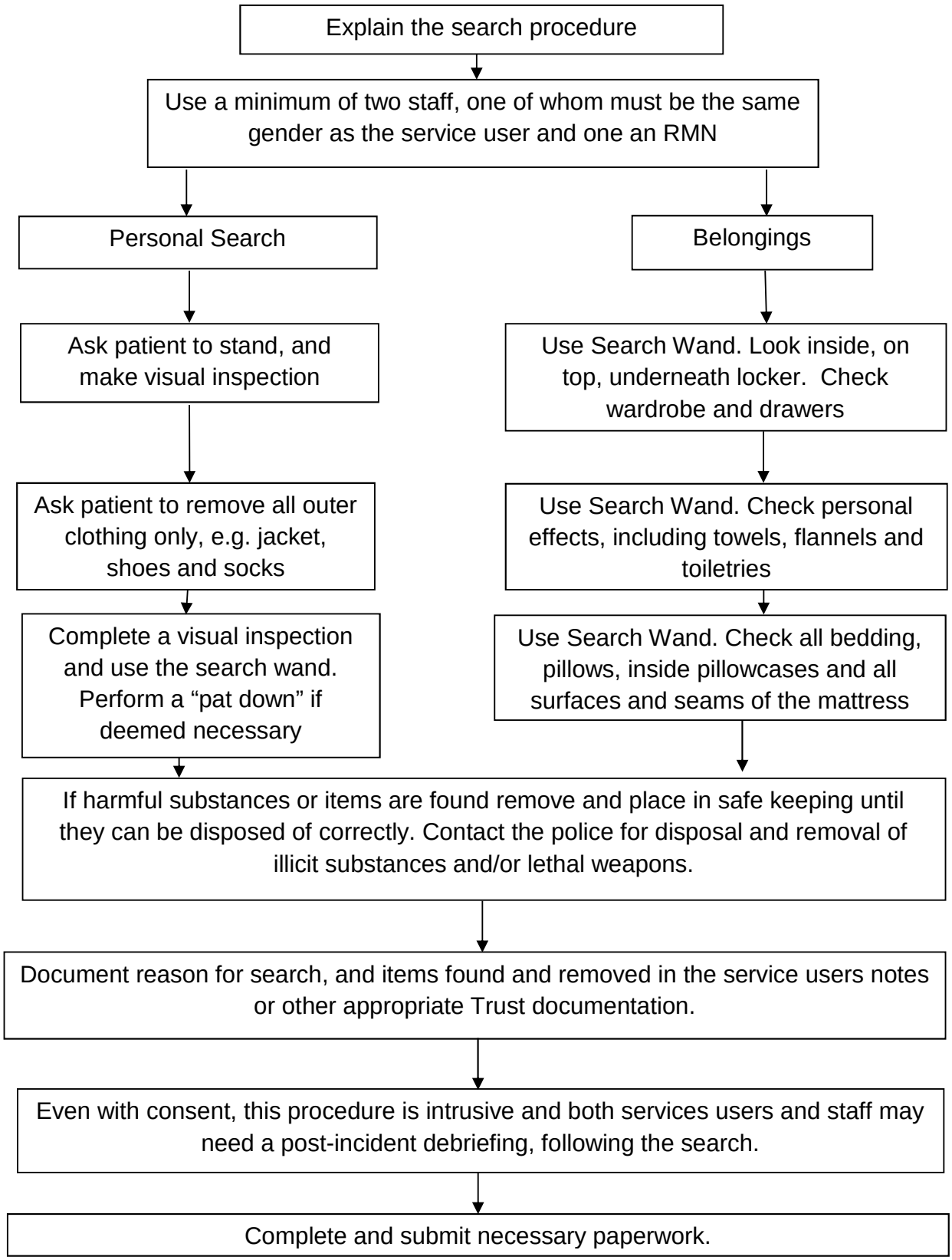
Appendix 1

FLOWCHART 1: THE SEARCH PROCEDURE FOR PATIENT'S



Appendix 2

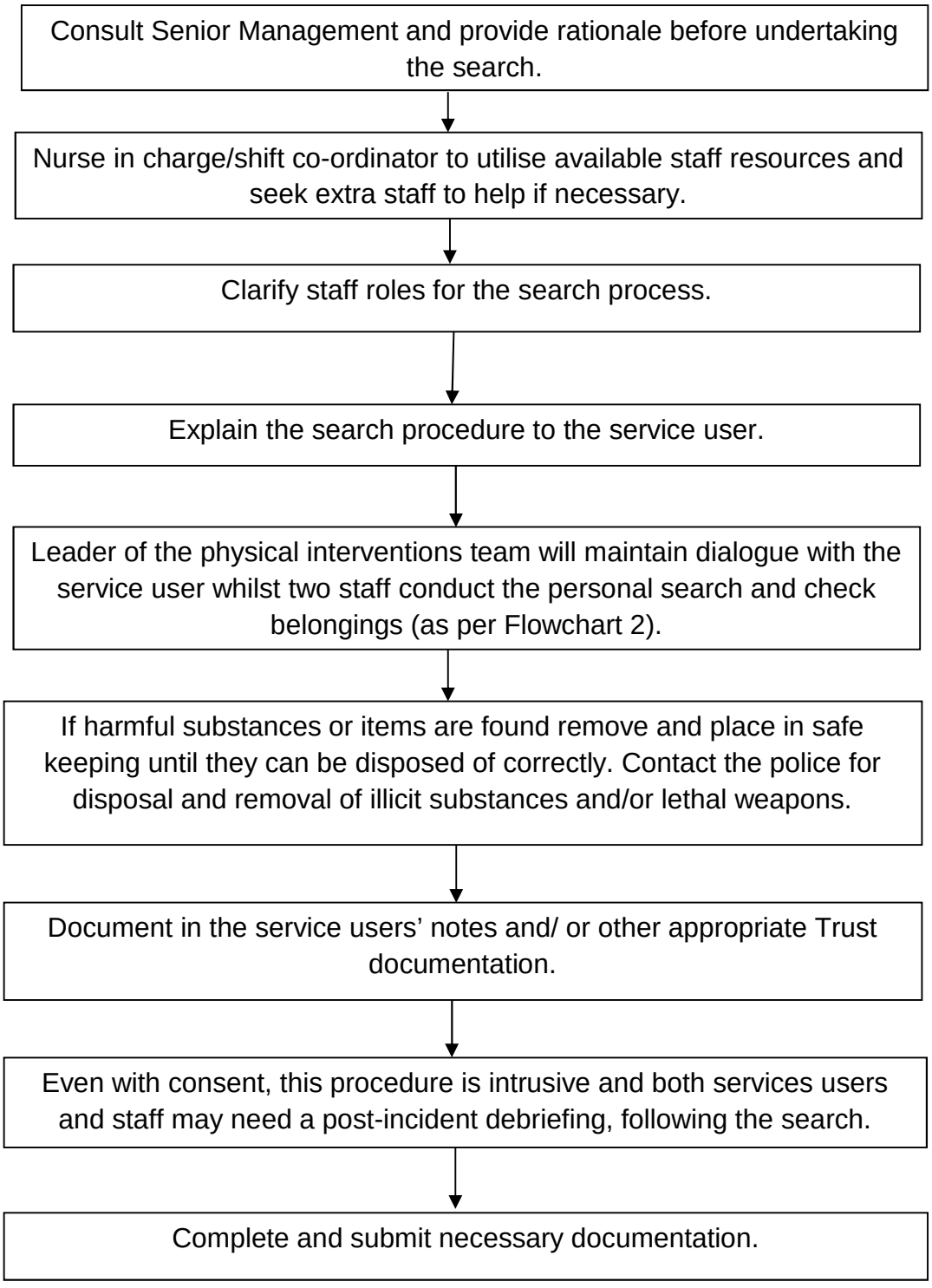
FLOWCHART 2: SEARCH WITH PATIENT'S INFORMED CONSENT



NB: This flowchart relates only to searching of patient's suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

Appendix 3

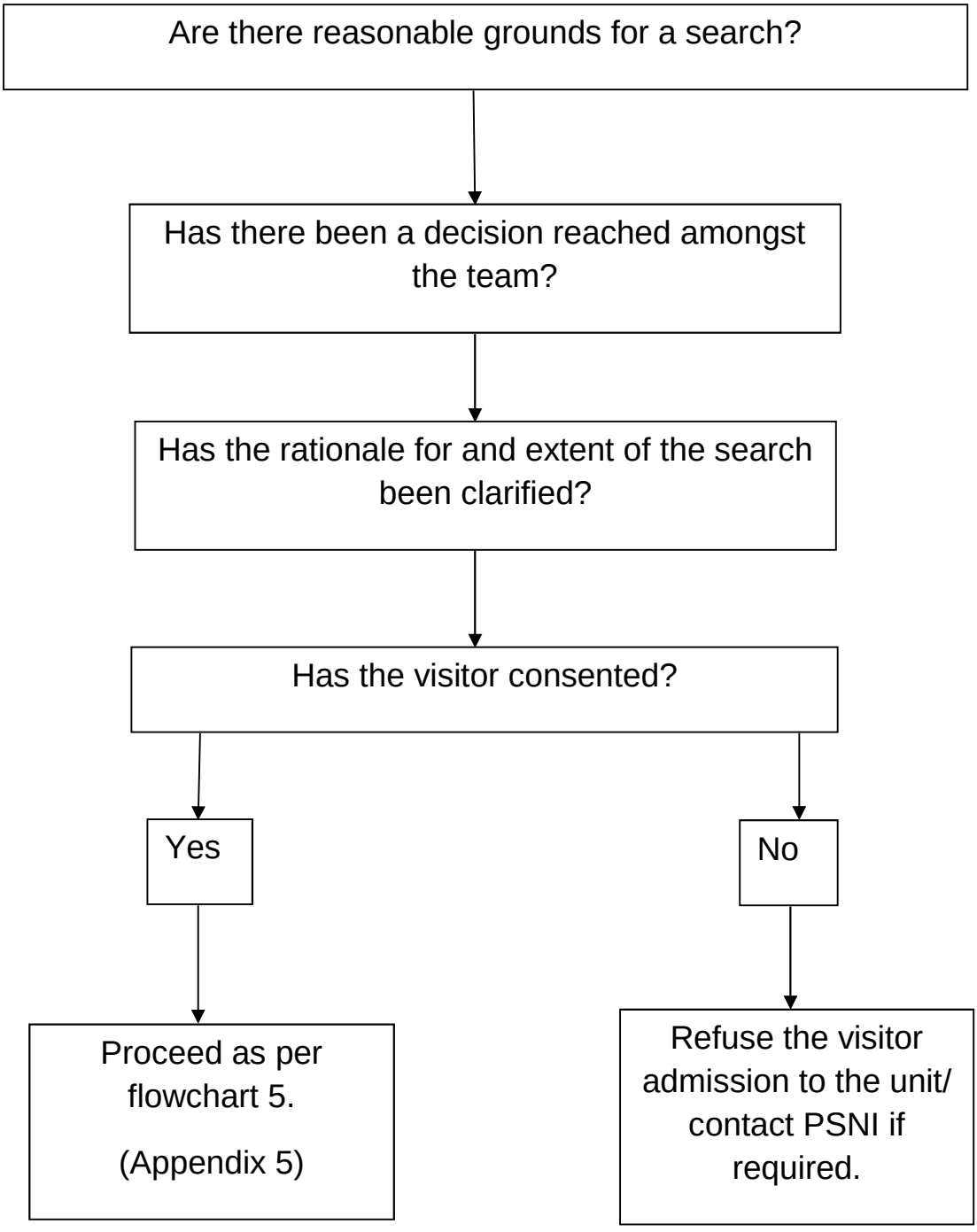
FLOWCHART 3: SEARCH WITHOUT THE PATIENT'S CONSENT



NB: This flowchart relates only to the searching of those patients suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

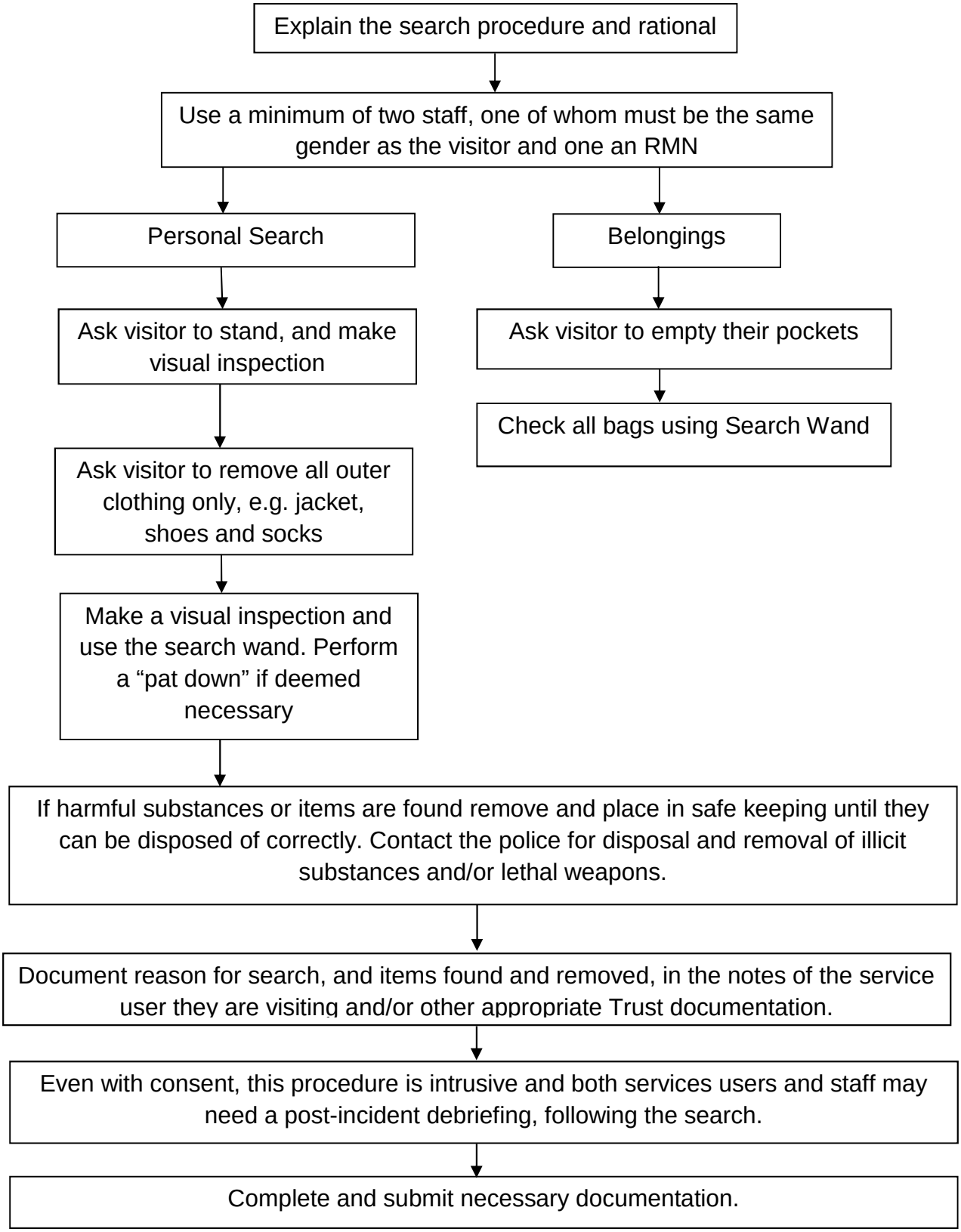
Appendix 4

FLOWCHART 4: THE SEARCH PROCEDURE FOR VISITORS



Appendix 5

FLOWCHART 5: SEARCH OF VISITORS



NB: This flowchart relates only to searching of visitors suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

Appendix 6

Pat Down Search Procedure

1. Searches should be carried out in an area where there is room to carry out the search effectively.
2. All searches of a patient's/visitor's person must be carried out by a staff member of the same sex in the presence of a witness from staff of the same sex.
3. Where a staff member of the same gender is not available the search will be carried out using a handheld metal detector with one staff member carrying out the search and the other acting as a witness.
4. Hand held metal detectors should be available in each clinical area.
5. Colleagues should be informed of what you are doing and where you are.
6. Searches should be carried out away from public sight, away from other patients/visitors if possible and with due regard for the dignity of the patient/visitor.
7. It is important to approach the person to be searched in a friendly and courteous way as some people are quite uncomfortable with the invasiveness of a pat down search and may need to be reassured. A very officious approach may be misconstrued as confrontational.
8. When searching be aware that you are physically very close to the person being searched and therefore vulnerable to attack. Try to minimise the area of your body presenting a target by maintaining a side on stance when possible.
9. Keep your head up and your arms in a position where they are ready to be raised in defence. Maintaining a defensive stance does not need to be obvious. The act of searching will require your arms to be raised and by positioning your body tactically throughout a search you can reduce the risk of injury to yourself in the event of an attack.
10. DO NOT PLACE YOUR HAND INSIDE POCKETS OR BAGS AS YOU SEARCH IN CASE OF NEEDLES OR OTHER SHARP ITEMS. Always ask the subject to remove items for inspection.

11. Any items removed should be recorded and the person informed of where they are being kept.

12. When the patient is discharged/visitor leaves, all confiscated property should be returned to the patient/visitor unless the police have been involved in removing the item, such as illicit substances.

Appendix 7

Pat down body search (Male)

1. Stand facing the subject.
2. Ask him if he is in possession of any banned items.
3. Ask him to empty all pockets. If he is wearing a coat or jacket, ask him to remove it after emptying any pockets.
4. If he is in possession of any bags ask him to place these to one side for searching after the pat down search.
5. Use Search Wand.
6. Search through items removed from pockets.
7. Placing the coat or jacket on a flat surface, run hands over the entire surface of the garment feeling for any lumps. This may indicate the presence of contraband. Check under the collar, sleeves and the lining of the jacket as well as the pockets.
8. If you discover a lump which could indicate concealed items, ask the subject to remove the item and place it with his other belongings so that you may identify it. DO NOT PUT YOUR HANDS INTO ANY POCKETS OR AREAS IF YOU CANNOT SEE WHAT IS IN THERE. DOING SO COULD RESULT IN A NEEDLE STICK INJURY OR SIMILAR.
9. Ask the subject to remove any headgear and pass to you for searching.
10. If his hair is long or thick ask him to run his fingers through his hair. Again, this is to prevent the risk of needle stick injury to you. Needles are sometimes hidden in the hair.
11. If the subject is wearing a tie ask him to remove it and search it using the same method as for a jacket.
12. Lift his collar and carry out a visual check before feeling around it.
13. Pat your hands over the top of the subject's shoulders.
14. Ask him to raise his arms level with his shoulders, keeping his arms straight, his fingers open and apart and his palms facing down. Step slightly to one side, and search that arm by running your hands along the upper and lower sides of the arm from shoulder to wrist. Check between the fingers and look at the palm and back of the hand.
15. Repeat for the other arm.

16. Pat down the front of the body from neck to waist including the front of the waistband. Check both sides of the body from armpit to waist including waistband.

17. Ask the subject to turn around so that his back is to you keeping his arms in the raised position.

18. Search his back from neck to waist including the waistband and the seat of his trousers.

19. Before searching the lower portion of the body assume a kneeling position, placing yourself side on to the subject with the forward knee on the floor and the furthest leg from the subject flexed and propping back thereby keeping a stable base. The process of searching will keep your arms in a raised position which could be used as a defensive posture should the need arise.

20. Check one leg from crotch to ankle including the inside of the leg, the back of the leg and the outside of the leg. When searching the outside of the leg the search is from the waist to the ankle.

21. Repeat for the other leg.

22. Stand up.

23. Ask the subject to turn and face you keeping the arms raised, palms down posture.

24. Check the abdominal area of the subject.

25. Use the same kneeling position and technique as before to search the front and sides of one leg.

26. Repeat for the other leg.

27. In the event that you feel or see anything to indicate hidden items during the search, ask the subject to remove the items for inspection.

28. If you suspect that something is hidden inside footwear, ask the subject to remove them for inspection. DO NOT PUSH YOUR HANDS INTO THE SHOE. Carry out a visual check of the sole and heel of the shoe, as these can be adapted to carry contraband. First tap the heel of the shoe against the floor as this may cause any contraband to drop out. Carry out a check of the shoe by feeling for lumps from the outside and looking inside the shoe.

29. Study the area around the subject for any items that may have been dropped before or during the search.

30. Ask the subject to step to one side to check that he is not standing on anything he has dropped before or during the search.

31. In cases where it is strongly believed that a patient may be hiding something harmful to their person or to others, but a pat down search has proven fruitless due to the restricted nature of the search, the Police should be contacted.

Appendix 8

Pat down body search (Female)

1. Stand facing the subject.
2. Ask her if she is in possession of any banned items.
3. Ask her to empty all pockets.
4. If she is wearing a coat or jacket, ask her to remove it after emptying any pockets.
5. Use Search Wand.
6. If she is in possession of any bags, ask her to place these to one side for searching after the pat down search.
7. Search through items removed from pockets.
8. Placing the coat or jacket on a flat surface, run hands over the entire surface of the garment feeling for any lumps, this may indicate the presence of contraband. Check under the collar, sleeves and the lining of the jacket as well as the pockets.
9. If you discover a lump which could indicate a concealed item, ask the subject to remove the item and place it with her other belongings so that you may identify it. DO NOT PUT YOUR HANDS INTO ANY POCKETS OR AREAS IF YOU CANNOT SEE WHAT IS IN THERE. DOING SO COULD RESULT IN A NEEDLE STICK INJURY OR SIMILAR.
10. Ask the subject to remove any headgear and pass to you for searching.
11. If her hair is long or thick ask her to run her fingers through her hair. Again, this is to prevent the risk of needle stick injury to you. Needles are sometimes hidden in the hair.
12. If the subject is wearing a tie or scarf ask her to remove it and search it using the same method as for a jacket.
13. Lift her collar and carry out a visual check before feeling around it.
14. Pat your hands over the top of the subject's shoulders.
15. Ask her to raise her arms level with her shoulders, keeping her arms straight, her fingers open and apart and her palms facing down. Step slightly to one side, and search that arm by running your hands along the upper and lower sides of the arm from shoulder to wrist. Check between the fingers and look at the palm and back of the hand.

16. Repeat for the other arm.
17. Using the back of the hand search from the neck to the top of the bra.
18. AT NO TIME TOUCH THE BREASTS.
19. Using the back of the hand search directly beneath the bra.
20. Using the flat of the hand search from beneath the bra down the front and sides of the body to and including the waistband.
21. Ask the subject to turn around so that her back is to you, keeping her arms in the raised position.
22. Search her back from neck to waist including the waistband and the seat of her trousers or skirt.
23. Before searching the lower portion of the body assume a kneeling position presenting yourself side on to the subject, with the forward knee on the floor and the furthest leg from the subject flexed and propping back thereby keeping a stable base. The process of searching will keep your arms in a raised position which could be used as a defensive posture should the need arise.
24. Check one leg from crotch to ankle including the inside of the leg, the back of the leg and the outside of the leg. When searching the outside of the leg the search is from the waist to the ankle.
25. If the subject is wearing a skirt the search must be carried out by running the hands down both sides of the leg from the outside of the skirt (this makes it very difficult to search the tops of the legs and it may be necessary to use the hand held metal detector).
26. Repeat for the other leg.
27. Stand up.
28. Ask the subject to turn and face you keeping the raised arms, palms down posture.
29. Check the abdominal area of the subject.
30. Use the same kneeling position and technique as before to search the front and sides of one leg.
31. Repeat for the other leg.
32. In the event that you feel or see anything to indicate a hidden item during the search, ask the subject to remove the item for inspection.

33. If necessary ask the subject to remove footwear and search shoes. DO NOT PUSH YOUR HANDS INTO THE SHOE. First, tap the heel of the shoe against the floor as this may cause any contraband to drop out. Carry out a check of the shoe by feeling for lumps from the outside and looking inside the shoe. If you suspect that something is hidden inside footwear ask the subject to remove it for inspection. Carry out a visual check of the sole and heel of the shoe as these can be adapted to carry contraband.

34. Study the area around the subject for any item the subject may have dropped before or during the search.

35. Ask the subject to step to one side to check that she is not standing on anything she has dropped before or during the search.

36. In cases where it is strongly believed that a patient may be hiding something harmful to their person or to others but a pat down search has proven fruitless due to the restricted nature of the search, the Police should be contacted.

The Regulation and Quality Improvement Authority

Monitoring of Patient Finances Under Article 116 of The Mental Health (Northern Ireland) Order 1986

2015-16

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Table of Contents

1.0 The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. The Mental Health and Learning Disability Team (MHLD) undertake a range of responsibilities for people with mental ill health and those with a learning disability, in accordance with the Mental Health (Northern Ireland) Order, 1986 (the Order).

1.1 Monitoring of Patient Finances by RQIA in accordance with the Mental Health (Northern Ireland) Order, 1986

Article 116 of the Order outlines specific expectations in relation to the trusts' handling of patients' property as follows:

(1) Subjects to paragraphs (4) and (5), where it appears to a trust that any patient in any hospital or in any accommodation administered by it under the Health and Social Services (Northern Ireland) Order 1972 is incapable, by reason of mental disorder, of managing and administering his property and affairs, the trust may receive and hold money and valuables on behalf of that patient.

(2) A receipt or discharge given by a trust for any such money or valuables shall be treated as a valid receipt.

(3) Where a trust holds money or valuables on behalf of a person in pursuance of paragraph (1), it may expend that money or dispose of those valuables for the benefit of that person and in the exercise of the powers conferred by this paragraph, the trust shall have regard to the sentimental value that any article may have for the patient, or would have but for his mental disorder.

(4) A trust shall not receive or hold under paragraph (1) on behalf of any one patient without the consent of the RQIA money or valuables exceeding in the aggregate such sum as the Department of Health may from time to time determine.

(5) Paragraph (1) shall not apply where a controller has been appointed in Northern Ireland in relation to the property and affairs of the patient.

The Order also defines a role for RQIA in relation to oversight of patients' property at Article 86 (2) (c) (iv) in preventing or redressing loss or damage to [patients] property;

RQIA is required to monitor the arrangements put in place by trusts to safeguard patients' monies. Specifically under Article 116(4) of the Order, trusts are not permitted to receive or hold balances in excess of an agreed sum without the consent of RQIA. This sum was set by the Department of Health, in September 2012, at no more than £20,000 for any single mental health or learning disability patient.

1.2 Methodology used by RQIA in 2015-16 to Monitor Compliance with Article 116

In the 2015-16 inspection year, RQIA monitored compliance with Article 116 by requesting and receiving quarterly returns from all five HSC trusts containing information regarding patients' finances. The MHLD team also requested and received up to date policies, procedures and Standing Financial Instructions (SFIs) from each trust. This information was reviewed by a designated MHLD inspector. Advice was sought from a finance inspector to obtain assurances that trusts apply best practice in the management of patients' property and monies through:

- Compliance with DHSSPS Circular 57/2009 - Misappropriation of Residents' Monies – Implementation and Assurance of Controls in Statutory and Independent Homes. This applies to all trust facilities including hospitals;

- Application of accounting policies as detailed in their SFIs; and;

- Implementation of comprehensive local procedures.

2.0 Follow up on Inspection Findings 2015-16

The MHLD team followed up on progress in relation to recommendations made during the financial inspections of 63 MHLD wards in 2013/14. During inspection visits each of the wards compliance was reviewed against recommendations that had been previously evidenced to be 'partially met' or 'not met'.

2.1 Belfast Health and Social Care Trust (BHSCT)

In 2013-14 financial inspections were undertaken on 22 wards across three hospital sites in the BHSCT. A total of 39 recommendations were made.

During follow up inspections in 2014-15 inspectors evidenced 33 recommendations to have been 'met' and three recommendations to have been 'not met'. Recommendations made for the two wards that had closed since the last finance inspection were not reviewed.

The three recommendations that were 'not met' were reviewed again during unannounced inspections in 2015-16; and were evidenced to been have 'met'. See Appendix 2.

The BHSCT reported holding finances over £20,000 on behalf of 24 patients in quarter 1 (01 April 15 – 30 June 15), 23 patients in quarter 2 (01 July 15 – 30 September 15) and quarter 3 (01 October 15 – 31 December 15) and 21 patients in quarter 4 (01 January 16 – 31 March 16). In all cases a controller was not appointed. RQIA will continue to monitor the BHSCT's quarterly returns in the 2016-17 inspection year, and were necessary give consent to the trust to hold pateints monies, or make recommendation that the trust make a referral to the Office of Care and Protection were these amounts continue to be over the agreed sum of £20,000.

2.2 Northern Health and Social Care Trust (NHSCT)

In 2013-14 financial inspections were undertaken on 12 wards across two hospital sites in the NHSCT. A total of 41 recommendations were made for 10 wards.

During follow up inspections in 2014-15 inspectors evidence 26 recommendations to have been 'met', 12 to have been 'not met' and two recommendations to be 'no longer applicable' (see Appendix 1). Recommendations made for the two wards that had closed since the last finance inspection in 2013-14 were not reviewed.

The 12 recommendations that were 'not met' were reviewed again during unannounced inspections in 2015-16, and were evidenced to have been 'met'. See Appendix 3.

The NHSCT reported holding finances over the agreed sum of £20,000 on behalf of five patients throughout the year. In quarter 1 (01 April 15 – 30 June 15) and quarter 2 (01 July 15 – 30 September 15) four patients had a controller appointed. In quarter 3 (01 October 15 – 31 December 15) and quarter 4 (01 January 16 - 31 March 16) all five patients had a controller appointed. In these cases consent was not required from RQIA. Monitoring of the NHSCT's quarterly returns will continue by RQIA in the 2016-17 inspection year.

2.3 South Eastern Health and Social Care Trust (SEHSCT)

In 2013-14 financial inspections were undertaken on seven wards across four hospital sites. A total of 15 recommendations were made for six wards.

During follow up inspections in 2014-15 inspectors evidenced all 15 recommendations to have been 'met'. As a result there were no recommendations requiring further follow up during unannounced inspections in the SEHSCT wards during the 2015-16 inspection year.

The SEHSCT reported holding finances over the agreed sum of £20,000 on behalf of five patients throughout the year. In all cases a controller was not appointed. RQIA will continue to monitor the SEHSCT's quarterly returns in the 2016-17 inspection year, and were necessary give consent to the trust to hold pateints monies, or make recommendation that the trust make a referral

to the Office of Care and Protection were these amounts continue to be over the agreed sum of £20,000.

2.4 Southern Health and Social Care Trust (SHSCT)

In 2013-14 financial inspections were undertaken on eight wards across three hospital sites in the Southern Trust. A total of 18 recommendations were made across all eight wards.

During follow up inspections in 2014-15 inspectors evidenced 12 recommendations to have been 'met', two recommendations to have been 'partially met' and three recommendations to have been 'not met'. Recommendations made for the three wards that had closed since the last finance inspection in 2013-14 were not reviewed.

The two recommendations that were 'partially met' and the three recommendations that were 'not met' where reviewed again during unannounced inspections in 2015-16 and were all evidenced to have been 'met'. See Appendix 4.

The SHSCT reported holding finances over £20,000 on behalf of two patients in quarter 1 (01 April 15 – 30 June 15), no patients in quarter 2 (01 July 15 – 31 September, one patient in quarter 3 (01 October 15 – 31 December 15) and 15) and no patients in quarter 4 (01 January 16 – 31 March 16). RQIA will continue to monitor the SHSCT's quarterly returns in the 2016-17 inspection year.

2.5 Western Health and Social Care Trust (WHSCT)

In 2013-14 financial inspections were undertaken on14 wards across five hospital sites in the WHSCT. A total of 48 recommendations were made for 13 wards.

During follow up inspections in 2014-15 inspectors evidenced 30 recommendations to have been 'met', 11 recommendations to have been 'not met' and one recommendation to be 'no longer applicable' (see Appendix 1). Recommendations made for the two wards that had closed since the last finance inspection in 2013-14 were not reviewed.

The 11 recommendations that were 'not met' were reviewed again during unannounced inspections in 2015-16. Inspectors evidenced 10 of the recommendations to have been 'met'. One recommendation relating to procedure for authorisation of larger purchases was evidenced to have been 'partially met' and will be followed up during an unannounced inspection in the 2016-17 inspection year. See Appendix 5.

The WHSCT reported that they held finances over £20,000 on behalf of two patients in quarters 1 – 3 (01 April – 31 December) and one patient in quarter 4 (01 January – 31 March). In all cases a controller was not appointed. RQIA will continue to monitor the WHSCT's quarterly returns in the 2016-17

inspection year, and were necessary give consent to the trust to hold pateints monies, or make recommendation that the trust make a referral to the Office of Care and Protection were these amounts continue to be over the agreed sum of £20,000.

3.0 Conclusions from Inspection Findings

Findings from the follow up inspections would indicate that patients' monies and property in the mental health and learning disability wards inspected by RQIA had been properly safeguarded. One recommendation remains 'partially met' and will be followed up again during the 2016-17 inspection year.

4.0 Next Steps

This report will be shared with the Director of Finance for each of the five HSC trusts.

RQIA will continue to monitor the management of patient finances as part of its statutory functions in accordance with the Mental Health (Northern Ireland) Order 1986. This will include continuing to review;

- trusts' SFI's, policies and procedures on an annual basis,
- the management of quarterly returns and action plans detailing the trust held funds for individual patients' monies and valuables with balances greater than £20,000,
- the arrangements put in place by trusts to safeguard patients' monies where a referral to the Office of Care and Protection has not been deemed appropriate, and;
- where a controller has not been appointed.

An annual report will be compiled by 30 June 2017. This will be published annually by the responsible MHLD inspector to include details of the total number of persons and amount of monies managed by each of the five HSC trusts. Details of any action taken by RQIA and the HSC trusts to safeguard patients' monies under Article 116(4) of the Order will be contained in this report.

Appendix 1 – Recommendations Evidenced to be 'No Longer Applicable' During the 2014-15 Inspection Year

Inspection	Recommendation	Action Taken	Compliance
Tobernaveen Centre, Holywell Hospital, 29 & 30 January 2015	It is recommended that the ward manager ensures that a system to verify clothes and other items purchased for patients are checked by ward staff against the receipt, confirmed as received by the patient and receipts retained.	This practice no longer takes place on the ward as the function of the ward has changed to patients being admitted who are over 65 and have a mental health problem. The ward manager informed the inspector that these patients predominantly ask their relatives/carers to purchase items for them. However the ward manager advised that if patients did want to purchase clothes or any other items they would set up a record book to check purchases against receipts and ask patients to sign that they have received the items and they would retained the receipt.	**No Longer Applicable**
Inver 4, Holywell Hospital, 22 June 2015	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the safe where patients' money is temporarily stored including the reason for access.	The inspector was informed by the ward sister that patients' money is held in hospital accounts. There was no patient money held on the ward.	**No Longer Applicable**
Beech, Tyrone and Fermanagh Hospital, 25 February 2015	It is recommended that the Trust develops and implements a policy and procedure in relation to group purchases.	There was no evidence that the practice of group purchasing is ongoing and as a result the policy has not been developed.	**No Longer Applicable**

Appendix 2 Belfast HSC Trust Finance Recommendations Reviewed During the 2015-16 Inspection Year

Inspection	Recommendation	Action Taken	Compliance
Innishfree (NRU), Knockbracken, 07 July 2015	It is recommended that the ward manager ensures that regular individual patient statements are received from the cash office at the ward to facilitate reconciliation of expenditure and receipts	The inspector reviewed a sample of the cash statements received by the ward manager for all patients. These are crossed referenced with the ward records for any discrepancies.	**Met**
Moylena, Muckamore Abbey, 20 & 21 June 2015	It is recommended that the ward manager ensures that a record of staff who access the key to the Bisley drawer, and the reason for access, is maintained.	Inspectors reviewed the records in relation to patient finances and noted that a record of staff who had access to the key to the Bisley drawer and the reason for access was maintained	**Met**
Ward L, Mater Hospital, 06 August 2014	It is recommended that the Trust introduce a uniform policy for managing patients' finances across all wards.	The Trust's *'Patients' Finances and Private Property-Policy for Inpatients within Mental Health and Learning Disability Hospitals'* was up to date and had been implemented in September 2014. A copy of the policy was available in the ward's main office and on the Trust's intranet. A staff declaration sheet evidenced that staff had read and understood the procedures concerning the management of patient's private property.	**Met**

Appendix 3 Southern HSC Trust Finance Recommendations Reviewed During the 2015-16 Inspection Year

Inspection	Recommendation	Action Taken	Compliance
Cloughmore, Craigavon Area Hospital, 23 April 2015	It is recommended that the ward manager ensures that all items brought into the ward on admission are listed appropriately, the area of their storage or transfer recorded, and appropriate receipting undertaken, particularly when relatives remove items from the ward.	The inspector reviewed the patients property book. The patient signature indicated that the patient agreed and understood that 'items in their possession remain their responsibility'. On admission a record of the patient's property is recorded; records reviewed evidenced that this was signed by two staff and retained in the individual patient's file.	**Met**
	It is recommended that the Trust develops and implements a uniform policy for managing patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safes.	The inspector was advised by the ward manager and patient flow and bed management coordinator that the uniform policy had not been created. The inspector was advised that this recommendation is currently being managed by the Trust's finance department. The inspector was advised that there was no draft policy available but that the policy will be made available from 31 May 2015.	**Not Met (See below for follow up)**
Cloughmore, Craigavon Area Hospital, 14 September 2015	It is recommended that the Trust develops and implements a uniform policy for managing patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safes.	The inspectors reviewed the trust's policy and procedure for managing patients' private property which was issued in May 2015. This policy included the management of patients' finances within the Bluestone Unit, including managing and securing patients' property held in the ward safe.	**Met**

		Cloughmore does not currently have a safe on the ward.	
Silverwood, Craigavon Area Hospital, 27 August 2015	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit.	The inspectors reviewed the policy and procedure for managing patients' private property this was issued in May 2015.	**Met**
Willow, Craigavon Area Hospital, 29 July 2015	It is recommended that the Trust develops and implements a uniform policy for managing patient's finances within the Bluestone Unit.	The ward manager stated that patients' money is not retained on the ward. A procedure was in place to direct staff on what to do when a patient is admitted with a large sum of money or valuable items. The inspectors reviewed the policy and procedure for managing patients' private property issued in May 2015.	**Met**
	It is recommended that the ward manager ensures that all staff attend relevant training in policies and procedures for management of patient's finances.	The ward manager stated that staff had not received formal training in the management of patients' finances. However, the policy was circulated to staff for comments before it was issued in May 2015. The policy and procedure for managing patients' private property was available for staff on the ward.	**Met**

Appendix 4 Northern HSC Trust Finance Recommendations Reviewed During the 2015-16 Inspection Year

Inspection	Recommendation	Action Taken	Compliance
Carrick 4, Holywell Hospital, 08 & 15 May 2015	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	The inspector reviewed the training matrix for the ward and noted that 6 (23%) of the 26 staff currently working on the ward had no record of having attended this training. The inspector was informed that there were currently no further dates available for staff to attend.	**Not met (See inspection dated 19-25 November 15 for follow up)**
	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct	The Deputy Ward Manager advised the inspector that this practice was still not in place for any of the patients. A copy of the statements were obtained from the cash office by the Deputy Ward Manager by the end of the inspection, however these had not been cross referenced to the ward records of patients' finances.	**Not met (See inspection dated 19-25 November 15 for follow up)**
	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	The inspector reviewed the patients' account/safe register audit sheets for all patients and noted that weekly checks were not being completed. In the case of three of the 15 patients on the ward there had been no review of their records since February 2015. The deputy ward manager confirmed that these were the only checks currently undertaken. The ward manager confirmed that they had not been completing weekly checks of all patients' records.	**Not met (See inspection dated 19-25 November 15 for follow up)**

Carrick 4, Holywell Hospital, 19-23 November 2015	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	Inspectors reviewed the training records and noted that all staff had attended up to date training on the management of patient's monies and valuables.	**Met**
	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct	Inspectors reviewed documentation in relation to patient's monies and noted that a copy of each patient's statement was received from the cash offices every month and retained in each patient's financial file. Inspectors also noted that the Ward Manager completes and documents a weekly safe audit and verifies that transactions were correct.	**Met**
	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	Inspectors reviewed documentation in relation to the patient's monies. An audit was completed every week of the amount of money held for each patient in the safe against the cash ledger.	**Met**
Inver 4, Holywell Hospital, 22 June 2015	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	The inspector reviewed a sample of the statements received from the cash office and could confirm that these are audited monthly by the ward manager. A receipt is returned to the cash office to confirm that the statements have been checked and are correct.	**Met**
Lissan 1, Holywell Hospital, 21 May 2015	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	The inspector reviewed a copy of the staff training records and was pleased to note that 19 of the 20 staff currently working on the ward had completed this training.	**Met**
Ross Thompson Unit, Causeway Hospital 23 July 2015	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded.	The ward's patient property book evidenced that all valuable items brought into the ward by the patient were recorded. In circumstances where a relative removed	**Met**

	Record of receipt by the relative should be obtained.	items this was discussed with the patient, the relative and the multi-disciplinary team (as required). The removal of items registered in the patient property book was recorded. The inspector noted posters displayed on the wall opposite the ward's main entrance advising patients, relatives and visitors of their responsibility to inform staff should items of property be removed from the ward. This included clothing being removed for laundry.	
	It is recommended that the ward manager ensures that records of purchases made and change returned to patients are maintained along with appropriate receipting processes.	Purchases made by staff on behalf of a patient were recorded on a patient monies receipt form. The form was retained on the patient's file and included a record of the money spent and associated receipts. Entries onto the form were signed by two members of staff and the patient. Patient money receipt forms reviewed by the inspector had been completed in accordance to Trust policy and procedure.	**Met**
Tobernaveen Upper, Holywell Hospital, 08 June 2015	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	The inspectors noted posters displayed at ward level advising patients, relatives and visitors of their responsibility to inform staff should items of property be removed from the ward.	**Met**
	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	From May 2015 cash statements have been provided to the ward from the cash office. The inspectors reviewed a sample of the statements and could confirm that these are audited monthly by the ward manager. A	**Met**

		receipt is returned to the cash office to confirm that the statements have been checked and are correct.	
Tobernaveen Centre, Holywell Hospital, 25 June 2015	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	The inspector reviewed a sample of the statements received from the cash office which confirmed that these are audited monthly by the ward manager. A receipt is returned to the cash office to confirm that the statements have been checked and are correct.	**Met**
Tobernaveen Lower, Holywell Hospital, 14 May 2015	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	The inspector noted that ward management had displayed notices throughout the ward advising patients and visitors of their responsibilities regarding patient property. On the day of admission a record of patient property returned home is completed the inspector can confirm this is receipted accordingly.	**Met**
	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	The inspector met with the ward manager who advised that there were currently no patients on the ward deemed incapable of managing their finances. As a result the ward was not currently managing any patients' finances. The ward manager advised that any patient deemed incapable of managing their finances a statement would be obtained from the cash office. Ward management had displayed notices on the ward advising patients that a statement can be provided from the cash office on request.	**Met**

Appendix 5 Western Trust HSC Finance Recommendations Reviewed During the 2015-16 Inspection Year

Inspection	Recommendation	Action Taken	Compliance
Beech, Tyrone and Fermanagh Hospital, 20 July 2015	It is recommended that the Trust reviews the current practice for authorisation of larger purchases, including eliminating the practice of the same staff authorising the purchase and verifying the receipt. A policy and procedure should be developed and implemented.	Inspectors reviewed records regarding authorisation of larger purchases and there was evidence of 3 signatures to authorise the purchase, purchase the item and to verify receipts. However two policies in relation to this practice had not been reviewed and updated - the Cash Handling Policy Sept 2011 and the Patient Property Policy which had not been updated since March 2012 to reflect this new practice. A new recommendation will be made in relation to reviewing these two policies and procedures. This will be followed up during an unannounced inspection in the 2016-17 inspection year.	**Partially Met**
	It is recommended that the ward manager trust introduces a weekly audit of receipts against expenditure on this ward.	Inspectors reviewed financial records held on the ward. The acting ward manager had completed a weekly audit of receipts received and had checked this against expenditure.	**Met**
	It is recommended that the Trust introduces a secondary check of expenditure records on this ward.	There was evidence in the financial records that two staff members had checked receipts on the ward. The acting ward manager also completed a weekly check of records.	**Met**

	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the safe where patients' money is stored is maintained including the reason for access.	Staff had recorded who obtained the key to the safe in the "Safe Key Register" book; this was signed by two members of staff. A book was also held to record the reason for access to the safe. This was audited each week by two members of staff	**Met**
Brooke Lodge, Lakeview Hospital, 6 & 7 May 2015 **(Now Known as Lakeview Hospital)**	It is recommended that the ward manager ensures that regular statements are received from the cash office to facilitate verification of transactions and expenditure.	Inspectors were informed that the patients admitted to the ward during the inspection did not have their money retained by the Trust's cash office. Patient's monies were held on the ward in the wards safe. Inspectors reviewed the safe records and noted that each patient had an individual cash record. Records had been completed in accordance to the Trust's cash handling procedures. Inspectors noted that the Trust's policy directed that staff ensure that only small amounts of patients' monies (under £50) should be retained in the safe. The Trust's policy detailed that patients presenting with more than £50 should have their money deposited within the Trust's cash office. However, inspectors evidenced that one patient had received a sum of £170 one week prior to the inspection. Inspectors were informed that the money had been provided by the patient's relative to purchase essential items. Inspectors were concerned that retaining this amount of money was contrary to section 1.4.10 of the Trust's patient	**Met**

		property procedures. Section 1.4.10 states that *'A maximum of £50.00 can be held at ward level for any patient'.* A new recommendation regarding this issue has been made. In circumstances where patients' money was retained by the Trust's finance department, statements of transactions and expenditure were provided to the patient on a monthly basis. It was good to note that the Trust's finance department conducted ongoing audits of the ward's petty cash, patient property, and the ward's safe and the safe records.	
	It is recommended that the Trust develops and implements a policy and procedure in relation to operating individual patient saving accounts.	The Trust's Cash Handling Procedures detailed the steps to be taken by ward staff regarding the management of patient property. Section 2.1.2 of the Trust's patient property procedures detailed that upon admission a patient's cash/valuable items must be sealed in the patient's property envelope and forwarded to the Trust's finance department. A finance officer informed inspectors that patients' monies (above the sum of £50) were deposited in a Trust account, under the patient's name, within a local branch of a national bank. A Trust finance officer	**Met**

		informed inspectors that the Trust's finance department reviewed each patient account and forwarded individual statements to the patient on a monthly basis.	
	It is recommended that the ward manager ensures that updated training in the management of patients' finances is prioritised for all staff.	Updated training for nursing staff in relation to the management of patients' finances had not taken place since the last inspection. This recommendation will be restated for a third time.	**Not met (Please see below for follow up)**
Brooke Lodge, Lakeview Hospital, 7-11 September 2015 **(Now known as Lakeview Hospital)**	It is recommended that the ward manager ensures that updated training in the management of patients' finances is prioritised for all staff.	Inspectors were informed a training package had been developed by the hospital manager. The training package was available and reviewed by inspectors and included the trust policy and procedure on the management of patient's property. Inspectors reviewed the record of attendees at the training. All staff were recorded as having attended the training. The training was delivered by the hospital manager and deputy ward manager.	**Met**
Cedar, Gransha, 9 June 2015 **(This ward has now closed)**	It is recommended that the ward manager ensures that regular statements are received from the cash office to facilitate verification of transactions and expenditure.	Eight of the patients admitted to the ward had accounts with the Trust's cash office. Inspectors reviewed the ward's patient cash balances book. The book evidenced that the ward manager received a patient balances update sheet from the cash office, for each patient, every two weeks. Cash office updates recorded the patient's name, hospital number, account balance, completed transactions and a subsequent	**Met**

		brought forward balance. Inspectors reviewed the records from the 4 November 2014. Records evidenced that patient monies retained by the cash office had been recorded in accordance to Trust policy and procedure.	
Lime, Tyrone and Fermanagh Hospital, 21 July 2015	It is recommended that the ward manager develops a system to ensure that where staff are making purchases on behalf of patients, a transparent record is maintained of the amount of money received, purchases made and change returned and verified by another staff member.	The inspectors reviewed the records for the management of patient finances. The inspectors observed that when staff where spending money on a patient's behalf, the money was signed out to the responsible member of staff. Records maintained evidenced the amount of money received, purchases made and change returned. Records were verified by a second member of member.	**Met**
	It is recommended that the ward manager ensures that a record is kept of the staff member who obtains the key to the patient's safe, and the reason for access is maintained.	The inspectors reviewed the finances records for the ward and noted that the safe key was signed by two nursing staff at the handover of each shift. In addition the contents of the safe were also checked daily by two nursing staff. Within each patient's finance records staff record the reason for removal of monies on each occasion. Individual patient's monies were also checked weekly and the records signed by two nursing staff.	**Met**

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Subject: **Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings.**	Circular Reference: **HSC(F) 08-2015** Date of Issue: **13 February 2015**
For Action by: Chief Executive and Director of Finance of each HSC Trust, HSCB, BSO **For Information to:** HSC Head of Internal Audit and RQIA. **Summary of Contents:** The purpose of this circular is to remind organisations to ensure that service users' finances are safeguarded in residential and nursing homes and supported living services within the statutory and independent sectors. **Enquiries**: Any enquiries about the contents of this Circular should be addressed to: Finance Policy, Accountability and Counter Fraud Unit DHSSPS Room D3 Castle Buildings Stormont BELFAST BT4 3SQ Tel: 028 9076 5696 fpau@dhsspsni.gov.uk	**Related documents:** Residential Care Homes – Minimum Standards Nursing Homes – Minimum Standards Domiciliary Care Agencies – Minimum Standards **Superseded Document:** HSS(F) 57/2009 Misappropriation of Residents' Monies – Implementation and Assurance of Controls in Statutory and Independent Homes **Expiry Date:** Not Applicable **Status of Contents:** Action **Implementation:** Immediate

BACKGROUND

1. The purpose of this guidance, which supersedes HSS (F) 57/2009 - Misappropriation of Residents' Monies – Implementation and Assurance of Controls, is to remind you of your responsibility to ensure that service users' finances are safeguarded within both the statutory and independent sectors. This follows a recent review by RQIA – 'Oversight of Services Users' Finances in Residential and Supported Living Settings'. In particular, this review highlighted the need to strengthen the level of assurances received from the Independent sector and to extend these assurances to supported living settings.

ACCOUNTABILITY ARRANGEMENTS/CONTROLS

2. Robust financial controls must be in place in all residential, nursing homes and supported living settings in both the statutory and independent sectors. This circular sets out the mandatory controls that must be in place within the statutory sector to ensure robust financial controls are in place and seeks assurances that similar controls (as appropriate) are in place within the Independent and Supported Living sector.

3. Within the Statutory sector, Accounting Officers must ensure that these controls are operating successfully, are in compliance with extant Departmental guidance and that they are reviewed on a regular basis.

4. Within the Independent and Supported Living sector, Accounting Officers must be able to demonstrate that they have taken reasonable steps to ensure that adequate financial controls are in place within Independent and Supported Living settings to ensure that Trusts' interests are protected.

5. Trusts have a statutory duty of care to its service users', regardless of the particular setting in which care is delivered, whilst it is accepted that Accounting Officers cannot be held **directly** accountable for the ongoing operation of controls in independent or supported living settings, Accounting Officers must ensure there is a proportionate level of oversight of service users' finances.

6. There are a number of existing controls within Trusts to ensure that robust arrangements are in place for handling service users' finances. These include entering into contractual arrangements with the independent care home/supported living service which provides recourse where the level of care is not as expected or where there are circumstances involving financial issues. This also includes liaison with service providers re: implementation of Internal Audit recommendations. It is further recognised that the care management review arrangements, together with the reporting procedures for complaints and untoward incidents reporting mechanisms provide additional control mechanisms for each Trust. Notwithstanding this, it is important that Accounting Officers can also demonstrate that they have taken appropriate steps to ensure that adequate financial controls are in place to safeguard service users' interests. Accounting Officers should also ensure that liaison between Trust finance and care colleagues is taking place and operating effectively.

FINANCIAL CONTROLS IN RESIDENTIAL AND NURSING HOMES AND SUPPORTED LIVING SETTINGS WITHIN BOTH THE STATUTORY AND INDEPENDENT SECTORS

7. To assist with this process, two pro forma templates have been developed to seek assurances that robust financial controls are in place within (i) residential and nursing homes and (ii) supported living settings. These have been developed in conjunction with HSC finance and care management colleagues. We have developed two templates to allow for the different levels of control within the different settings. These templates reflect the minimum controls for which assurance should be sought and Trusts can add additional controls to the templates if they wish. It should be noted that these templates reflect controls only and are not a list of procedures. Each service should have a detailed set of financial procedures which underpin these controls.

8. These templates are attached at Annex A & B and include controls in relation to authorisation, procedures, clients' agreements & accounts, deposits and income, withdrawals and expenditure, monitoring, authorising signatures and property security.

9. There are a few additional controls in respect of supported living settings and these include controls in relation to tenancy agreements and inventory listing.

ASSURANCES

10. Accounting Officers should ensure that there are effective processes in place to seek and obtain as a minimum, assurances in relation to financial controls for each setting (residential, nursing home and supported living in both statutory and independent sectors) within its geographical area. As the host Trust they should do this by:
    - Issuing the attached pro forma to each service within its geographical area by the end of February each year, relating to the current year;
    - Ensuring that these assurances are received by 31 March and reviewed for each service on a timely basis;
    - Where possible, use these assurances as part of the annual contract review process and consider failure to return the template as unsatisfactory performance and manage this in accordance with the terms of the regional contract/performance framework;
    - Sharing significant issues within the Trust and with other Trusts/ Internal audit and RQIA;
    - Providing copies of the assurances to other Trusts when requested, where service users' are placed outside their geographical area; and
    - Taking appropriate action for non-compliance.

INTERNAL AUDIT

11. Internal audit carry out an annual audit programme which includes residential and nursing homes within statutory and independent sectors. In line with the increasing use of supported living settings, internal audit have already extended their programme to include supported living settings. Trusts should use information from the assurance process (as at paragraph 10) to help inform their internal audit programme of any services which pose a greater level of risk.

CARE MANAGEMENT

12. An annual care review is carried out by a care manager with each service user to consider the standard / level of care that the service user is receiving and also seeks

assurances in relation to the service users' finances. Trusts must ensure there are adequate processes in place for sharing all information in relation to safeguarding service users' finances and ensuring there is regular liaison between finance and care management and others as necessary, such that the care manager has a complete picture and understanding of a service users finances in advance of the care review. To assist with this, Trusts should ensure that they have a standardised file structure to allow a complete picture of a service users finances. The Trust must ensure that care management staff are adequately trained to be able to carry out this annual review of service users' finances. Concerns about potential misappropriation of service users' monies identified via care management or other process, e.g. RQIA/Internal Audit inspections will trigger a referral to Trusts' adult protection services.

REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

13. RQIA is responsible for inspecting the availability of health and social care services and encouraging improvements in the quality of service provision. Its work provides assurance to the Department in respect of compliance with the regulations and minimum standards and the quality of service provision. RQIA's reports are published on its website at www.rqia.or.uk/inspections.

14. As a regulatory body, RQIA monitors compliance with the relevant regulations and minimum standards for residential and nursing home care through its programmes of inspections. RQIA takes action as necessary to ensure that the provider rectifies non-compliance. RQIA publishes all inspection reports on its website at www.rqia.org.uk/inspections and will alert Trusts immediately of any instances it may find of actual or potential abuse of vulnerable adults as well as actual or potential financial irregularity. It is the responsibility of Trusts to carry out such further investigations or audits as may be necessary; it is for Trusts to determine and take appropriate action on behalf of its service users'. However, RQIA will require reports from Trusts on the timescale and outcome of such enquiries when complete.

15. For practical purposes, responsibility for an investigation rests with the Trust in whose area the service is located and it will communicate and liaise closely with other Trusts which have placed their service users' in the facility.

RECOMMENDATIONS

16. Accounting Officers should ensure that existing controls operating in Trust services are reviewed to satisfy themselves that there are appropriate controls in place and that they are in compliance with extant Departmental guidance. Accounting Officers should also take steps to ensure that there are adequate financial controls in place in independent sector homes and supported living settings to ensure that Trusts' service users' interests are protected.

OTHER DEPARTMENTAL GUIDANCE

17. This circular should be read in conjunction with Care Management, Provision of services and charging guidance HSC (ECCU) 1/2010 or subsequent guidance.

18. In addition, your attention is drawn to the existing mandatory Departmental guidance which can be accessed through the following links:-

Residential Care Homes – Minimum Standards
http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

Nursing Homes – Minimum Standards
http://www.dhsspsni.gov.uk/care_standards_-_nursing_homes-2.pdf

Domiciliary Care Agencies – Minimum Standards
http://www.dhsspsni.gov.uk/domiciliary_care_standards-4.pdf

HSS (F) 13/2007 – Financial Governance Model for New HSS Trusts
http://www.dhsspsni.gov.uk/hss_f_13-2007.pdf

Patients and Clients' Property can be found in section 28 of the Standing Financial Instructions within Circular HSS (F) 13/2007
http://www.dhsspsni.gov.uk/sos_res__del_of_p_sfis_mar_07.pdf

ACTION

19. Please ensure that this circular is brought to the attention of the appropriate staff within your organisation and that any relevant action points are noted.

This Circular supersedes HSS (F) 57/2009 Misappropriation of Patients' Monies – Implementation and Assurance of Controls.

Should you have any queries please contact Paula Shearer on 02890 765689.

Paula Shearer
Finance Policy, Accountability and Counter Fraud Unit

Annex A

Template for Residential Homes and Nursing Homes

Dear Provider,

Oversight of Service Users' Finances in Residential and Nursing Homes

The Department of Health, Social Services and Public Safety (DHSSPS) issues guidance for implementation by all Health and Social Care Trusts.

The guidance details the Trust's responsibility to take reasonable steps to ensure adequate financial controls are in place to safe guard residents' monies in all statutory and independent homes with which it places clients.

I would therefore be grateful if you would complete the attached declaration confirming the following controls are in operation within the above named facility, for which you are responsible.

Control/Process		**Response**
1. Authorisation	1.1. Where your facility is appointee/controller, do you hold written authorisation to support these arrangements for each client? If no applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
2. Procedures	2.1. Do you hold up-to-date comprehensive financial procedures for managing clients' monies and clients' accounts? 2.2. Do all staff who are involved in the mgt of residents monies' receive adequate and regular training on these procedures?	Yes / No Yes / No

	If no applies to any of the above, please provide details/reasons below (or separately if necessary). _____ _____ _____	
3. Clients' Agreements	3.1. Do you have agreements in place, which clearly set out financial arrangements for each client? 3.2. Are these agreements reviewed, updated, agreed and signed annually to reflect changes in circumstances? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement) If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No
4. Clients' Accounts[1] & Reconciliations	4.1. Is there a separately identifiable bank account where clients' monies are held, separate from the facility's business bank account? 4.2. Are reconciliations between the bank account (as above) & clients' ledgers completed on a monthly basis? 4.3. Are all reconciliations prepared and reviewed by 2 separate Officers? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No

[1] Clients' Accounts are those accounts managed by the facility, which hold monies on behalf of clients.

5. Deposits & Income	5.1. Are all deposits to Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 5.2. Is supporting documentation obtained and held on file for all deposits and income? 5.3. Are receipts given for monies received (where appropriate e.g. relatives)? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No
6. Withdrawals & Expenditure	6.1. Are all withdrawals from Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the home? 6.2. Is supporting documentation obtained and held on file (receipts/invoices) for all withdrawals and expenditure? 6.3. Are excessive withdrawals from Clients' Accounts reviewed by a Senior Officer of the facility on a regular basis? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No
7. Monitoring Of Clients' Income & Expenditure	7.1. Is there regular detailed monitoring of clients' income & expenditure by a senior officer? 7.2. Is consideration given to clients' spending patterns and appropriateness of spend and are changes in spending patterns reviewed? 7.3. Are any irregularities reported to key worker?	Yes / No Yes / No Yes / No

	If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	
8. Client Records	8.1. Are ledger cards maintained for each client to record all income, deposits, withdrawals and expenditure? 8.2. Are these ledger cards appropriately completed, and authorised by a separate senior officer of the facility? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No
9. Authorising Signatures	9.1. Is there an up to date copy of specimen authorised signatures held on file? If no applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
10. General Security of Property Held	10.1. Is clients' property (monies/valuables) held in a safe place within the facility and adequately secured? 10.2. Is the client or their representative aware of what is being held on their behalf and have authorised the safekeeping of these? 10.3. Are there robust controls around access to clients' property (including PIN numbers, passwords etc.) and restricted to minimal named staff?	Yes / No Yes / No Yes / No

	10.4. Are up to date and accurate records maintained of all items held for safekeeping? 10.5. Are up to date and accurate records maintained of all items of furniture and equipment brought into the service users' room? 10.6. Are there procedures to ensure that amounts kept for safekeeping are not excessive? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No
11. Internal Audit Recommendations	11.1. Have the internal audit recommendations circulated by the Trust to you during the year been considered? 11.2. If so, has an action plan been put in place to address any issues raised? If no applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____ _____	Yes / No Yes / No
12. RQIA Financial Inspection Recommendations	12.1. Have any RQIA requirements (under the relevant regulations) as well as recommendations issued to you during the year been considered? 12.2. If so, has an action plan been put in place to address any issues raised? If no applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____	Yes / No Yes / No

	_____	
13. Serious Adverse Incidents	13.1. Have there been any Serious Adverse Incidents in respect of management of clients' finances in the past 12 months? If YES applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No

Signed: _____ (**Registered Manager)**

Print Name: _____

Date: _____

Signed: _____ (**Registered Person)**

Print Name: _____

Date: _____

Completed forms should be returned to following address or scanned and emailed to …… by …… (Insert date)

Failure to complete this pro forma will be considered as unsatisfactory performance and be appropriately managed.

In addition, as part of a rolling internal audit programme, a number of facilities will be visited during the financial year to ensure that they have the necessary controls in place. This may include a review of the process and evidence used by the facility to conduct the self – assessment above.

The Trust may share Information provided in this return with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

This return will form part of the contract management review.

Your co-operation in this matter is greatly appreciated and if you wish to discuss this further please contact …… on

…….

Yours Sincerely

_____

Name and Designation

Annex B

Template for Supported Living Services

Dear Provider,

Oversight of Service Users' Finances in Supported Living Settings

The Department of Health, Social Services and Public Safety (DHSSPS) issues guidance for implementation by all Health and Social Care Trusts.

The guidance details the Trust's responsibility to take reasonable steps to ensure adequate financial controls are in place to safe guard residents' monies in supported living facilities with which it places clients.

I would therefore be grateful if you would complete the attached declaration confirming the following controls are in operation within the above named facility, for which you are responsible.

Control/Process		**Response**
1. Authorisation	1.2. Where your facility is appointee/controller, do you hold written authorisation to support these arrangements for each client? If no applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
2. Procedures	2.1. Do you hold up-to-date comprehensive financial procedures for managing clients' monies and clients' accounts? 2.2. Do all staff who are involved in the mgt of residents monies' receive adequate and regular	Yes / No

	training on these procedures? If no applies to any of the above, please provide details/reasons below (or separately if necessary). _____ _____ _____	Yes / No
3. Financial Support Agreements	3.1. Do you have agreements in place, which clearly set out financial arrangements for each client? 3.2. Are these agreements reviewed, updated, agreed and signed annually to reflect changes in circumstances? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement) 3.3. Is income and expenditure clearly documented in FSA and updated annually? 3.4. Is there an up to date schedule of clients' benefits entitlements for each client? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No Yes / No
4. Tenancy Agreements	4.1. Are there Tenancy Agreements in place for all tenants and signed by both parties (or representatives)? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement) 4.2. Do you maintain an Inventory listing detailing tenants' ownership of additional items in the event of a tenant leaving the facility?	Yes / No Yes / No

	If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	
5. Clients' Accounts & Reconciliations	5.1. Is there a separately identifiable bank account where clients' monies are held, separate from the facility's business bank account? 5.2. Are reconciliations between the bank account (as above) & clients' ledgers completed on a monthly basis? 5.3. Do you operate common household accounts/shared kitties? 5.4. Are these accounts/kitties reconciled monthly? 5.5. Are all reconciliations prepared and reviewed by 2 separate Officers? 5.6. Does the facility actively seek to minimise the use of cash by tenants through the use of standing orders for bills etc? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No
6. Deposits & Income	6.1. Are all deposits to Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 6.2. Is supporting documentation obtained and held on file for all deposits and income?	Yes / No Yes / No

	6.3. Are receipts given for monies received (where appropriate e.g. relatives)? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
7. Withdrawals & Expenditure	7.1. Are all withdrawals from Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 7.2. Is supporting documentation obtained and held on file (receipts/invoices) for all withdrawals and expenditure? 7.3. Are excessive withdrawals from Clients' Accounts reviewed by a Senior Officer of the facility on a regular basis? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No
8. Monitoring Of Clients' Income & Expenditure	8.1. Is there regular detailed monitoring of clients' income & expenditure by a senior officer? 8.2. Is consideration given to clients' spending patterns and appropriateness of spend and are changes in spending patterns reviewed? 8.3. Are any irregularities reported to key worker? If no applies to any of the above, please provide details below (or separately if necessary). _____	Yes / No Yes / No Yes / No

	_____ _____	
9. Client Records	9.1. Are ledger cards maintained for each client to record all income, deposits, withdrawals and expenditure? 9.2. Are these ledger cards appropriately completed, and authorised by a separate senior officer of the facility? If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No
10. Authorising Signatures	10.1. Is there an up to date copy of specimen authorised signatures held on file? If no applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
11. General Security of Property Held	11.1. Is clients' property (monies/valuables) monies held in a safe place within the facility and adequately secured? 11.2. Is the client or their representative aware of what is being held on their behalf and have authorised the safekeeping of these? 11.3. Are there robust controls around access to clients' property (including PIN numbers, passwords etc.) and restricted to minimal named staff? 11.4. Are up to date and accurate records maintained of all items held for safekeeping? 11.5. Are there procedures to ensure that amounts kept for safekeeping are not excessive?	Yes / No Yes / No Yes / No Yes / No Yes / No

	If no applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	
12. Internal Audit Recommendations	12.1. Have the internal audit recommendations circulated by the Trust to you during the year been considered? 12.2. If so, has an action plan been put in place to address any issues raised? If no applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____ _____	Yes / No Yes / No
13. RQIA Financial Inspection Recommendations	13.1. Have any RQIA requirements (under the relevant regulations) as well as recommendations issued to you during the year been considered? 13.2. If so, has an action plan been put in place to address any issues raised? If no applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____ _____	Yes / No Yes / No
14. Serious Adverse Incidents	14.1. Have there been any Serious Adverse Incidents in respect of management of clients' finances in the past 12 months?	Yes / No

	If YES applies above, please provide details below (or separately if necessary). _____ _____ _____	

Signed: _____ (**Registered Manager)**

Print Name: _____

Date: _____

Signed: _____ (**Registered Person)**

Print Name: _____

Date: _____

Completed forms should be returned to following address or scanned and emailed to …… by …… (Insert date)

Failure to complete this pro forma will be considered as unsatisfactory performance and be appropriately managed.

In addition, as part of a rolling internal audit programme, a number of facilities will be visited during the financial year to ensure that they have the necessary controls in place. This process may include a review of the process and evidence used by the facility to conduct the self-assessment above.

The Trust may share Information provided in this return with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

This return will form part of the contract management review.

Your co-operation in this matter is greatly appreciated and if you wish to discuss this further please contact …… on

…….

Yours Sincerely

_____

Name and Designation

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Subject: **Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings.**	**Circular Reference: HSC(F) 15-2016** **Date of Issue: 18 February 2016**
For Action by: Chief Executive and Director of Finance of each HSC Trust, and HSCB **For Information to:** HSC Head of Internal Audit and RQIA. **Summary of Contents:** This circular replaces HSC(F) 08-2015 and reminds organisations to ensure that service users' finances are safeguarded in residential and nursing homes and supported living services within the statutory and independent sectors. **Enquiries**: Any enquiries about the contents of this Circular should be addressed to: Finance Policy, Accountability and Counter Fraud Unit DHSSPS Room D3 Castle Buildings Stormont BELFAST BT4 3SQ Tel: 028 9076 5696 fpau@dhsspsni.gov.uk	**Related documents:** Residential Care Homes – Minimum Standards Nursing Homes – Minimum Standards Domiciliary Care Agencies – Minimum Standards **Superseded Documents:** HSC(F) 08-2015 **Expiry Date:** Not Applicable **Status of Contents:** Action **Implementation:** Immediate

BACKGROUND

1. The purpose of this guidance is to update HSC (F) 08-2015 to reflect additional assurances to be sought and further checks to be put in place to ensure that service users' finances are safeguarded within both the statutory and independent sectors. Circular HSC (F) 08-2015 was issued following a review by RQIA – 'Oversight of Services Users' Finances in Residential and Supported Living Settings' which highlighted the need to strengthen the level of assurances received from the Independent sector and to extend these assurances to supported living settings. Circular HSC(F) 08-2015 provided comprehensive guidance and included templates to be issued to facilities on an annual basis to gain satisfactory assurances.

2. A review of the process in 2014/15 identified areas where further clarification was needed to include minor amendments to the templates and additional guidance on the process for reviewing the returns. This circular reflects these changes and replaces Circular HSC (F) 08-2015 which is now superseded.

Changes to the templates

3. The templates have been amended to include 3 additional questions:

    - Do you have a transport scheme in place? (Question 2.3 on amended templates attached).
    - Is your transport scheme in line with RQIA guidelines? (Question 2.4 on amended templates attached).
    - Do you have a holiday policy if you facilitate staff to support residents/tenants to go on holiday? (Question 2.5 on amended templates attached).
    - Are RQIA aware of clients' monies in excess of £20,000 per client being managed by the facility? (Question 5.4 / 6.4 on amended templates attached).

4. Furthermore the templates are addressed to 'Dear Registered Manager' rather than 'Dear Service Provider'.

5. Amended templates can be found at Annex A and Annex B.

Other changes

6. A new section (section 16) has been added to the guidance below to incorporate the issues below.

- All returns should be checked to ensure that they have been signed by the registered manager / owner; otherwise they will need to be returned to the facility for re submission.
- Returns with 'N/A' or 'No' responses without explanations, where appropriate, should be followed up with the facility.
- Outstanding returns to be chased up.
- Trust Finance to share any issues identified in the returns with internal audit, contract management and care/case management.
- Trusts to carry out, where possible, rolling sample inspections particularly where issues have been identified or no explanations provided or no return received.
- Trust cover letter to highlight the issues above and emphasise that returns will be shared and compared with internal audit, RQIA and other bodies as appropriate

THE FOLLOWING SECTIONS FORM PART OF THE ORIGINAL GUIDANCE ISSUED IN CIRCULAR HSC(F) 08-2015 (ALONG WITH THE AMENDMENTS ABOVE) AND ARE STILL APPLICABLE

ACCOUNTABILITY ARRANGEMENTS/CONTROLS

7. Robust financial controls must be in place in all residential, nursing homes and supported living settings in both the statutory and independent sectors. This circular sets out the mandatory controls that must be in place within the statutory sector to ensure robust financial controls are in place and seeks assurances that similar controls (as appropriate) are in place within independent homes and supported living facilities.

8. Within the statutory sector, Accounting Officers must ensure that these controls are operating successfully, are in compliance with extant Departmental guidance and that they are reviewed on a regular basis.

9. Within independent homes and supported Living facilities, Accounting Officers must be able to demonstrate that they have taken reasonable steps to ensure that adequate financial controls are in place within independent homes and supported living settings to ensure that Trusts' interests are protected.

10. Trusts have a statutory duty of care to its service users', regardless of the particular setting in which care is delivered, whilst it is accepted that Accounting Officers cannot be held **directly** accountable for the ongoing operation of controls in independent homes or supported living settings, Accounting Officers must ensure there is a proportionate level of oversight of service users' finances.

11. There are a number of existing controls within Trusts to ensure that robust arrangements are in place for handling service users' finances. These include entering into contractual arrangements with the independent care home/supported living service which provides recourse where the level of care is not as expected or where there are circumstances involving financial issues. This also includes liaison with service providers re: implementation of Internal Audit recommendations. It is further recognised that the care/case management review arrangements, together with the reporting procedures for complaints and untoward incidents reporting mechanisms provide additional control mechanisms for each Trust. Notwithstanding this, it is important that Accounting Officers can also demonstrate that they have taken appropriate steps to ensure that adequate financial controls are in place to safeguard service users' interests. Accounting Officers should also ensure that liaison between Trust finance and care colleagues is taking place and operating effectively.

FINANCIAL CONTROLS IN RESIDENTIAL AND NURSING HOMES AND SUPPORTED LIVING SETTINGS WITHIN BOTH THE STATUTORY AND INDEPENDENT SECTORS

12. To assist with this process, two pro forma templates have been developed to seek assurances that robust financial controls are in place within (i) residential and nursing homes and (ii) supported living settings. These have been developed in conjunction with HSC finance and care/case management colleagues. We have developed two templates to allow for the different levels of control within the different settings. These templates reflect the minimum controls for which assurance should be sought and Trusts can add additional controls to the templates if they wish. It should be noted that these templates reflect controls only and are not a list of procedures. Each service should have a detailed set of financial procedures which underpin these controls.

13. These templates are attached at Annex A & B and include controls in relation to authorisation, procedures, clients' agreements & accounts, deposits and income, withdrawals and expenditure, monitoring, authorising signatures and property security.

14. There are a few additional controls in respect of supported living settings and these include controls in relation to tenancy agreements and inventory listing.

ASSURANCES

15. Accounting Officers should ensure that there are effective processes in place to seek and obtain as a minimum, assurances in relation to financial controls for each setting (residential, nursing home and supported living in both statutory and independent sectors) within its geographical area. As the host Trust they should do this by:
    - Issuing the attached pro forma to each service within its geographical area by the end of February each year, relating to the current year;
    - Ensuring that these assurances are received by 31 March and reviewed for each service on a timely basis;
    - Where possible, use these assurances as part of the annual contract review process and consider failure to return the template as unsatisfactory performance and manage this in accordance with the terms of the regional contract/performance framework;
    - Sharing significant issues within the Trust and with other Trusts/ Internal audit and RQIA;

- Providing copies of the assurances to other Trusts when requested, where service users' are placed outside their geographical area; and
- Taking appropriate action for non-compliance.

REVIEW OF COMPLETED TEMPLATES

16. Upon receipt of completed templates:
    - All returns should be checked to ensure that they have been signed by the registered manager and registered owner, otherwise they will need to be returned to the facility for re submission.
    - Returns with 'N/A' or 'No' responses without explanations, where appropriate, should be followed up with the facility.
    - Outstanding returns to be chased up.
    - Trust Finance to share any issues identified in the returns with internal audit, contract management and care/case management.
    - Trusts to carry out, where possible, sample inspections particularly where issues have been identified or no explanations provided or no return received.
    - Trust cover letter to highlight the issues above and emphasise that returns will be shared and compared with internal audit, RQIA and other bodies as appropriate

INTERNAL AUDIT

17. Internal audit carry out an annual audit programme which includes residential and nursing homes within statutory and independent sectors. In line with the increasing use of supported living settings, internal audit have already extended their programme to include supported living settings. Trusts should use information from the assurance process (as at paragraph 10) to help inform their internal audit programme of any services which pose a greater level of risk.

CARE/CASE MANAGEMENT

18. An annual care review is carried out by a care/case manager with each service user to consider the standard / level of care that the service user is receiving and also seeks assurances in relation to the service users' finances. Trusts must ensure there are adequate processes in place for sharing all information in relation to safeguarding service users' finances and ensuring there is regular liaison between finance and care/case management and others as necessary, such that the care/case manager has a complete picture and understanding of a service users finances in advance of the care review. To assist with this, Trusts should ensure that they have a standardised file structure to allow a complete picture of a service users finances. A useful template for the financial section of the care/case management review has been attached at Annex C. The Trust must ensure that care/case management staff are adequately trained to be able to carry out this annual review of service users' finances. Concerns about potential misappropriation of service users' monies identified via care/case management or other process, e.g. RQIA/Internal Audit inspections will trigger a referral to Trusts' adult protection services.

REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

19. RQIA is responsible for inspecting the availability of health and social care services and encouraging improvements in the quality of service provision. Its work provides assurance to the Department in respect of compliance with the regulations and minimum standards and the quality of service provision. RQIA's reports are published on its website at www.rqia.org.uk/inspections.

20. As a regulatory body, RQIA monitors compliance with the relevant regulations and minimum standards for residential and nursing home care through its programmes of inspections. RQIA takes action as necessary to ensure that the provider rectifies non-compliance. RQIA publishes all inspection reports on its website at www.rqia.org.uk/inspections and will alert Trusts immediately of any instances it may find of actual or potential abuse of vulnerable adults as well as actual or potential financial irregularity. It is the responsibility of Trusts to carry out such further investigations or audits as may be necessary; it is for Trusts to determine and take appropriate action on behalf of its service users'. However, RQIA will require reports from Trusts on the timescale and outcome of such enquiries when complete.

21. For practical purposes, responsibility for an investigation rests with the Trust in whose area the service is located and it will communicate and liaise closely with other Trusts which have placed their service users' in the facility.

RECOMMENDATIONS

22. Accounting Officers should ensure that existing controls operating in Trust services are reviewed to satisfy themselves that there are appropriate controls in place and that they are in compliance with extant Departmental guidance. Accounting Officers should also take steps to ensure that there are adequate financial controls in place in independent sector homes and supported living settings to ensure that Trusts' service users' interests are protected.

OTHER DEPARTMENTAL GUIDANCE

23. This circular should be read in conjunction with Care Management, Provision of services and charging guidance HSC (ECCU) 1/2010 or subsequent guidance.

24. In addition, your attention is drawn to the existing mandatory Departmental guidance which can be accessed through the following links:-

Residential Care Homes – Minimum Standards

https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/care-standards-residential-care-homes.pdf

Nursing Homes – Minimum Standards

https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/care-standards-nursing-agencies.pdf

Domiciliary Care Agencies – Minimum Standards

https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/care-standards-domiciliary-care.pdf

HSS (F) 13/2007 – Financial Governance Model for New HSS Trusts

https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2007-13.pdf

Patients and Clients' Property can be found in section 28 of the Standing Financial Instructions within Circular HSS (F) 13/2007
https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2007-13.pdf

ACTION

25. Please ensure that this circular is brought to the attention of the appropriate staff within your organisation and that any relevant action points are noted.

This Circular supersedes HSC(F) 08-2015 Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings.

Should you have any queries please contact Paula Shearer on 02890 765689.

Paula Shearer
Finance Policy, Accountability and Counter Fraud Unit

Annex A

Template for Residential Homes and Nursing Homes

Dear Registered Manager,

Oversight of Service Users' Finances in Residential and Nursing Homes

The Department of Health, Social Services and Public Safety (DHSSPS) issues guidance for implementation by all Health and Social Care Trusts.

The guidance details the Trust's responsibility to take reasonable steps to ensure adequate financial controls are in place to safe guard residents' monies in all statutory and independent homes with which it places clients.

I would therefore be grateful if you would complete the attached declaration confirming the following controls are in operation within the above named facility, for which you are responsible.

Please ensure explanations are provided for all No and N/A responses.

Control/Process		**Response**
1. Authorisation	1.1. Where your facility is appointee/controller, do you hold written authorisation to support these arrangements for each client? If **No** applies above, please provide details below (or separately if necessary).	Yes / No
2. Procedures	2.1. Do you hold up-to-date comprehensive financial procedures for managing clients' monies and clients' accounts? 2.2. Do all staff who are involved in the mgt of residents monies' receive adequate and regular training on these procedures?	Yes / No Yes / No

	2.3. Do you have a transport scheme in place? 2.4. Is this transport scheme in line with RQIA guidelines? (If not applicable please state). 2.5. Do you have a holiday policy IF you facilitate staff to support residents to go on holiday? (If not applicable please state). If **No** applies to any of the above, please provide details/reasons below (or separately if necessary).	Yes / No Yes / No Yes / No
3. Clients' Agreements	3.1. Do you have agreements in place, which clearly set out financial arrangements for each client? 3.2. Are these agreements reviewed, updated, agreed and signed annually to reflect changes in circumstances? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement). If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No Yes / No
4. Clients' Accounts[1] & Reconciliations	4.1. Is there a separately identifiable bank account where clients' monies are held, separate from the facility's business bank account? 4.2. Are reconciliations between the bank account (as above) & clients' ledgers completed on a monthly basis?	Yes / No Yes / No

[1] Clients' Accounts are those accounts managed by the facility, which hold monies on behalf of clients.

	4.3. Are all reconciliations prepared and reviewed by 2 separate Officers? If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No
5. Deposits & Income	5.1. Are all deposits to Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 5.2. Is supporting documentation obtained and held on file for all deposits and income? 5.3. Are receipts given for monies received (where appropriate e.g. relatives)? 5.4. Are RQIA aware of clients' monies in excess of £20,000 per client being managed by the facility? If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No Yes / No Yes / No Yes / No
6. Withdrawals & Expenditure	6.1. Are all withdrawals from Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the home? 6.2. Is supporting documentation obtained and held on file (receipts/invoices) for all withdrawals and expenditure? 6.3. Are excessive withdrawals from Clients' Accounts reviewed by a Senior Officer of the facility on a regular basis?	Yes / No Yes / No Yes / No

	If **No** applies to any of the above, please provide details below (or separately if necessary).	
7. Monitoring Of Clients' Income & Expenditure	7.1. Is there regular detailed monitoring of clients' income & expenditure by a senior officer? 7.2. Is consideration given to clients' spending patterns and appropriateness of spend and are changes in spending patterns reviewed? 7.3. Are any irregularities reported to key worker? If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No Yes / No Yes / No
8. Client Records	8.1. Are ledger cards maintained for each client to record all income, deposits, withdrawals and expenditure? 8.2. Are these ledger cards appropriately completed, and authorised by a separate senior officer of the facility? If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No Yes / No
9. Authorising Signatures	9.1. Is there an up to date copy of specimen authorised signatures held on file? If **No** applies above, please provide details below (or separately if necessary).	Yes / No
10. General Security of Property Held	10.1. Is clients' property (monies/valuables) held in a safe place within the facility and adequately secured? 10.2. Is the client or their representative aware of what is being held on their behalf and have authorised the safekeeping of these?	Yes / No Yes / No

	10.3. Are there robust controls around access to clients' property (including PIN numbers, passwords etc.) and restricted to minimal named staff?	Yes / No
	10.4. Are up to date and accurate records maintained of all items held for safekeeping?	Yes / No
	10.5. Are up to date and accurate records maintained of all items of furniture and equipment brought into the service users' room?	Yes / No
	10.6. Are there procedures to ensure that amounts kept for safekeeping are not excessive?	
	If **No** applies to any of the above, please provide details below (or separately if necessary).	
11. Internal Audit Recommendations	11.1. Have the internal audit recommendations circulated by the Trust to you during the year been considered?	Yes / No
	11.2. If so, has an action plan been put in place to address any issues raised?	Yes / No
	If **No** applies above, please detail below any reasons why and the outstanding actions planned to be taken.	
12. RQIA Financial Inspection Recommendations	12.1. Have any RQIA requirements (under the relevant regulations) as well as recommendations issued to you during the year been considered?	Yes / No
	12.2. If so, has an action plan been put in place to address any issues raised?	Yes / No

	If **No** applies above, please detail below any reasons why and the outstanding actions planned to be taken.	
13. Serious Adverse Incidents	13.1. Have there been any Serious Adverse Incidents in respect of management of clients' finances in the past 12 months? If **YES** applies above, please provide details below (or separately if necessary).	Yes / No

Signed: _____ (**Registered Manager)**

Print Name: _____

Date: _____

Signed: _____ (**Registered Person)**

Print Name: _____

Date: _____

Completed forms should be returned to following address or scanned and emailed to …… by …… (Insert date)

Failure to complete this pro forma will be considered as unsatisfactory performance and be appropriately managed.

In addition, as part of a rolling internal audit programme, a number of facilities will be visited during the financial year to ensure that they have the necessary controls in place. This may include a review of the process and evidence used by the facility to conduct the self – assessment above.

The Trust may share Information provided in this return with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

This return will form part of the contract management review.

Your co-operation in this matter is greatly appreciated and if you wish to discuss this further please contact …… on

…….

Yours Sincerely

Name and Designation

Annex B

Template for Supported Living Services

Dear Registered Manager,

Oversight of Service Users' Finances in Supported Living Settings

The Department of Health, Social Services and Public Safety (DHSSPS) issues guidance for implementation by all Health and Social Care Trusts.

The guidance details the Trust's responsibility to take reasonable steps to ensure adequate financial controls are in place to safe guard residents' monies in supported living facilities with which it places clients.

I would therefore be grateful if you would complete the attached declaration confirming the following controls are in operation within the above named facility, for which you are responsible.

Please ensure explanations are provided for all No and N/A responses.

Control/Process		**Response**
1. Authorisation	1.2. Where your facility is appointee/controller, do you hold written authorisation to support these arrangements for each client? If **No** applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No
2. Procedures	2.1. Do you hold up-to-date comprehensive financial procedures for managing clients' monies and	Yes / No

	clients' accounts?	
	2.2. Do all staff who are involved in the mgt of residents monies' receive adequate and regular training on these procedures?	Yes / No
	2.3. Do you have a transport scheme in place?	Yes / No
	2.4. Is this transport scheme in line with RQIA guidelines? (If not applicable please state).	Yes / No
	2.5. Do you have a holiday policy IF you facilitate staff to support residents/tenants to go on holiday? (If not applicable please state).	Yes / No
	If **No** applies to any of the above, please provide details/reasons below (or separately if necessary). _____ _____ _____	
3. Financial Support Agreements	3.1. Do you have agreements in place, which clearly set out financial arrangements for each client?	Yes / No
	3.2. Are these agreements reviewed, updated, agreed and signed annually to reflect changes in circumstances? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement)	Yes / No
	3.3. Is income and expenditure clearly documented in FSA and updated annually?	Yes / No
	3.4. Is there an up to date schedule of clients' benefits entitlements for each client?	Yes / No
	If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	

4. Tenancy Agreements	4.1. Are there Tenancy Agreements in place for all tenants and signed by both parties (or representatives)? (Note: RQIA guidance recognises that where a client does not have capacity to sign and no one else is willing/available, a facility should note this on the agreement) 4.2. Do you maintain an Inventory listing detailing tenants' ownership of additional items in the event of a tenant leaving the facility? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No
5. Clients' Accounts & Reconciliations	5.1. Is there a separately identifiable bank account where clients' monies are held, separate from the facility's business bank account? 5.2. Are reconciliations between the bank account (as above) & clients' ledgers completed on a monthly basis? 5.3. Do you operate common household accounts/shared kitties? 5.4. Are these accounts/kitties reconciled monthly? 5.5. Are all reconciliations prepared and reviewed by 2 separate Officers? 5.6. Does the facility actively seek to minimise the use of cash by tenants through the use of standing orders for bills etc? If **No** applies to any of the above, please provide details below (or separately if necessary).	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No

	_____ _____ _____	
6. Deposits & Income	6.1. Are all deposits to Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 6.2. Is supporting documentation obtained and held on file for all deposits and income? 6.3. Are receipts given for monies received (where appropriate e.g. relatives)? 6.4. Are RQIA aware of clients' monies in excess of £20,000 per client being managed by the facility? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No Yes / No
7. Withdrawals & Expenditure	7.1. Are all withdrawals from Clients' Accounts authorised by the client (where possible) and signed by two appropriate officers of the facility? 7.2. Is supporting documentation obtained and held on file (receipts/invoices) for all withdrawals and expenditure? 7.3. Are excessive withdrawals from Clients' Accounts reviewed by a Senior Officer of the facility on a regular basis? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____	Yes / No Yes / No Yes / No

	_____	
8. Monitoring Of Clients' Income & Expenditure	8.1. Is there regular detailed monitoring of clients' income & expenditure by a senior officer? 8.2. Is consideration given to clients' spending patterns and appropriateness of spend and are changes in spending patterns reviewed? 8.3. Are any irregularities reported to key worker? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No
9. Client Records	9.1. Are ledger cards maintained for each client to record all income, deposits, withdrawals and expenditure? 9.2. Are these ledger cards appropriately completed, and authorised by a separate senior officer of the facility? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No
10. Authorising Signatures	10.1. Is there an up to date copy of specimen authorised signatures held on file? If **No** applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No

11. General Security of Property Held	11.1. Is clients' property (monies/valuables) monies held in a safe place within the facility and adequately secured? 11.2. Is the client or their representative aware of what is being held on their behalf and have authorised the safekeeping of these? 11.3. Are there robust controls around access to clients' property (including PIN numbers, passwords etc.) and restricted to minimal named staff? 11.4. Are up to date and accurate records maintained of all items held for safekeeping? 11.5. Are there procedures to ensure that amounts kept for safekeeping are not excessive? If **No** applies to any of the above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No Yes / No Yes / No Yes / No Yes / No
12. Internal Audit Recommendations	12.1. Have the internal audit recommendations circulated by the Trust to you during the year been considered? 12.2. If so, has an action plan been put in place to address any issues raised? If **No** applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____ _____	Yes / No Yes / No
13. RQIA Financial Inspection Recommendations	13.1. Have any RQIA requirements (under the relevant regulations) as well as recommendations issued to you during the year been considered?	Yes / No

	13.2. If so, has an action plan been put in place to address any issues raised? If **No** applies above, please detail below any reasons why and the outstanding actions planned to be taken. _____ _____ _____	Yes / No
14. Serious Adverse Incidents	14.1. Have there been any Serious Adverse Incidents in respect of management of clients' finances in the past 12 months? If **YES** applies above, please provide details below (or separately if necessary). _____ _____ _____	Yes / No

Signed: _____ (**Registered Manager)**

Print Name: _____

Date: _____

Signed: _____ (**Registered Person)**

Print Name: _____

Date: _____

Completed forms should be returned to following address or scanned and emailed to …… by …… (Insert date)

Failure to complete this pro forma will be considered as unsatisfactory performance and be appropriately managed.

In addition, as part of a rolling internal audit programme, a number of facilities will be visited during the financial year to ensure that they have the necessary controls in place. This process may include a review of the process and evidence used by the facility to conduct the self-assessment above.

The Trust may share Information provided in this return with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

This return will form part of the contract management review.

Your co-operation in this matter is greatly appreciated and if you wish to discuss this further please contact …… on

…….

Yours Sincerely

_____

Name and Designation

Annex C

Resident's/Tenant's Review Record

Finance Section (Final V. 17.6.15)

(Residential/Nursing/Supported Living)

Name of Client: _____

Placement Details: _____

Date of Placement: _____

Date of Review: _____

1. Is the resident placed at the appropriate regional tariff rate for their assessed Category of Care (as per RQIA classifications)? **(For Residential/ Nursing Home only)**

   Regional Rate ☐

   Rate paid by Trust ☐

2. Please outline reasons if the payment is above the appropriate regional tariff rate. **(For Residential/ Nursing Home only)**

   _____
   _____
   _____
   _____

3. Does the file contain the necessary assessment and subsequent specialist letter from contracts (if appropriate) corroborating the need for payment above the appropriate regional tariff rate? **(For Residential/ Nursing home only)**

   Yes ☐
   No ☐

If no specify what action you have taken:

_____

_____

4. Does the resident/tenant have capacity to manage finances, confirmed at multi-disciplinary review?

Yes ☐
No ☐

5. Does the Tenant have a Financial Support Agreement (FSA) and is it up to date? **(Statutory Supported Living Only)**

Yes ☐
No ☐

6. Who is the Tenant/Resident's appointee (where applicable)?

---

7. Is there a Third party "Top Up" in place? **(For Residential/ Nursing Home only)**

Yes ☐
No ☐
Amount of Top up: - £_____

8. Has the Top Up changed this year? **(For Residential/ Nursing Home only)**

Yes ☐ Complete a NEW "Top-up Undertaking to pay form"
No ☐

9. Have there been any changes to arrangements for the management of finances since the last review?

Yes ☐
No ☐

10. List any changes to the services within the Care Plan/Individual Agreement since the previous review and record the reason or these.

_____

_____

_____

_____

11. Does the resident/tenant have available resources to fund those services which he/she privately funds? (this does not refer to top up)

Yes ☐
No ☐

If no, please highlight the issues

_____

_____

12. What are the additional resources/activities required above contract? Does the person have assessed need?

_____

13. What additional expenditure has been made from the resident's/tenant's personal account since the last review? For example; holidays, payments to other parties including family and transport costs.

_____

_____

14. Have these costs been agreed and recorded in the Care Plan?

Yes ☐
No ☐

If not, why? _____

_____

_____

15. Is the Home holding an accumulating balance in the Resident's Personal Allowance? If so please address how the Personal Allowance is being spent (refer to the resident's care plan).

_____

_____

_____

16. Please detail any changes to the weekly fees since the last review and the reason for this. This should include changes to any third party agreements in place.

_____

_____

_____

17. Are resident's/tenants contributions (Assessed charge) to weekly care fees up to date? (key worker checks with Finance Department in advance of review)
(For Residential/ Nursing home only)

Yes ☐
No ☐

If no, please outline why. _____

_____

_____

18. Has the Home confirmed that all financial transactions are properly receipted in accordance with RQIA Standards?

Yes ☐
No ☐

19 Keyworker to review a sample amount of receipts e.g. a month, during the last 12 months in the residents/ tenants personal cash books? Do they reconcile and are they reasonable?

_____

20. Record any other concerns in respect of the resident's/tenant's finances.

_____

21. State actions taken to address the above concerns

Signed by Keyworker: _____

Designation: _____

Date: _____

Signed by Home/Facility Manager or Representative: _____

Designation: _____

Date: _____

Signature of Resident or Relative/Representative (*delete as appropriate):

_____

Date: _____

Belfast Health and Social Care Trust

Reference no: SG 09/15

Title:	Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals		
Author(s)	Brendan Ingram, Business and Service Improvement Manager		
Ownership:	Catherine McNicholl, Director, Adult Social and Primary Care		
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting	**Approval date:**	11/3/2015 01/04/2015 03/04/2015
Operational Date:	April 2015	**Next Review:**	April 2018
Version No.	V1	**Supercedes**	Legacy Trust policies
Key words	Mental Health, Learning Disability, Finance, In-Patient, Private Property and Hospital		
Links to other policies	Belfast Health and Social Care Trust Patients' Property Policy http://intranet.belfasttrust.local/policies/Documents/Patient%20Property%20-%20Handed%20in.pdf Belfast Health and Social Care Trust Records Retention and Disposal Policy http://intranet.belfasttrust.local/policies/Documents/Records%20Retention%20and%20Disposal.pdf Belfast Health and Social Care Trust Records Management Policy http://intranet.belfasttrust.local/policies/Documents/Records%20Management%20Policy.pdf Belfast Health and Social Care Trust Patient Searches in Mental Health and Learning Disability Inpatient Facilities		

Date	Version	Author	Comments
17/9/14	0.1	Brendan Ingram	Created from a Previous Mental Health Team document

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

All staff have a responsibility to ensure that patients' finances and private property' are safeguarded and that their money is used in a way which reflects their wishes and is in keeping with their treatment or person centered plan.

1.2 Purpose

This policy provides staff with guidelines regarding the handling of patients' finances and private property across the Belfast Health and Social Care Trust in-patient mental health and learning disability wards. This policy should be read in conjunction with: -

- Belfast Health and Social Care Trust Patients' Property Policy
- Belfast Health and Social Care Trust Records Retention and Disposal Policy
- Belfast Health and Social Care Trust Records Management Policy
- Regional Guidelines for the Search of Patients, their belongings and the environment of care within Adult Mental Health/Learning Disability Inpatient Settings
- Belfast Health and Social Care Trust Patient Searches in Mental Health and Learning Disability Inpatient Facilities

1.3 Objectives

This document aims to: -

- Establish a uniform policy and practices for staff in relation to the handling of patients' finances and private property;
- Safeguard the interests of patients;
- Guide and protect staff when dealing with patients' finances and private property

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all patients in a mental health or learning disability inpatient ward and to all staff working within Mental Health and Learning Disability Services within the Belfast Health and Social Care Trust.

3.0 ROLES/RESPONSIBILITIES

Service Managers responsible for inpatient wards within Mental Health and Learning Disability must ensure that this policy and its procedures are disseminated to all staff and implemented.

Operations Managers/Senior Nurse Managers responsible for inpatient wards within Mental Health and Learning Disability must ensure that: -

- Staff are aware of the Management of Patient's Finances and Private Property Policy and Procedures;
- They provide staff with guidance regarding the implementation of this policy.
- Monitor the implementation of the Policy and Procedures within their service area

Charge Nurses/Ward Sisters (hereafter referred to as Ward Manager) responsible for the Mental Health or Learning Disability inpatient ward must ensure that: -

- The Policy and its procedures are made available to all staff;
- Staff have an understanding of the policy and its procedures and have filled in the policy template confirming this;
- This policy is fully implemented within their area of responsibility;
- This policy forms part of the ward's local induction;
- Any updates or issues arising in relation to this policy are discussed at ward meetings or supervision sessions;
- Any issues not resolved should be escalated to their line management.
- It is the responsibility of all staff within Mental Health and Learning Disability Services, Belfast Health and Social Care Trust to adhere to this policy.

Community Social Worker

- It is the responsibility of the patient's community Social Work to ensure that the patient is receiving all benefits that they are entitled to – this can be done in conjunction with the Benefits advice officer – there is now a benefits officer attached to each benefits office.

Staff member

- All staff have a responsibility to ensure that patients' finances and private property' are safeguarded and that their money is used in a way which reflects their wishes and is in keeping with their treatment or person centered plan.
- If a staff member has any concerns regarding the way in which a patient's money is being used they should immediately inform the Ward Manager or Senior Nurse Manager/Operations Manager.
- Where the patient is not capable of understanding their affairs, staff must ensure that all purchases on their behalf are appropriate for their needs and individual to them.

4.0 KEY POLICY PRINCIPLES

Where possible, patients will be able to go out of hospital to make their purchases.

No patient should be purchasing items from their own finances which should be provided by Public Funds (e.g. essential food items, furniture, or large cost items).

All patients' finance records must be retained for seven years.

Therapeutic earnings – (Muckamore Abbey Only – Not applicable to Mental Health In-Patient Units)

As of 2010 and upon direction from the then Hospital Services Manager, therapeutic earnings are no longer requested for newly admitted patients to Muckamore Abbey Hospital. Those currently on therapeutic earnings will continue to receive these as they have always done. Amounts currently being received by patients should not be revised up or down for any reason.

Article 15 Payments

Definition
An Article 15 is an extraordinary payment to a patient and should be issued if the following circumstances arise:

a) Patient has no access to their own money whilst in the Hospital and the Hospital cannot get access to their money via a third party (i.e. relative).
b) Patient has no money and has no right to benefits (i.e. overseas patient).
c) If Patient does not get access to finances their behaviour could cause an adverse incident to occur.

Process

1) If any of the above applies, then the Nurse In Charge completes an Article 15 request which must be signed by the Operations Manager/Senior Nurse Manager who is on duty.
2) A staff member who is on the authorised signatory list can bring the Article 15 to the patient bank/cash office between the hours of 10:00am to 12:30am (Monday to Friday) when the patient bank/cash office is open and the money will be released.
3) Outside these hours they must ring the patient bank on 028950 47818 (Knockbracken) and 02895046119 (Muckamore) to inform them that a member of staff will be coming to them to release money under Article 15.
4) No Article 15 money will be released to the patient directly.
5) There is no facility to issue Article 15 payments at the weekend.
6) A copy of the Article 15 request will be retained by the patient bank/cash office and this will be signed by the staff member who is receiving the money.
7) The staff member must record that this money has being brought onto the ward in a patient ledger for the client. This should be signed in by two staff members.
8) If the money is handed to the patient it must be signed by the patient as well as the staff member who released the money. If the patient can't sign it must be signed by two staff members.
9) If staff are spending the Article 15 money on behalf of the patient then receipts must be retained on the ward and a clear record of how the money was utilised.
10) If possible this money should be recouped from the patient when they get access to finances

Remand Prisoners who are admitted to a Mental Health or Learning Disability In-Patient Unit are entitled to £20/week – the ward sister or charge nurse should put in place the necessary arrangements to have this paid into a PPPA Account for the patient for the duration that they remain on remand status.

4.1 ADMISSION TO WARD

The pre-numbered Property to Cash Office/Patient Bank (Appendix 1) should be completed for patients admitted to hospital where property is to be lodged to the Cash Office.

This form should be used to detail 'valuables' such as money, bank cards, jewellery. Clothes or items of low value should not be documented on this form.

The patient should sign and date the form when completed. Where the patient is not capable of signing the form, a relative may sign in their place. The form should then be signed and dated by two members of staff, one of whom should be a registered nurse. The top copy of the form should be given to the patient (or relative where appropriate).

The Property to Cash Office/Patient Bank form (Appendix 1) along with the property in the Property Envelope (Appendix 7), should be brought to the cash office (with the second and third copy still fast in the book). The Cash Office should sign and date the bottom of the form, acknowledging receipt of the property. The cash office should then take the second copy of the form for their records. The third copy of the form should be retained in the Property to Cash Office book permanently. This is the ward's permanent record. Staff should take cognisance of the following when completing the Property to Cash Office/Patient Bank Form (Appendix 1): -

- Tippex must not be used when making alterations to the form – all alterations must be made with black ink and signed by the person making the change.
- Jewellery (and any other valuables) should be described in non value adding terms (e.g. white/yellow coloured metal with white stone rather than silver/gold with diamond)
- Forms must not be removed from the book if an error is made. In such cases forms should be cancelled with two diagonal lines across the form with "cancelled" in between. A new form should then be started.

Any cash in possession of the patient on admission that is not to be lodged to the cash office should be entered onto a Cash Record (Ledger) (Appendix 2). This should document 'cash on admission' under 'transaction details'. This should then be completed as per the procedures below under 'Cash on Wards'.

Any property in possession of the patient on admission that is not to be lodged to the cash office should be entered onto a Property Ledger (Appendix 3). This should document 'property on admission' under 'transaction details'. This should then be completed as per the procedures below under 'Cash on Wards'.

If a patient arrives to a Mental Health or Learning Disability In-Patient Ward with no money, the Ward Manager or Nurse in Charge should consider the following,

- Discussion with family regarding access to money for the patient

- Access to the patient's community bank Account – note that this will be dependent on whether the patient is deemed to have capacity or not.
- Article 15 Payment.

There should be a record in the patient's Care Plan of the amount of money they receive from Benefits and on what basis this is received, e.g. weekly fortnightly, monthly etc. In some cases, because of length of stay, a patient's benefits may not be transferred into the hospital.

The Care Plan should indicate the patient's ability to manage their own money within the confines of this policy. Where appropriate, family members may be involved in this discussion if it is in the patient's best interests. It should be recorded in the front of the Care Plan if the patient is capable of managing their cash card and/or bankbook. Staff should refer to Appendix 9 guidance on "Deeming a patient capable, incapable or temporarily incapable"

Where staff assume responsibility for patients' monies or property/valuables held in patient safes or bisley drawers, appendix 4 should always be completed when it has been necessary to access either the safe or the bisley drawers.

4.2 CAPABILITY OF PATIENT

Within the Mental Capacity Act April 2005, the wording regarding Incapacity is:

"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"

Until there is Northern Ireland specific legislation, this Act is the most definitive guidance available.

Where a person is considered capable of managing his or her own finances, in certain cases the Multidisciplinary Team and/or Nurse in Charge may take interim measures to control a capable patient's access to money and valuables, until the Multidisciplinary Team fully assesses the patient's capability. Examples of this may include admissions out of hours or admissions over a long weekend which includes bank holidays and whereby a Multidisciplinary Team may not be immediately available. Refer to guidance (Appendix 7) on **Procedure to Follow for Deeming a Patient Capable or Incapable at the point of Admission**

A Financial Control Form (Appendix 10) should be used for both capable (Where the patients is agreeable to this) and incapable patients, however the limits established for capable patients should be discussed with the patient, and where appropriate their family or advocate. Applied limits for capable patients should be reviewed regularly with the patient. This will allow cash office staff to modify the amounts of money that they request for delivery to the hospital weekly.

The Cash Office must enter the information from this Financial Control Form onto their computerised Patients' Private Property system so that it can be referenced by Cash Office staff at all transactions.

Cash Office Staff will have a record on each patient's account regarding their capability. This will assist them in applying the procedures to each patient's circumstances. The Ward Manager is responsible for informing the Cash Office of any change in the capability status of a patient on their ward. A Financial Control Form (Appendix 10) must be completed, and forwarded to the Cash Office, to notify of any change in status of the patient.

4.3 WITHDRAWALS & EXPENDITURE

Withdrawals will be limited to what has been agreed for each patient on the financial control form, however the amounts can be changed should a patient's circumstances change. In the case of capable patients, flexibility must be provided for them to increase the amount on the financial control form should they request this. However it is recommended that withdrawals are limited in order to keep the cash float in the Cash Office to a minimum.

Cash will be issued up to the agreed amount on the financial control form.

Authorisation Levels – A Senior Nurse Manager/Operations Manager will be able to sign withdrawals up to £500.00, Hospital Service Manager will be able to sign withdrawals up to £2000.00, anything above this must be authorised by a Co-Director/Director

Patients Bank/Cash Office will contact the Ward Manager about exceptionally high withdrawal requests.

A request for expenditure will be processed only after considering whether the patient has sufficient funds available. Accounts must never become overdrawn.

Capable Patients may withdraw their agreed limit of money (as per financial control form) using Withdrawal Form 1 (Appendix 5). Capable Patients will require a staff signature to withdraw money; however as a further safety measure staff must now complete in words as well as a figure the amount of money that the patient has requested to withdraw. Again as an added safety measure, if they are willing to do so, staff may ask the patient to sign the form so that there is both a staff signature and a patient signature. Full and complete information must be recorded on this form.

Incapable Patients may have access to their money using Withdrawal Form 2 (Appendix 6). This is the same form that will be used for Group Withdrawals. This form will be signed by two members of staff. Both members of staff must be on the authorised signatory list for that ward. The word Purpose has been changed as a result of audit to read "Specific Purpose" – Staff completing the form should complete as much detail as possible in this column. Full and complete information must be recorded on this form.

A decision should be made regarding any large purchases for incapable patients between: -

- Patient
- Family/Advocate
- Multidisciplinary Team
- Appointee/Controller

Where the patient is incapable, the money should be returned to the ward and documented on the Patient Cash Record (Ledger) (Appendix 2), ensuring a full audit trail.

Wards may also request monies for a number of patients. In such instances, ward staff should complete Group Withdrawal form (Appendix 6). This form should detail:

- Patient Name
- Patients' Private Property Account Number
- Amount Requested
- Purpose – this has been changed as a result of audit to read "Specific Purpose" – Staff completing the form should complete as much detail as possible in this column.

The form should be signed off by the member of staff filling out the form. It should then be passed to a senior member of ward staff who should review and sign off the form. This person should be listed on the Authorised Signatory list for that ward; if not, the form will not be processed by the Cash Office. The approving officer should also detail the name of a staff member to collect the monies from the Cash Office. The same member of staff cannot request, approve and collect monies on behalf of patients. The details on this form can be emailed in advance to allow Cash Office staff sufficient notice to prepare monies/cheques, however the original signed copy of the form will be required when collecting the money.

The patient (or two staff where the patient is deemed incapable) must sign the sheet on receipt of money as evidence that it has been placed in the cash cabinet and recorded in the Patient Cash Record (Ledger) (Appendix 2). Receipting of monies and subsequent transactions should always be dated sequentially, there should be no retrospective recordings made.

Each ward must send their staff members for cash collections with appropriate identification.

4.4 STAFF SIGNATURES

Each ward will provide the Cash Office with a list of staff signatures on a quarterly basis.

The ward managers must notify the Cash Office of any amendments to the list during each quarter. The ward manager must retain a list of these signatures to ensure that any changes are reported to the Cash Office. The Cash Office must only process

transactions in line with the current signatory lists. Senior Nurse Managers/Operations Managers will as part of their monthly monitor check to ensure that these lists are being updated accordingly.

4.5 RECEIPTS

If the patient is capable of handling their own money when going out e.g. home leave, hairdressing trip, they may complete a Withdrawal Form 1 (Appendix 5) as detailed previously. Where the patient/ is capable and can sign for withdrawals, no receipts are required.

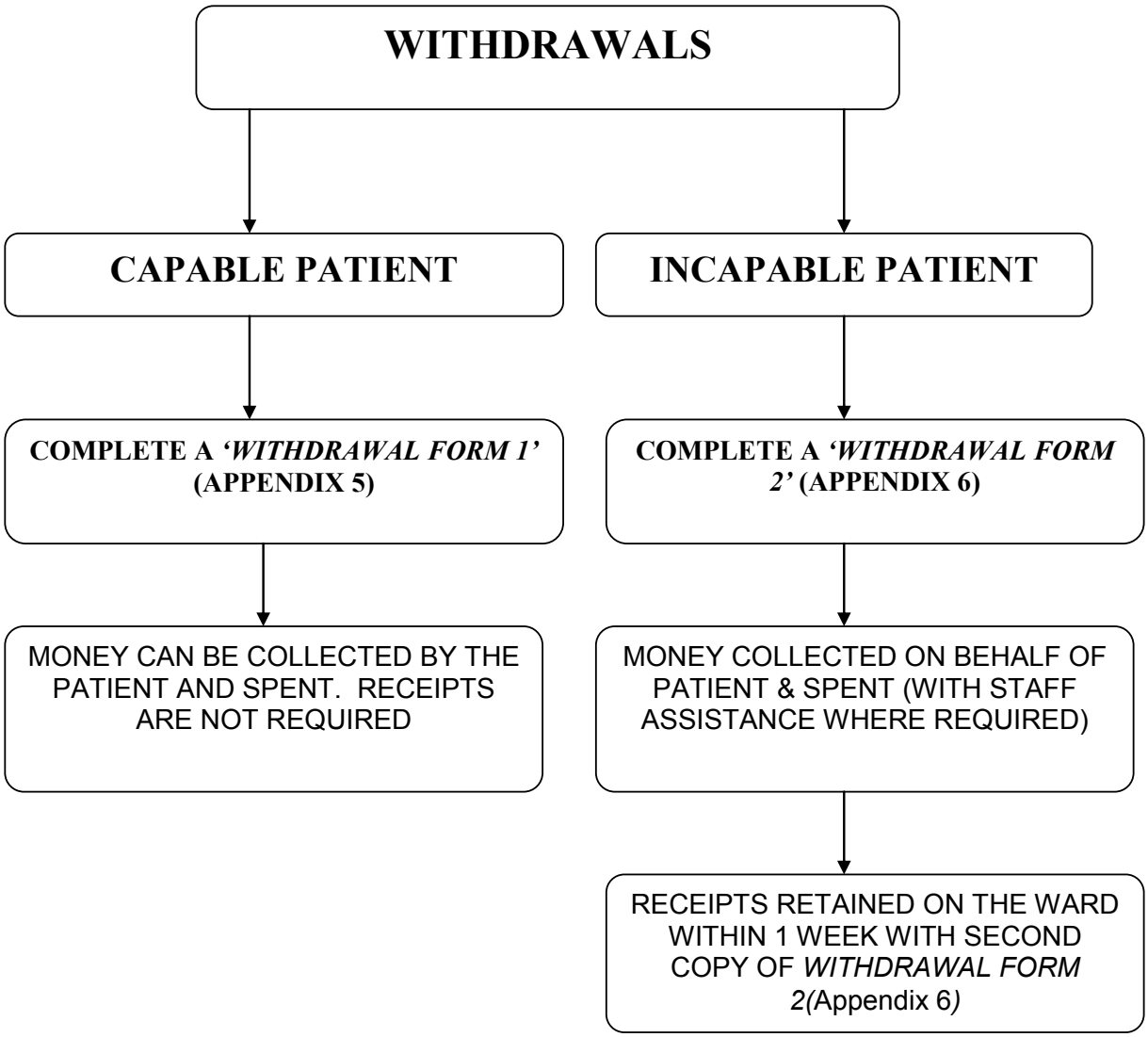
Where a patient is deemed incapable, all receipts for expenditure should be produced within 1 week of the issue of cash and should be retained on the ward and attached to the pink sheet of the withdrawal form 2. The purpose of the withdrawal should be clearly documented on the form and the form has now been updated to request staff to complete specific purpose. This form must carry two staff signatures, both of whom must be qualified members of staff and whose name is on the authorised signatory list. This is to facilitate goods which may have to be exchanged at a later date. If receipts are not present at the time of any SNM/Operations Manager Monitor Visit, an investigation should be commenced. If there is a small amount of residual monies left after purchases have been completed, this should be noted on the pink withdrawal sheet as well as the patient's cash ledger on the ward. The ledger should also detail the relevant PPPA Form number. Alternatively residual monies can be lodged back to the cash office but again should be detailed on the pink withdrawal form and the patient's cash ledger.

All group expenditure must be supported by receipts which must have the date and specific purpose that it relates to easily identifiable. Receipts for group expenditure such as ward entertainment etc should be noted on the Withdrawal Form 2 and an equitable amount should be payable by each patient. Where group purchases are being used for entertainment, outings etc, i.e. more than one patient involved, consent must be sought and evidenced for each patient. Items such as toiletries/clothes are not to be bought as group purchases. Individual monies for group purchases should not be used directly from cash drawers, but instead should have a Withdrawal form 2 (Appendix 6) completed so that a full audit trail can be completed.

These receipts should be retained in a ward diary under the date of the expenditure to allow for an audit trail. These receipts should be returned to the cash office at the end of each financial year to allow finance staff to carry out random internal audit checks.

No receipt should be tampered with at any time.

Withdrawals, Expenditure and Receipts



4.6 CASH ON WARDS

When a patient receives money from, therapeutic earnings, their Patient's Private Property Account, the cash should be locked in the individual's cash drawer/keypad safe in the ward and recorded on the Patient Cash Ledger (Appendix 2) immediately. Where a patient receives money from a relative or visitor, this should be documented in the ward receipt book and the top copy given to the relative or visitor – the receipt book should carry two staff signatures one of which is on the authorised signatory list. A decision should then be taken in conjunction with the patient as to whether this money is to be retained in their cash drawer or sent to the cash office. In either case the appropriate forms should be completed and signed as stated previously. Where cash handed in by a relative or visitor is to be lodged to the patient's PPPA in the cash office, this should be completed within 24 hours with the only exceptions being at weekends or over bank holidays. Where this occurs, the monies should be securely locked in the cash drawers and witnessed by two members of staff.

The keys for cash drawers should be held by the Nurse in Charge of each shift and should not be attached to any keys including medicine keys.

Where staff have reason to access patient keypad safes, bisley drawers or any other form of storage where a patient may keep their monies or property, the staff member/s must sign the proforma (Appendix 4) detailing who and why accessed the keypad safe, bisley drawer, or any other form of storage. It is preferable that two members of staff sign this proforma as evidence of the need to access these either on the patient's behalf or when reconciliations or the addition of monies is being made.

An upper limit of cash to the value of £100.00 may be held on the ward for any individual patient. (this may be seasonal) The exception to this is when an amount of money has been placed in the cash drawers to be spent within a 24-hour period or over a weekend for a specific purpose e.g. weekend leave, shopping trip. Monies should not be requested from the cash office to simply act as a top up to the £100.00 agreed limit.

Withdrawals of monies from the cash office should as far as is practicably possible have a specific purpose.

Excess money i.e., above the agreed £100.00 limit for any individual should be lodged in their Private Property Account. This will be monitored by the ward Manager and the Senior Nurse Manager/Operations Manager as part of their monitoring visits.

A Patient Cash Ledger (Appendix 2) has been devised and must be used on every ward for each patient. Each ledger should record:

- The date/time of the transaction
- Description of the transaction
- The amount of cash received or withdrawn
- The remaining cash balance
- The signature of the staff member adding/withdrawing funds and countersigned by a second member of staff. These staff must assure themselves that balances are correct and any discrepancies noted and adjusted.

All signatures should be in full in black ink and should be legible

If the ledger is signed by one nurse and the patient or their family, a second nurse's signature is not required.

Monies held at ward level should be checked by two nurses at the start and end of each handover, preferably by one nurse coming on shift and one nurse going off shift. Any discrepancies should be referred to the Duty Nursing Officer immediately for investigation.

4.7 GROUP EXPENDITURE

Group expenditure is where purchases are made for a group of patients at the same time (e.g. a ward party or entertainment which is for more than one patient). As far as is practicable, these costs should be ascertained in advance so that equitable amount of monies can be withdrawn therefore negating the need for "Change" to arise.

Money for such expenditure should be requested in line with the procedures outlined above and using the (Group) Withdrawal Form 2 (Appendix 6).

The officer authorising the expenditure must satisfy themselves that the money being requested is reasonable and appropriate for each patient.

4.8 RECEIPTS FOR GROUP EXPENDITURE

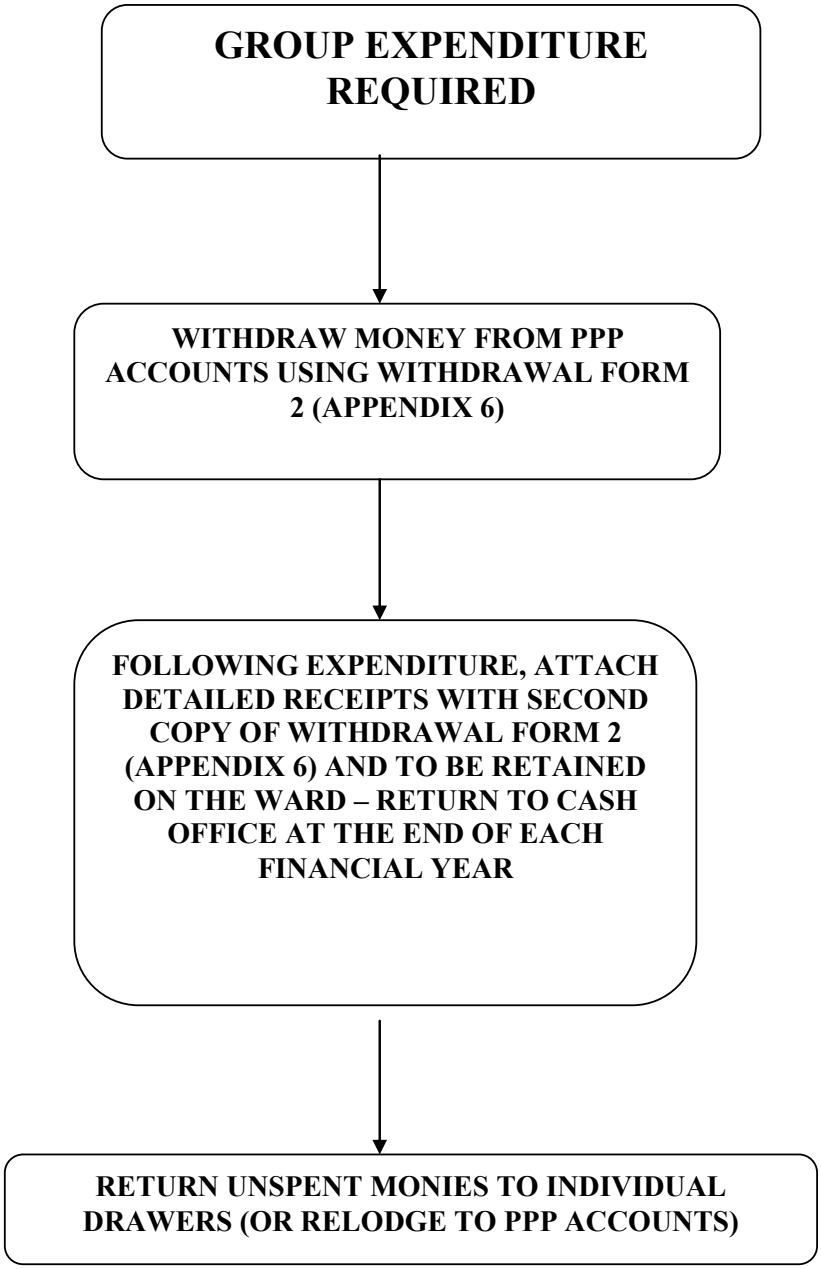
All group expenditure must be supported by detailed receipts which must have the date and specific purpose that it relates to easily identifiable.

These receipts should be retained with the Withdrawal Form 2 (Appendix 6) in a ward diary under the date of the expenditure to allow for an audit trail.

No receipt should be tampered with at any time.

The procedure to be followed for Withdrawals, Expenditure and Receipts is illustrated below.

GROUP EXPENDITURE



4.9 TRANSACTION AND FLUCTUATION REPORTS

Cash Office/Bank Staff will issue a monthly transaction report to each ward manager which will detail all incoming monies and outgoing expenditure – this should be reviewed by either the ward manager or deputy ward manager for any discrepancies and signed on the day that the report is reviewed – the Senior Nurse Manager/Operations Manager will audit this as part of their monthly checks.

Cash Office/Bank Staff will issue a monthly fluctuation report to Senior Nurse Managers/Operations Managers for all patients within their respective wards – the Senior Nurse Manager/Operations Manager will review, sign and date the fluctuation report and report any discrepancies to the Service Manager for immediate investigation.

4.10 SAFE KEEPING OF ITEMS OTHER THAN CASH (Property)

Each Ward should operate a Patient Property Admission book to detail all items of clothing/property that a patient brings into the ward and which will not be considered for safekeeping in their property drawer or in the Cash Office. The patients clothes/property should be documented by two nurses, or one nurse and the patient or the next of kin.

When a member of staff accepts any item for a patient which is to be placed into a property drawer this is accepting responsibility for safe keeping of the item.

All items must be recorded on a separate Patient Property Ledger (Appendix 3). Such items could include electoral cards, cash withdrawal cards. Any personal jewellery or other items must have a brief description recorded on the ledger, in non-value adding terms, where possible (e.g. yellow coloured metal, watch).

Any of the items described above can also be lodged into the cash office for safe keeping using the “Property to Cash Office” Form (Appendix 1). Where this is used, two staff will evidence and document on the “Property to Cash Office” form clear details of the property being transferred to the Cash Office. Ward Staff and Cash Office staff will check and agree the contents of each envelope when it arrives in the cash office and will both sign to validate each other’s agreement to the contents. The process should be repeated when patient’s property is being removed from the Cash Office for return to the patient.

Property which a patient may wish to hand in for safe keeping during any part of their stay may be managed using either of the above methods. Generally the value of the item will dictate whether it should be stored on the ward or in the cash office – this may also be dependent on how often the patient wishes to access the item.

Property held at ward level should be checked and documented by two nurses at least weekly by one nurse coming on shift and one nurse going off shift. Any discrepancies should be referred to the Duty Nursing Officer immediately for investigation.

4.11 DECEASED PATIENTS' PROPERTY

The Cash Office/Patient's Bank have very specific guidelines in place for dealing with deceased patient's cash and property/valuables, however the following provides some guidance for staff to manage deceased patients' cash and property/valuables.

Any property belonging to deceased patients and held at ward level should be lodged in the Cash Office, using the Property to Cash Office Form (Appendix 1). This avoids the possibility of issuing property to the wrong person.

Any property/valuables belonging to deceased patients and held at ward level should be gathered, an inventory created, signed by two qualified members of nursing staff and retained in a secure area of the ward until such times as letters of administration or forms of declaration have been finalised by either the Cash Office/Patient's Bank.

Letters of administration are sent to the Next Of Kin by the Cash Office/Patient's Bank staff where the patient's estate (includes monies and property/valuables) is in excess of £5000 and the administration is directed by the courts.

Forms of declaration are sent to the Next of Kin by the Cash Office/Patients' Bank staff where the patients' estate (includes monies and property/valuables) is less than £5000. Upon receipt of these back to the Cash Office/Patients' Bank, (signed by a family solicitor)the Cash Office/Patients' Bank staff will then proceed to forward all monies to the Next of Kin.

Once the Cash Office/Patients' Bank staff are in possession of either of the above "Letters of Administration or Forms of Declaration", a copy will be forwarded to the ward manager who will notify the Next of Kin in respect of property/valuables so that a decision can be reached with them in respect of disposal of said items, i.e. it may be that the Next Of Kin may not wish to take away all property/valuables and it may be that they will want to donate some of the items to the ward or to the hospital in general.

Both of the situations described above refer to patients where there is no known will – where there is the existence of a will, Grant of Probate will have to be applied for, and in such cases staff should follow the steps described above for both monies and property/valuables until the Grant of Probate is obtained.

Nursing staff must not give money or valuables directly to relatives.

Next of Kin of deceased patients should be informed that property/valuables are being retained by the ward until such times as one of the above processes has been completed depending on what the patient's situation was at that time.

A record should be retained in the Patient Care Plan of any items disposed of, including clothing and equipment.

4.12 RESETTLEMENT/DISCHARGE OF A PATIENT

This guidance only applies to those patients who are being resettled/discharged and are deemed to be incapable of managing their own financial affairs.

Assumptions:

The Multidisciplinary Team alongside Care Managers meet to discuss the resettlement of patients. At these meetings and in conjunction with families there will be discussions on what is considered to be the facility most suited to meet the needs of the patient.

a) At this meeting, Finance staff consider that it is important to discuss the financial implications of the resettlement/discharge for the patient.
   As part of this review of the patient's finances, money should be set aside if practicable for the following types of expenditure
   - Funeral Plan
   - Furniture if going into supported living (Care Manager's will have responsibility to ensure that all expenditure in this respect is both reasonable and necessary)

Trial Resettlement

Whilst the patient is on a trial resettlement, Finance recommends that the appointeeship and benefits are relinquished at Learning Disability and Mental Health In-Patient Facilities as this is impacting on benefits which the patient should be able to claim once they have proceeded on trial resettlement.

The financial implications of the resettlement should be discussed at the resettlement meetings, therefore allowing everyone to have a good understanding of what the financial impact is for the patient. Hospital finance staff can release the following if it is addressed at the resettlement meetings until such times as the patient is in receipt of all of the benefits they are entitled to living in the community.

i) Rent for Supported living if the patient is eligible to pay, i.e. has more in their personal account than the threshold for payment allows.

ii) If a patient requires daily living cost monies while on Trial Resettlement, the facility to which they are resettling must request in writing from the care manager/social worker the amount that is required for the patient. The facility should as far as is practicable indicate why the monies are being requested.

iii) Appendix 12 should be completed and a copy sent to Cassandra McAuley (Muckamore Abbey Hospital Cash Office) for Learning Disability Patients or Maria

McLean (Knockbracken Patients' Bank) for Mental Health Patients at least two weeks prior to the patient commencing resettlement.

iv) The care manager/social worker will sign the request and forward to Hospital Finance for payment of a cheque to the facility. Hospital Finance will forward the cheque to the facility. The cheque will have to be paid into the facility's business account as the patient will not have a personal account at this stage. Each facility will have a responsibility for ensuring that it has robust internal accounting procedures for patients' personal spend.

v) When Hospital staff use the current Withdrawal Form 2 to withdraw monies for a patient who is going out on resettlement, they must make an entry into the patient's ledger stating that this was withdrawn for the purposes of trial resettlement and the name of the location where the patient is going. This should also be clearly indicated in the column "Specific Purposes" on the Withdrawal Form 2.

vi) The facility will be responsible for all receipting of the patients' monies. Corporate Finance staff will have the responsibility for inspection of receipts in all community facilities.

vii) Payment to other Trusts for placements in Residential & Nursing accommodation. The care manager or in the absence of the care manager, the social worker identifies the cost of the trial resettlement placement and forwards the finance form which includes the cost of the placement and senior manager authorisation to the finance department at Glendinning House so that the provider can send the invoices for this direct to the finance department at Glendinning House. All third party providers need to ensure that their bank details are included on all invoices submitted for payment. On-line payment transfers can be completed within 24-48hours if requested, again bank details need to be included on all invoices submitted for payment.

viii) Finance will release the money on these instructions without the need to go back to the discharge ward for approval. If a request for expenditure is significantly higher than was planned in the resettlement meeting then Finance will request additional information from whomever is requesting the money and liaise with the patients care manager/social worker to ascertain if the expenditure is reasonable before they release the money.

Permanent Resettlement

If the patient is eventually resettled on a permanent basis, the following should happen with immediate effect:

i. Savings will automatically be transferred to the relevant Trust except for the Belfast Trust where the patient's savings will remain and all future benefits will continue to be managed by the Belfast Trust.

ii. Any additional costs incurred and identified by the Belfast Trust after the patient has been discharged will be invoiced directly to the Trust to which the patient has been discharged.

iii. All future releases of money for patients' resettled in the Belfast Trust from the patient accounts will be in consultation with their community worker – the proforma (Appendix 9) should be completed and forwarded to finance staff.

iv. Finance staff will inform the Office of Care and Protection of any patient balance above £20K who has been resettled to any 3rd Party non-trust facility.

4.13 Patient Discharge to Home

If a patient/resident is discharged to their own home, then on a receipt of notification from the Ward/Medical Records or the Officer in Charge, the money is paid directly to the patient/resident.

4.14 MONITORING PROCEDURES

Monitoring of patients finances and property will be managed through the following actions:

Each patients' monies will be checked at each handover by two qualified nurses both of whom should be authorised signatories.

The ward manager will check at least once a week that Patient's Cash/Property Ledger (Appendix 2&3) have been updated (Random sample minimum 3) and that balances tally. Any discrepancies noted should be reported to the Senior Nurse Manager/Operations Manager and an immediate investigation commenced.

The Senior Nurse Manager/Operations Manager will randomly select two patients, per ward, per month and check that their finances/property are being managed properly and in keeping with the policy. The Senior Nurse Manager/Operations Manager will sign and date the ledger that they check as well as completing their own monitoring sheet (Appendix 11) which should be retained for inspection by internal audit or any regulatory body. The Senior Nurse Manager/Operations Manager will also check and document on their monitoring sheet (Appendix 11) that the ward manager has checked the required number of cash and property ledgers each week. Any discrepancies noted at this stage should be reported to the Hospital Services Manager/Service Manager and an immediate investigation commenced.

The Cash Office/Patient Bank staff will produce monthly fluctuation reports for each of the wards which will be sent to the Senior Nurse Managers/Operations Managers for verification of significant increase or decrease in patient PPPA Balances.

The Cash Office/Patient Bank staff will produce monthly patient reports which will be sent to each charge nurse/ward sister detailing income, expenditure and balance for each patient – the charge nurse/ward sister will check each months report to ensure that there are no discrepancies in income, expenditure or balances.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination
This policy will be disseminated to all staff working within a mental health or learning disability inpatient facility.

5.2 Resources
Nil

5.3 Exceptions
This policy applies to mental health and learning disability inpatient facilities

6.0 MONITORING

Please refer to procedures

7.0 EVIDENCE BASE / REFERENCES

1. Belfast Health and Social Care Trust Patients' Property Policy
http://intranet.belfasttrust.local/policies/Documents/Patient%20Property%20-%20Handed%20in.pdf

2.Belfast Health and Social Care Trust Records Retention and Disposal Policy
http://intranet.belfasttrust.local/policies/Documents/Records%20Retention%20and%20Disposal.pdf

3.Belfast Health and Social Care Trust Records Management Policy
http://intranet.belfasttrust.local/policies/Documents/Records%20Management%20Policy.pdf

8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: -
Finance Staff
MHLD Ward Managers
MHLD Senior Nurse Managers/Operations Managers
MHLD Service Managers
Hospital Services Manager
MHLD Co-Directors

9.0 APPENDICES / ATTACHMENTS

App 1: Property to Cash Office
App 2: Cash Record (Ledger)
App 3: Patients/Clients Private Property Record
App 4: Record of Staff Access to Patient Keypad Safes or Bisley Drawers
App 5: Withdrawal Form 1
App 6: Withdrawal Form 2
App 7: Property Envelope
App 8: Capability Guidance
App 9: Guidance for deeming a patient capable/incapable/temporarily incapable
App 10: Medical Financial Control Form
App 11 : Senior Nurse Manager/Operations Manager's Monitoring Form
App 12: Financial Support Plan
App 13: Staff Declaration

10.0 EQUALITY STATEMENT

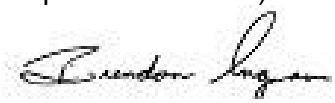
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

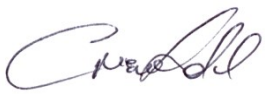
Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



_____ Date: _____April 2015_____
Author



_____ Date: _____April 2015_____
Director

Belfast Health and Social Care Trust

PROPERTY TO CASH OFFICE

1000001

APPENDIX 1

NAME OF PATIENT _____ WARD/FACILITY _____

PATIENT NUMBER _____ DATE ADMITTED _____

PATIENT ADDRESS _____

_____

_____

	DETAILS
CASH CREDIT CARDS DEBIT CARDS	
OTHER VALUABLES Including: BANK BOOKS CHEQUE BOOKS BENEFIT BOOKS JEWELLERY	

The details of my property as recorded above are correct. I understand that any articles retained in my possession are my own responsibility and that the Belfast Health & Social Care Trust will not accept liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt has not been obtained.

PATIENT SIGNATURE _____ DATE / / 20___

Witnessed, checked and received by:

STAFF SIGNATURE 1 _____ DATE / / 20___

STAFF SIGNATURE 2 _____ DATE / / 20___

TO BE COMPLETED BY CASH OFFICE

I ACKNOWLEDGE RECEIPT OF THE PROPERTY AS DETAILED

CASH HAS BEEN LODGED TO PPP ACCOUNT _____

SIGNATURE _____ DATE _____

TOP COPY - TO PATIENT
SECOND COPY - TO CASH OFFICE (WHERE APPROPRIATE)
THIRD COPY - REMAINS IN BOOK

Belfast Health and Social Care Trust

PATIENTS'/CLIENTS' PRIVATE PROPERTY
CASH RECORD (LEDGER)

APPENDIX 2

Name Of Patient	
Name Ward/Facility	

Date	Time	Transaction Details	Amount Received	Amount Withdrawn	Balance	Staff Signature 1	Staff Signature 2/ Patient Signature	Sister/Charge Nurse/SNM Weekly/Monthly Monitor
		Balance Brought Forward						
		Balance Carried Forward						

Belfast Health and Social Care Trust

Appendix 3

PATIENTS / CLIENTS PRIVATE PROPERTY

HOSPITAL: _____ WARD / FACILITY: _____

PATIENT NAME: _____ HOSPITAL NUMBER: _____

DATE: _____ TIME: _____

Reason for Completion (please circle) Admission /Transfer / Discharge / New Purchase / Other (_____)

Please List Property below

I Understand that any property retained in my possession are my own responsibility and that The Belfast Health & Social Care Trust will not accept liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt is not obtained.

Patient / Client Signature: _____

Staff Signature 1: _____ Staff Signature 2: _____

Appendix 4

Record of Staff Access to Patient Keypad Safe, Bisley Drawer, or Any Other Form of Storage for Patients' Monies or Private Property.

Please note that two staff should sign the form below when requesting access to a master key for any of the above forms of storage for patients' monies or private property at the patient's request or to perform reconciliations, add monies to a patient's existing balance or to withdraw monies from existing balances. (This should occur on every occasion as recommended by RQIA in their Quality Improvement Plan, Belfast Health and Social Care, Finance Inspection, December 2013

Date of Access	Signature 1	Signature 2	Reason for Access

Belfast Health and Social Care Trust

WITHDRAWAL FORM 1

APPENDIX 5

NAME OF PATIENT	
WARD/FACILITY	
PATIENT NUMBER	

ACCOUNT NUMBER		AMOUNT	£ :

PLEASE WRITE THE AMOUNT IN WORDS HERE

DETAILS OF EXPENDITURE:

PATIENT SIGNATURE _____ STAFF SIGNATURE _____

DATE _____ DATE _____

_____

TO BE COMPLETED BY CASH OFFICE

SIGNATURE _____

DATE _____ TRANSACTION # _____

Belfast Health and Social Care Trust

PATIENTS' PRIVATE PROPERTY
WITHDRAWAL FORM 2

APPENDIX 6

WARD/FACILITY	
DATE	

PATIENT NAME	A/C NUMBER	AMOUNT REQUESTED	SPECIFIC PURPOSE	TRANSACTION # (CASH OFFICE USE)
TOTAL			AMOUNT TO BE WRITTEN IN WORDS	

REQUESTED BY _____

APPROVED BY _____

TO BE COLLECTED BY _____

AUTHORISED SIGNATURE REQUIRED

CHEQUE SHOULD BE MADE PAYABLE TO: _____

PATIENTS' PRIVATE PROPERTY

PROPERTY ENVELOPE

APPENDIX 7

Belfast Health and Social Care Trust

HSC

PATIENT NAME _____

ADDRESS _____

PATIENT NUMBER _____

WARD/FACILITY _____

DATE _____

COUNTED BY _____

CHECKED BY _____

CONTENTS

MONEY	JEWELLERY	OTHER VALUABLES

Belfast Health and Social Care Trust

APPENDIX 8

PATIENT NAME	
WARD/FACILITY	
PATIENT NUMBER	

CAPABLE PATIENT

The above named patient is capable of managing their own financial affairs.

NURSES SIGNATURE (1) _____NURSES SIGNATURE (2) _____

DATE _____ DATE _____

MEDICAL OFFICER
SIGNATURE _____ DATE _____

I agree to a maximum withdrawal limit of £_____ per week. I will give one week's notice in writing to the cash office if I wish to withdraw more than this limit.

PATIENT SIGNATURE _____ DATE _____

impairment of, or a disturbance in the functioning of, the mind or brain. They are unable to make financial decisions free from undue influence. This opinion is based on the best evidence and information available at the time of signing.

This is a permanent feature of their condition.

Staff may withdraw up to £250.00 per week. Aounts above this need to be processed through the normal authorisation process.

MEDICAL OFFICER
SIGNATURE DATE

APPENDIX 8

TEMPORARILY INCAPABLE PATIENT

The above patient lacks capacity in relation to managing their finances due to an impairment of, or a disturbance in the functioning of, the mind or brain. They are unable to make financial decisions free from undue influence. This opinion is based on the best evidence and information available at the time of signing. This situation may change with treatment and should be reviewed in _____

Staff may withdraw up to £25-0.00 per week. Amounts above this need to be processed through the normal authorisation process.

NURSES SIGNATURE (1) _____NURSES SIGNATURE (2) _____

DATE _____ DATE

Belfast Health and Social Care Trust

APPENDIX 9

Guidance for Deeming a Patient Capable or Incapable At The Point of Admission

The new Financial Control Form has three options for the capacity of the patient to manage their own finances. These are:

- Capable
- Incapable
- Temporarily Incapable

There is an assumption under the Mental Health Act (England & Wales) that capacity is present. This is the starting point for assessing each patient's capacity. When a patient is admitted there should be an assessment undertaken to determine if there is evidence suggesting that the patient may lack capacity. This will be carried out using the formalized assessment tool developed by ARC. This tool is designed to be used by any qualified member of the MDT. At this assessment the patient can be found capable, incapable or temporarily incapable.

New Admissions:
At the post-admission meeting there will be further evidence available to the MDT regarding the person's circumstances in the community. It is essential that the Financial Capacity Form is reviewed at this stage. A form signed by the medical officer should then be submitted in light of the updated evidence.

The individual's financial capacity should be further reviewed either as triggered by the temporarily incapable review limit or on significant change in circumstances. This should result in an updated form being submitted.

At the discharge meeting a final agreement on the person's financial capacity should be noted. This should be documented in the person's care plan, medical notes and a financial capacity form submitted to ensure that there is timely referral to the Office of Care and Protection or release of patient's monies as appropriate.

Current Inpatients:
For those patients who are receiving inpatient care at the time of introduction of the new forms it is necessary that one of the new forms should be submitted as soon as practical for this population.

<u>Assessment</u>
Capable Assessment
All patients should be found capable unless there is evidence to suggest otherwise. It is not enough to assume that because they have a mental illness or intellectual disability that they do not have capacity. This can be signed by two members of nursing staff (band 5 or above) or the medical officer at point of admission.

Belfast Health and Social Care Trust

APPENDIX 9

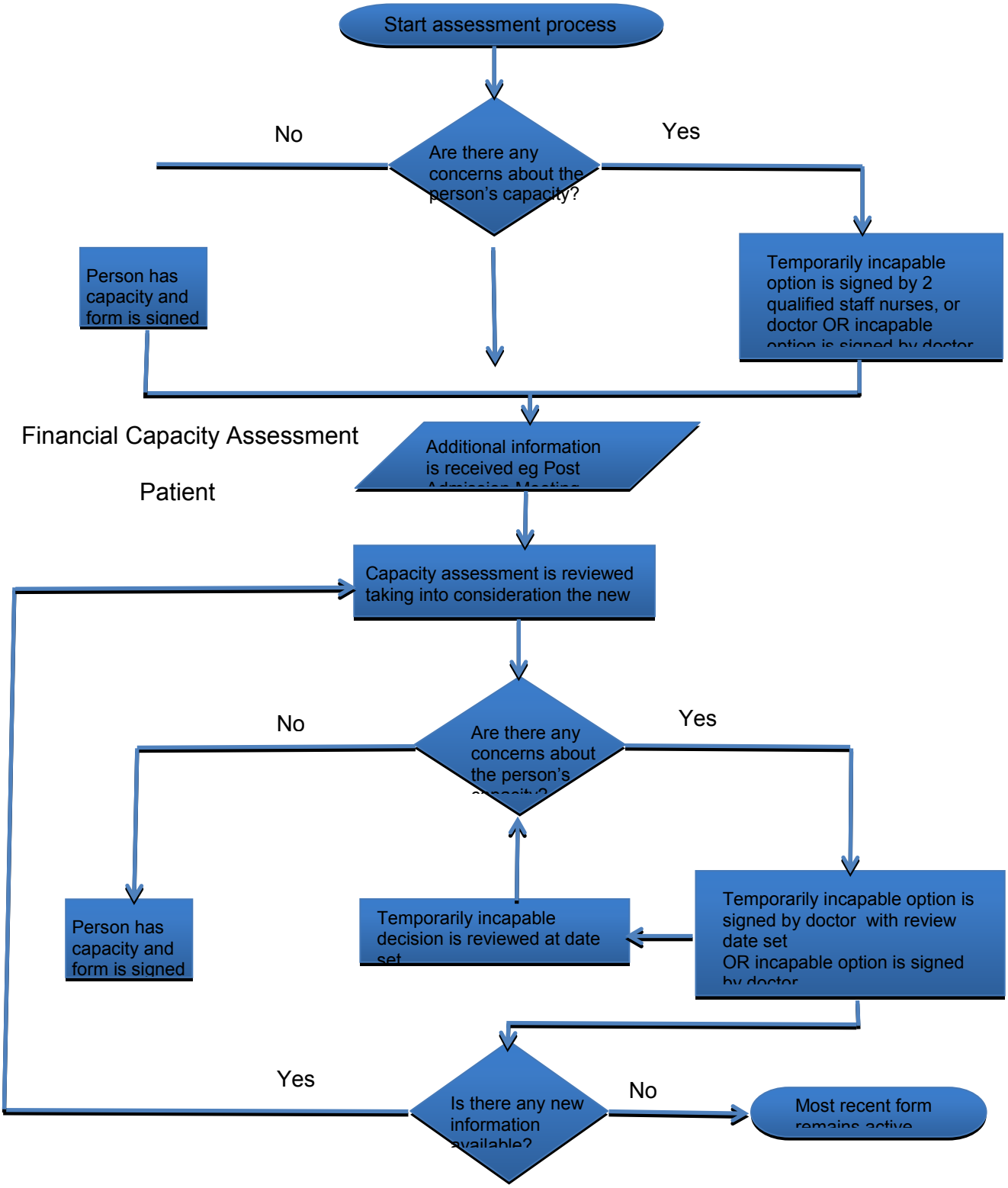
Incapable Assessment
This should only be signed if there is good evidence and assessment to support this. This decision requires the responsible medical officer to sign the form given the significance this would have on the patient's on-going ability to access money or make decisions regarding their finances.

Temporarily Incapable Assessment
If there is evidence or assessment to suggest that the patient may not have capacity to manage their financial affairs and that the situation may resolve with treatment and therapeutic intervention then this option should be signed. This can be signed by two members of nursing staff (band 5 or above) or the medical officer at point of admission. This option should also be used if there is evidence to suggest that the patient is incapable at point of admission but the responsible medical officer is not available to complete an Incapable Assessment.

This option is time limited and a review must be included at time of signing. This should be limited to the post-admission meeting in the first instance as it is anticipated that further information from the community would be available at this time to inform the decision. Further reviews must then be set as appropriate to the condition considered to be impacting on the capacity and are a clinical decision.

Belfast Health and Social Care Trust

APPENDIX 9



Belfast Health and Social Care Trust

MEDICAL FINANCIAL CONTROL FORM

APPENDIX 10

Name_____

	Score
Section A To assess mathematical capability	
Has no numeracy skill and cannot count	1
Has some numeracy skill but no understanding of the concept of money, e.g. does not recognise the different values of coins and notes.	2
Can count money in coins and notes up to the value of around £10.00.	3
Performs basic additions and subtractions using coins and notes.	4
Can perform all calculations necessary for dealing with own finances and can perform them in practical situations, e.g. whilst out shopping.	5
Section B To assess understanding of value of money.	
Has no awareness of the value of money, e.g. does not understand that it is used to buy things.	1
Understands that money may be used to buy things but has no understanding of how much money is worth in terms of purchasing individual goods/service, etc.	2
Can relate the cost of goods/services to the amount that needs to be paid in money.	3
Can tell the difference between expensive and inexpensive goods when out shopping.	4
Fully understands the importance and value of money.	5
Section C **To assess financial vulnerability in terms of theft and /or deception.**	
Would not understand or would not be able to communicate if financial abuse is taking place.	1
Would be easily manipulated or 'conned' into parting with money	2
Understands that other people may want to take their money away from them and so shows some evidence of protecting their money.	3
Takes steps towards protecting their money and would know and be able to communicate if they had been the target for financial abuse.	4
Protects their finances from abuse.	5
Section D **To assess understanding of 'abstract' money issues, e.g. bank accounts/benefit books/cheque books, etc.**	
Has no concept that items such as benefit book/cheques, etc. may have financial value. Has no concept of debt.	1
Has basic knowledge for 'abstract' monies, e.g. knows that their money may be kept in a bank account or post office but is unaware of the basic systems used to withdraw/put in cash and has no awareness of personal funds/benefit amounts due to or owed by them.	2
Understands the systems used for accounts/post office withdrawals, etc. and can relate bank statements/benefit books, etc. to their 'real' money value, but would not recognise discrepancies in forms/system/procedures and understand the consequences of debt. Would recognise and be able to communicate some discrepancies within the abstract money systems relevant to them.	3
Has good knowledge of abstract money systems/procedures and understands the consequence of debt. Would recognise and be able to communicate some discrepancies within the abstract	4

Belfast Health and Social Care Trust

money systems relevant to them.	
Has full understanding of the banking systems, benefits, consequences of debt, loans, overdrafts, etc. Would recognise discrepancies in these systems and would be able to communicate this information to the relevant parties.	5
Total	

For each section give the person a score of 1 – 5 depending on which level you think best describes their ability, e.g. for Level 1 award 1 point.

A score of less than 12 - 14 (out of a maximum of 20) would indicate an individual needs significant help with their finances and therefore is likely to need an appointee. This would be the level that a patient would be considered to lack capacity at point of admission.

APPENDIX 11

Senior Nurse Manager – Monthly Patient Finance Monitor Report

Date: _____
Ward: _____
Patient: _____

1. Is there a record in Patient's Care plan of the amount of money they receive from:
A Benefits **YES / NO**
B Therapeutic Earnings **YES / NO / NA**

(All patients admitted after November 2010, do not claim rewards)

2. Does the care plan indicate if the patient's has been assessed as capable of managing their finances: **YES / NO**

3. If the patient can manage their cash card and/or bank book is it recorded on an information sticker at the front of the care plan: **YES / NO**

4. Are all transactions in the patient cash record (ledger) recorded using (a) 2 staff signatures or (b) 1 staff and patient signatures (Where the patient has capacity to understand)? **YES / NO**

5. Are there any discrepancies in the Patient Ledger? **YES / NO**

6. Are purchases made on behalf of the patient by staff, appropriate and individual to them with records maintained as indicated in the policy? **YES / NO**

7. Has the record of staff access to Patient Keypad/Bisley Drawers being signed by two staff members? **YES/NO**

8. Are monthly transaction sheets signed by ward staff as evidence of having received and reviewed them? **YES/NO**

Comments:

Actions:

Name: _____ **Signature: _____**

APPENDIX 12

Financial Support Plan

1. Service Users Details

Service User Name _____

Service Name _____

Address _____

DOB _____

Key Worker Name _____

Team Leader/Manager Name _____

Operations Manager Name _____

2. What Financial Support is required

Opening of a bank/post office account (Please detail suggested bank/branch and if cheque book/ cash card required etc.) ☐

_____

_____

Management of a current bank/post office account (withdrawals/lodgements) ☐

_____

Opening a savings account (Please detail suggested bank/branch/type of account, access/cash card required etc.) ☐

_____

_____

Management of a savings account (including making withdrawals/lodgements) ☐

_____

Spending service users' money on their behalf ☐

_____

3. Please name the staff who will be managing the person's finances (maximum four names)

4. Authority
What authority has been granted by the OCP? (Documentation to be held on file).

5. Income Sources (if relevant)	
Salary	£
Pension	£
DLA – Care Component	£
DLA – Mobility Component	£
Income Support	£
Incapacity Benefit	£
Job Seekers Allowance	£
Housing Benefit	£
Educational Maintenance Allowance	£
SDA	£
Other	£

TOTAL	£

6. Appointeeship

Name of Appointee

Address of Appointee

Date Appointeeship Granted

7. Savings (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

Lodgement Arrangements (e.g. post/in branch/lodgement slips)

Withdrawal Arrangements (e.g. cash card/pass book etc.)

Current savings on (Date) Amount

8. Banking Management (Currents Accounts) (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

ATM Cash Card ☐Yes ☐No

Pass Book ☐Yes ☐No

Cash Card/Pass Book
Where is this held?

Who has access to it?

Pin Number
Details to be kept in safe on Trust premises and locked cash box in users home

Who has access to it?

9. Cash Box Arrangements (if relevant)

Where is the cash box held? _____

Who holds the key? _____

Where is the key kept? _____

Who has access to the key? _____

10. Anticipated Weekly/Monthly Expenditure

	Amount Per Week	Amount Per Month
Electricity	£	£
Gas/Oil	£	£
Rent/Mortgage	£	£
Rates	£	£
TV	£	£
Groceries	£	£
Telephone	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending (clothes, leisure etc.)	£	£
Other	£	£

11. Monitoring

The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.

12. Signatures

Key Worker _____

Date _____

Manager/Team Leader _____

Date _____

This financial support plan has been discussed and shared with me. ☐

Service User
(If appropriate) _____

Carer
(If appropriate) _____

STAFF DECLARATION

Appendix 13

I acknowledge that I have read and understand the procedures on Patient's Private Property:

STAFF NAME	STAFF GRADE	DATE

Belfast Health and Social Care Trust

TYPE OF DOCUMENT	☐ Trust Policy for approval by Trust Policy Committee ☐ Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
Patient Property	
Summary	Processes that will ensure the appropriate safe custody of patients' personal property handed in for safekeeping.
Purpose	To instigate the correct use and completion of patient property records consistently and accurately thus ensuring the safe keeping of property handed in.
Operational date	February 2008
Review date	February 2010
Version Number	Insert BHSCT Version Classification
Supersedes previous	
Director Responsible	Ms Brenda Creaney
Lead Author	Mrs Mary McElroy
Lead Author, Position	Senior Management Nursing
Additional Author(s)	Olive Macleod
Department / Service Group	Nursing
Contact details	*02890960089*

Reference Number	
Supercedes	

Date	Version	Author	Comments
March 2008	V 1.0	Mary McElroy	First draft

Policy Record

		Date	Version
Author (s)	Approval	March 2008	1
Director Responsible	Approval	March 2008	

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Full Description

Reference No:	
1	**Title: Patient Property**
2	**Introduction** Care of property handed in for safekeeping must be checked and recorded accurately to ensure confidence and reliability. Adherence to this policy will ensure safety for personal property handed in and protection for staff
3	**Purpose:** Processes that will ensure the appropriate safe custody of patients' personal property handed in for safekeeping.
4	**The scope:** This policy will apply to all Trust employees.
5	**Objectives:** • To ensure patients and/or their carers will be informed of the measures to be taken to protect their property before and/or the time of their admission. • To provide accurate and written evidence of custody of property • To ensure that staff can clearly identify record and return property • To ensure a standardised approach to custody of handed in property throughout the Belfast Trust
6	**Roles and Responsibilities:** It is the responsibility of all Trust employees to adhere to this policy
7	**The definition and background of the policy:** To minimise the loss of property handed in for safekeeping, it is essential to have a robust checking and recording mechanism in place. This will ensure that personal property handed in for safe keeping is not lost and the Trust doesn't incur a financial penalty as a result of any such losses.

8.	**Policy** • The Trust will not accept liability for patient's personal property or money brought onto its sites unless it is handed in for safe custody and a written confirmation is obtained as a receipt • On appointment staff will be made aware of their duties in the care of handed in patient property • A patient property record will be completed by a member of hospital staff in the presence of a second member of staff and or a patient/his/her personal representative where practicable • It is important that terms such as gold/diamond etc not be used but should be described as yellow metal/white stone etc • Any alterations to the record should be validated by a signature and date of a member of staff and validated by second member of staff and or a patient/his/her personal representative where practicable • Money handed over for safe keeping must be sent to the cash office except when there is no office staff present, in those circumstances the valuables should be placed in a secure place and sent to the cash office as soon as practicable. • In the event of death, and where cash or valuables have been deposited for safe custody they will only be released to the documented care giver, significant other or solicitor as appropriate • On transfer within or without the hospital there must be an interim 'cross check' of handed in sent with the patient against the original documentation. • Where accidental damage or loss occurs to hand in patient property the member of staff must report to the Ward Manager immediately. The Ward Manager will complete a WO1 form and return to Finance Department
9.	**References, including relevant external guidelines:** Follows Best Practice Guidelines Legacy Trust Policy
10	**Consultation Process:** Director of Nursing, HR Department, Trust Service Group Directors, Staff Side and standards and guidelines committee.
11.	**Equality and Human Rights screening carried out:** In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment. √ Screening completed No action required. ☐ Full impact assessment to be carried out.

Brenda McCreaney

Mary McElroy

Director Brenda Creaney **Author Mary McElroy**

Date: March 2011 **Date: March 2011**

Belfast Health and Social Care Trust

Standards and Guidelines Committee

Patient Property	
Summary	Processes that will ensure the appropriate safe custody of patients' personal property handed in for safekeeping.
Purpose	To instigate the correct use and completion of patient property records consistently and accurately thus ensuring the safe keeping of property handed in.
Operational date	February 2008
Review date	May 2014
Version Number	V2
Director Responsible	Brenda Creaney, Director of Nursing and User Experience
Lead Author	Mrs Olive MacLeod
Lead Author, Position	Co-Director for Corporate Nursing
Additional Author(s)	
Department / Service Group	Nursing
Contact details	

Reference Number	SG 005/08
Supercedes	V1

Date	Version	Author	Comments
March 2008	V 1.0	Mary McElroy	First draft
April 2011	V2	Olive MacLeod	Review - no amendments – date changed

Policy Record

		Date	Version
Author (s)	Approval	April 2011	V2
Director Responsible	Approval	April 2011	V2

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

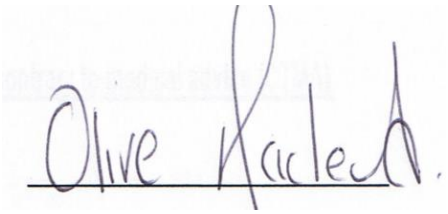
Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval	21/04/2011	V2
Policy Committee	Approval	16/05/2011	V2
Executive Team	Authorise	19/05/2011	V2

Full Description

Reference No:	*SG 005/08*
	Title: Patient Property
1.	**Introduction** Care of property handed in for safekeeping must be checked and recorded accurately to ensure confidence and reliability. Adherence to this policy will ensure safety for personal property handed in and protection for staff
2.	**Purpose:** Processes that will ensure the appropriate safe custody of patients' personal property handed in for safekeeping.
3.	**The scope:** This policy will apply to all Trust employees.
4.	**Objectives:** • To ensure patients and/or their carers will be informed of the measures to be taken to protect their property before and/or the time of their admission. • To provide accurate and written evidence of custody of property • To ensure that staff can clearly identify record and return property • To ensure a standardised approach to custody of handed in property throughout the Belfast Trust
5.	**Roles and Responsibilities:** It is the responsibility of all Trust employees to adhere to this policy
6.	**The definition and background of the policy:** To minimise the loss of property handed in for safekeeping, it is essential to have a robust checking and recording mechanism in place. This will ensure that personal property handed in for safe keeping is not lost and the Trust doesn't incur a financial penalty as a result of any such losses.

7.	**Policy** • The Trust will not accept liability for patient's personal property or money brought onto its sites unless it is handed in for safe custody and a written confirmation is obtained as a receipt • On appointment staff will be made aware of their duties in the care of handed in patient property • A patient property record will be completed by a member of hospital staff in the presence of a second member of staff and or a patient/his/her personal representative where practicable • It is important that terms such as gold/diamond etc not be used but should be described as yellow metal/white stone etc • Any alterations to the record should be validated by a signature and date of a member of staff and validated by second member of staff and or a patient/his/her personal representative where practicable • Money handed over for safe keeping must be sent to the cash office except when there is no office staff present, in those circumstances the valuables should be placed in a secure place and sent to the cash office as soon as practicable. • In the event of death, and where cash or valuables have been deposited for safe custody they will only be released to the documented care giver, significant other or solicitor as appropriate • On transfer within or without the hospital there must be an interim 'cross check' of handed in sent with the patient against the original documentation. • Where accidental damage or loss occurs to hand in patient property the member of staff must report to the Ward Manager immediately. The Ward Manager will complete a WO1 form and return to Finance Department
8.	**References, including relevant external guidelines:** Follows Best Practice Guidelines Legacy Trust Policy
9.	**Consultation Process:** Director of Nursing, HR Department, Trust Service Group Directors, Staff Side and standards and guidelines committee.
10.	**Equality and Human Rights screening carried out:** In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment. √ Screening completed No action required. ☐ Full impact assessment to be carried out.



Director: B Creaney

Date: **May 2011**

Author: Olive MacLeod

Date **May 2011**

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 34/16

Title:	**Procedure for the Search of Patients, their Belongings and the Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh)**		
Author(s)	Davy Martin, Lead Nurse Noel McDonald, Operations Manager, Recovery Services Patricia Minnis, Quality and Information Manager Brendan Ingram, Business and Service Improvement Manager Jenni Armstrong, Resource Nurse Barry Mills, Clinical and Therapeutic Services Manager Cahal McKervey, Operations Manager, Acute Mental Health Services Johnny Killough, Charge Nurse, Ward L, Mater Hospital Paul McCabe, Senior Clinical Nurse, Acute Mental Health Services Seamus Coyle, Nurse Development Lead Garvin McKnight, Charge Nurse, Sixmile, Muckamore Abbey Hospital		
Ownership:	Catherine McNicholl, Director, Adult Social and Primary Care		
Approval by:	Learning Disability Governance Mental Health Governance Standards and Guidelines Policy Committee Executive Team Meeting	**Approval date:**	05/03/2016 28/04/2016 19/05/2016 01/06/2016 08/06/2016
Operational Date:	June 2016	**Next Review:**	June 2019
Version No.	1	**Supercedes**	
Key words:	Search, risk, pat, necessary		
Links to other policies	Use of Restrictive Interventions for Adult and Children's Services BHSCT Patient Privacy and Dignity Policy BHSCT Adult Protection Policy and Procedure BHSCT Mental Health and Learning Disability Services Admission and Discharge Policy Shannon Clinic Regional Secure Unit Admission/Discharge Procedure BHSCT Mental Health and Learning Disability Services Banned/ Restricted Items Procedure BHSCT Mental Health and Learning Disability Physical Interventions Procedure BHSCT Observations within Mental Health Services BHSCT Adult Mental Health and Learning Disability Services Absent Without Leave Procedure (AWOL) BHSCT Levels of Supervision/Observations within Learning Disability Inpatient Services BHSCT Protocol for the Management of Substance Misuse in Mental Health and Learning Disability Inpatient facilities		

Date	Version	Author	Comments
23/05/14	0.1	See above	Initial Draft
02/08/14	0.2	See above	Comments received and amended
10/12/14	0.3	See above	Comments received and amended
15/01/15	0.4	See above	Further amendments
23/01/15	0.5	M. Carney M. Mitchell E. Rafferty	Further amendments
30/01/15	0.6	N. McDonald	Further amendments
09/10/15	0.7		Further amendments
17/12/15	0.8	O. Tierney	Further amendments
05/03/2016	0.8		Approved by Learning Disability Governance
28/04/2016	0.8		Approved by Mental Health Governance

1.0 INTRODUCTION / PURPOSE of POLICY

1.1 Background

Belfast Health and Social Care Trust Mental Health and Learning Disability Services seeks to promote and maintain a caring and safe environment for all patients admitted into any of its inpatient facilities. It is recognised that a small number of patients/visitors may attempt to bring dangerous or illegal items into the inpatient facility, thus compromising the safety of themselves, other patients, visitors, and staff. Staff may feel it is necessary to search patients, their belongings, or the surrounding environment where there is a clear concern around their own, visitor or staff safety. Any searches taken should be reasonable and proportionate to the circumstances in which it is conducted.

A search is defined as

"any scrutiny of personal possessions or of an individual that exceeds the expected norms of any clinical environment."

Personal Search – this is the systematic mechanical, visual or "pat down" inspection of a patient which ordinarily takes place with consent but may be undertaken in some instances without consent. A personal search takes place with outer clothing removed i.e. coats/jackets/ jumpers/shoes/ socks.
Where a wand is used an explanation will be given as to how it works and procedure used.

Personal Property Search – this is considered to be anything exceeding usual routine checks of property during the admission process or return of a patient to the inpatient facility.

Unit Search – this is the systematic search of the environment, to seek out a missing object, potential stolen goods or hazardous/potentially hazardous items or substances that may jeopardise individual safety or the integrity of the inpatient facility. In the event a unit search is deemed necessary patient movement may be restricted.

1.2 Purpose

This procedure has been developed to ensure a standard approach is taken in implementing this procedure across all of its mental health and learning disability inpatient facilities as outlined in the Regional Guidelines for the Search of Patients, their belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Settings.
This procedure provides staff with standard guidance when considering the implementation of any search of a patient, visitor or the environment.

1.3 Objectives

This procedure aims to: -

- Provide staff with standard guidance where a search of any patient, visitor or the environment is being considered;
- Reduce the likelihood of patients having access to items, which may be harmful or inappropriate to themselves or others
- To maintain a safe environment for all patients, visitors and staff within the mental health or learning disability inpatient facility.

This procedure should be read in conjunction with: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Settings, March 2014
- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, November 2011
- Mental Health (NI) Order 1986
- Management of Aggression Guidelines
- BHSCT Compliments and Complaints Policy
- BHSCT Patient Privacy and Dignity Policy
- BHSCT Obtaining Consent for Examination, Treatment or Care in Adults and Children
- BHSCT Adult Protection Policy and Procedure
- BHSCT Patient Property
- BHSCT Learning Disability Services Admission and Discharge Policy
- BHSCT Mental Health Services Admission and Discharge Policy
- Shannon Clinic Regional Secure Unit Admission/Discharge Procedure
- BHSCT Restrictive Practices Policy
- BHSCT Mental Health and Learning Disability Physical Interventions Procedure
- BHSCT Observations within Mental Health Services
- BHSCT Levels of Supervision/Observations within Learning Disability Inpatient Services
- BHSCT Adult Mental Health and Learning Disability Services Absent Without Leave Procedure (AWOL)
- BHSCT Protocol for the Management of Substance Misuse in Mental Health and Learning Disability Inpatient facilities

2.0 SCOPE OF THE POLICY

This procedure applies to all patients, both voluntary and detained, admitted to an adult mental health or learning disability inpatient facility,

visitors and staff. Those working within a low or medium security facility should also refer to Appendix 9.

A search of personal property is considered to be anything exceeding usual routine checks of property during the admission process or return of a patient to the inpatient facility.

There will be no intimate body searches

3.0 ROLES/RESPONSIBILITIES

All staff working within the mental health or learning disability inpatient facility have a responsible role to play in achieving the above objectives. There are specific responsibilities highlighted as follows: -

Co-Directors for Mental Health and Learning Disability are responsible for:

- Ensuring the provision and distribution of the procedure;
- Ensuring the monitoring of implementation of the procedure.

Service Managers for Inpatient Facilities in conjunction with their Operations Managers/Senior Nurse Managers are responsible for: -

- Ensuring the procedure is circulated to all staff within their service area;
- Ensuring the procedure is consistently implemented across all inpatient facilities;
- Ensuring the monitoring of implementation of the procedure;
- Acting where there are concerns the procedure is being misused or misinterpreted or where there is the possibility of a more serious service issue;
- Ensure that the necessary training to implement this procedure is in place.

Inpatient facility Sisters/Charge Nurses are responsible for: -

- Ensuring the procedure is circulated to all staff;
- Ensuring staff within their inpatient facility are consistent in the application of the procedure;
- Ensuring a banned/restricted items list is developed for their respective inpatient facility and displayed on the ward;
- Ensuring that the patient welcome pack/booklet advises of the facility's banned/restricted items and of the possibility being searched;
- Ensuring staff are clear about their role and responsibilities;
- Ensuring that all staff implementing this procedure have relevant training;
- Informing their Line Manager/Duty Officer on each occasion the procedure is implemented and its outcome;
- Ensuring incident report is completed where a search has taken place without consent from the patient;

- Ensuring the update of care plans, risk assessments and other relevant documentation.

Multidisciplinary Team members are responsible for: -

- Ensuring they are clear as to their role and responsibilities in the implementation of this procedure;
- Ensuring they are competent to carry out the implementation of this procedure;
- Highlighting any concerns they have as to their competency to implement this procedure;
- Complete incident report where a search has taken place without consent from the patient;
- Updating all relevant documentation including the patient's care plan, risk assessment, search report etc.

4.0 KEY POLICY PRINCIPLES

4.1 All patients have the right to receive care in a safe environment. However it is recognised that a small number of patients/visitors may attempt to bring dangerous or illegal items into the inpatient facility which may compromise the safety of themselves, other patients, visitors and staff.

4.2 The decision to search a patient and/or their belongings can only take place if there are reasonable grounds to believe that this is necessary. Any searches taken should be reasonable and proportionate to the circumstances in which it is conducted. The search procedure should be referred to within the patient's welcome booklet/pack.

4.3 Each inpatient facility will have a banned/restricted items list in place which will be displayed on the inpatient facility's notice board. This list will consist of any dangerous/illegal/inappropriate items that are felt could compromise the safety of patients, visitors or staff. This list should be contained within the inpatient facility's patient welcome booklet/pack.

4.4 Search of Patients

All patients and where appropriate their carers/relatives should be made aware of banned/restricted items and the ward's search procedure on admission or as soon as is practicable following admission. This should be done both verbally and in writing. Consideration may need to be given to the involvement of an advocate or interpreter.

Patients should be asked if they are in possession of any banned/ restricted item during the admission process. Any such items should be removed by staff from the patient. Depending on the item and the patient's wishes if appropriate, it may either be taken into the care of staff until their discharge, given to a relative for safe keeping until their

discharge or handed over to the PSNI. Where an illegal item/ substance has been found this should be signed and countersigned in the patient's notes by two members of staff.

The decision to search a patient and/or their belongings can only take place if there are reasonable grounds to believe this is necessary i.e. where there is reasonable suspicion that they are in the possession of hazardous/potentially hazardous items or substance that may jeopardise individual safety or the integrity of the inpatient facility. The patient's risk assessment should be reviewed. Indicators that may lead to a decision to search could include where: -

- The patient has a known relevant history of carrying and/or hiding an offensive item/harmful substance;
- The patient has expressed the view that they intend to injure themselves or another person with an implement;
- Information has been received from other patients, staff or visitors that a patient has a dangerous item in their possession;
- A patient is acting in a threatening/unpredictable manner and where there is reason to believe that the patient is in possession of an item that is potentially dangerous to themselves or others.

It should be noted that this list is not exhaustive and professional judgement will remain a key factor in any decision taken.

A multidisciplinary discussion should take place as to the need for a search, ideally involving their Named Nurse. The reason for such a decision should be clearly documented in the patient's notes. All risks should be considered prior to any search being undertaken both to the patient and to staff. If necessary the PSNI should be called however this should only be in exceptional circumstances to prevent harm to the patient or others or to prevent a breach of the peace from occurring.

The reasons for the search and those conducting the search should be explained to the patient and documented in their progress notes, daily inpatient facility round and the search report (App 2). Consideration should be given to the need for the need for alternative modes of communication. Once a patient has been informed of the intended search they should not be left unsupervised.

The patient's consent must always be sought and recorded in the search report (App 2). Please see 4.5 for guidance regarding those patients without capacity to consent. If a patient does not consent to be searched: -

- Medical staff should be consulted. Outside of the hours of 0900 hours and 1700 hours the Duty Doctor should be consulted;
- A member of staff should remain with the patient and ensure they have no contact with other patients until the search has been completed;
- An incident form should be completed;
- If the situation dictates urgent intervention, the search team should follow management of aggression procedures;

- Any search carried out without consent must be conducted with the minimum force necessary.

The manner in which the search is conducted should ensure the greatest possible privacy and respect of the dignity of the patient. Full consideration must be given to the patient's human rights relating to the patient's race, gender, sexual orientation, spiritual beliefs, disability and age to ensure this is protected. If the patient's request cannot be provided the search must be postponed until that choice can be provided. A member of staff should remain with the patient and ensure they have no contact with other patients until the search has been completed.

The searching of a patient or their property should be conducted in a private area i.e. bedroom by two members of staff (one of whom must be a Registered Nurse and of the same gender as the patient). The patient should be offered the opportunity to be present during any search of belongings unless clinical assessment has indicated that it is not safe.

In the case of personal searches patients should be asked to remove their outer clothing i.e. coat, cardigan. A visual inspection will be completed with consideration being given to the use of the hand held metal detector. "Pat Down" searches may only be performed where significant concern remains (App 7 and 8). Staff members carrying out a patdown search must wear gloves at all times. Staff must not place themselves at risk by searching clothing or other items, which are not completely visible. If pockets or hidden areas are to be searched, the staff member should first ask the patient to turn these areas out for inspection.

Items removed from the patient should be put into appropriate bags. The patient will be informed in writing or in another appropriate manner of any items removed from them and who has custody and responsibility for these. This will also be recorded on the search report (App 2)

4.5 Capacity to Consent

Consent should be sought prior to a search being undertaken. Where a patient has been assessed as lacking capacity to give consent, consultation with a responsible person, relative, or independent advocate should take place prior to the search unless it is considered there is an immediate risk.

The identified person should be available to support the patient during the search unless not reasonably practicable to do so. Details of the capacity assessment specific to the search should be recorded on the search report (App 2) and other relevant documentation i.e. care plan, progress notes etc.

An incident form should be completed where a search has taken place without consent.

Where a patient under the age of 18 years is being cared for on an adult inpatient facility and the need for a search arises, the local Trust policy in relation to searching children/adolescents must be adhered to.

4.6 Post Incident Management

Staff should take time to speak to patients and if appropriate their carer following the search (this may not be straight after the event) to re-iterate the reason for the search and discuss the outcome of the search. Patients wishing to make a complaint should be referred to the Trust's Complaints Policy.

Where appropriate a physical examination to take place of the patient following the search i.e. where restraint has been used.

The multidisciplinary team should review the incident at the earliest opportunity following the search, review and if needed update the patient's care plan and other relevant documentation.

4.7 Visitors

Visitors should be made aware of any banned/restricted items during their initial visit to the inpatient facility. Where there is reasonable suspicion that a visitor has banned/restricted items on their person/property staff should supervise visits, halt the visit or refuse the visitor entry to the inpatient facility. If the visitor to the inpatient facility refuses to leave, staff should summon the PSNI if necessary.

Should a visitor wish to make a complaint, they should be advised of the Trust's Complaints policy.

Any such instance should be deemed an incident and staff should ensure that an incident form via DATIX is completed as per the reporting of adverse incidents policy.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This procedure will be disseminated to all managers and staff working within a mental health or learning disability inpatient facility.

5.2 Resources

Training resources will be required to ensure the full implementation of this procedure.

5.3 **Exceptions**
This procedure will not apply to CAMHS or Children's Learning Disability Services.

6.0 MONITORING

A search report must be completed following each search and a copy sent to the Resource Nurse (Learning Disability) or Information and Quality Manager (Mental Health). A review of the implementation of the search policy will be monitored six months following its implementation.

7.0 EVIDENCE BASE / REFERENCES

Mental Health (NI) Order 1986
NMC Code of Professional Conduct: Standards for conduct, performance and ethics (2008)
Nursing and Midwifery Council (NMC) The Code (2015)
Human Rights Act 1998
Regional Guidelines for the Search of Patients, their Belongings, and the Environment of Care within Adult Mental Health/Learning Disability Inpatient Settings, 2014
Deprivation of Liberty Safeguards – DHSSPS Interim Guidance 2014
Use of Physical Interventions for Adult and Children's Services
Reference Guide to Consent for Examination, Treatment or Care, DHSSPS, March 2003
NICE Guidance NG10: Violence and Aggression: Short Term Management in Mental Health, Health and Community Settings
NICE pathway: Anticipating, reducing the risk of and preventing violence and aggression in Adults

8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: -

- Belfast Trust Mental Health & Learning Disability Inpatient Services
- Belfast Trust Users, Advocacy and Carers Forums

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Search Procedure General Guidance
Appendix 2 – Search Report
Appendix 3 – Use of Hand held metal detector
Appendix 4 – Flowchart relating to Search of Patients Procedure
Appendix 5 – Flowchart relating to Search of Patients with Consent
Appendix 6 – Flowchart relating to Search of Patients without Consent
Appendix 7 – Flowchart relating to Pat down Search Process
Appendix 8 – Guidance as to the Search of Patients
Appendix 9 – Medium and Low Secure Specific Guidance

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ Date: ___June 2016____
Author

_____ Date: ___June 2016____
Director

APP 1

Search Procedure General Guidance

1.0 Searches – general guidance

1.1 All searches will be planned prior to them taking place.

1.2 In all cases the person's consent should be sought before any search is attempted.

1.3 Staff should always wear gloves when carrying out a search of a person or area.

1.4 In all cases a search of areas or person will only be conducted where there are two members of appropriately search trained staff.

1.5 Evidence should be appropriately bagged, tagged, and logged using the correct evidence bags.

1.6 Unauthorised/banned items should be appropriately stored/disposed of in accordance with the Belfast Trust Medicines Code.

1.7 Restricted items should be removed and recorded and stored safely. A note of same should be made in the patient's records.

1.8 Where a patient/visitor wishes to make a complaint, the complaints procedure will be followed.

1.9 A search report should be completed and forwarded to the search leader.

1.10 The search coordinator will always inform the nurse in charge of the inpatient facility of the outcome of any searches

1.11 Thereafter the nurse in charge of the inpatient facility will inform appropriate personnel of any issues arising

2.0 Patient Search (includes belongings, bedroom etc)

2.1 In all cases the person's consent should be sought before any search is attempted.

2.2 Once a patient has been informed that a search is intended, the patient should not be left unsupervised until the search has been completed.

2.3 If the patient wishes to observe, there should be an additional member of staff to observe the patient.

2.4 Details of the search and any findings must be documented in the patient's clinical notes and highlighted as appropriate.

2.5 Pat down searches[1]

2.5.1 Pat down searches will be conducted in a private area to ensure the greatest possible privacy and respect of the dignity of the patient.

2.5.2 A member of staff who is the same gender will always carry out pat down searches of female patients.

2.5.3 Pat down searches of male patients, where possible should be carried out by a staff member of the same gender but can be conducted by either male or female staff. However staff will ask for the patient's permission if a search is to be carried out by a member of the opposite sex.

2.5.5 Where a person is non-consenting to a pat down search a member of medical staff/duty doctor should be contacted before any search is attempted.

2.5.6 A patient's bedroom search will always be preceded by a pat down search of that patient.

2.6 Searches Requiring the Removal of Clothing

2.6.1 There **must be reasonable evidence** for believing that the patient is secreting on their person an illicit substance or item, which could adversely affect the safety and/or security of them, others or the unit.

2.6.2 Personal searches that require the full removal of the patient's clothing will only be instigated on the instruction of a member of medical staff/duty doctor.

2.6.3 Searches requiring the removal of clothing should be undertaken on the inpatient facility and in a private place. The patient should be kept under observation on the inpatient facility in an area away from the other patients until the situation has been resolved.

2.6.4 The patient will be informed that a search requiring the removal of clothing is required.

2.6.5 The patient will be escorted to a single room, which has been prepared for the procedure.

2.6.6 Two nursing staff of the same gender as the patient will conduct the search(one will be a qualified nurse).

2.6.7 The patient will be reassured at all times.

2.6.8 Staff conducting the search should wear disposable gloves.

2.6.9 The patient should never be completely naked at any time.

2.6.10 All clothing above the waist will be removed and searched. A visual check of the patient's upper body will be made including a check of the mouth, ears, nostrils and hair. The patient should then be allowed to re-dress.

2.6.11 All clothing below the waist will be removed after a visual check of the lower body; the patient will be allowed to re-dress.

2.6.12 Removed clothing must be thoroughly searched, paying particular attention to seams, linings, cuffs, collars, waistbands, shoes, and pocket items.

2.6.13 An incident form outlining the reason for the search must be completed. The form should outline who authorised the search and why. An entry should be made in the patient's notes.

2.6.14 **THERE WILL BE NO INTIMATE BODY SEARCHES**

2.7 Non Consent Searches

2.7.1 The staff team carrying out the search must first get the consent of a member of medical staff. The patient should remain on special observations and not in contact with other patients until the search can take place.

2.7.2 The incident should be recorded on an incident form.

2.7.3 Should the situation dictate urgent intervention, the team conducting the search should follow the Trust's Use of Physical Interventions in Adult and Children's Services guidance

3.0 Targeted Searches[2]

3.1 Targeted searches will be carried out where staff suspect that a particular patient(s) has on their person or in their room(s) restricted items

3.2 All patients returning from AWOL will be searched

4.0 Room Searches of More than One Bedroom

4.1 Patients whose rooms have been identified for targeted search will be asked to accompany staff. The patients must be informed of the reasons for the search.

4.2 A nurse trained in search procedure must stay with patients at all times

4.3 The rooms are searched as stated above in Section 2.

5.0 Large Scale Searches

A large-scale search may be required at anytime for various reasons i.e.

- A breach of security is suspected or known;
- To intercept illicit substances or potential weapons;
- To raise the profile of security and act as a deterrent to the movement of items into the establishment, or through the patient population;
- To inform staff of the security status of the unit.

The reason for the search should determine the immediacy of action required.

6.0 Immediate Searches

6.1 Reasons for an immediate search may include:
- Known sharps/ignitables missing
- Significant amount of drugs/alcohol suspected/known to be on the unit
- Reason to believe that there may be an item which may be used to cause self harm or injury to others.

6.2 Under these circumstances there should be as little delay as possible

6.3 The senior nurse co-ordinator should be contacted to discuss decision

6.4 As much manpower as possible should be summoned whilst maintaining adequate resources in other wards

6.5 Staff not trained in search may be drafted to participate under guidance / supervision.

6.6 A staff member should be identified to co ordinate search plan

6.7 Search Plan

Ultimately the search coordinator will give direction on how a search will be conducted. Below is a framework, which may be used as a guide

6.7.1 First patient is searched.

6.7.2 Moving to the next.

6.7.3 Searched patients may be allowed to return to searched bedrooms to ease tension but may not circulate with unsearched patients.

6.7.4 Search may run over shifts, oncoming shift should be asked to assist and search teams to discreetly search TV lounge, inpatient facility WC, these rooms to be locked of initially. These will become " clean rooms"

6.7.5 Patients to be gathered in central area for community meeting and informed of intended search. No patient should be left unattended / unsupervised from this point until search completed.

6.7.6 As each patient leaves room, room should be locked.

6.7.7 All other patient access rooms should be locked off

6.7.8 Corridors may be locked off to limit access / patient movement.

6.7.9 Each patient in turn should accompany staff to their bedroom for a person search and room search.

6.7.10 The patient where possible should have the option to observe the room search, but if they choose not to remain in their bedroom they may not circulate with the unsearched population and should only have access to "clean rooms".

6.7.11 All other patients to remain in the central area with staff observing.

6.7.12 Search should be systematic and be completed as quickly as possible so that the status quo can be regained. Where a search will take place across shifts, the members of staff going off shift should be asked to stay behind where possible.

6.7.13 Once all patients and bedrooms have been searched central dining area should be searched.

6.7.14 At this point patient may be allowed to circulate in the central area, with no access to other unsearched area e.g. ADL kitchen, Resource room

6.7.15 Other side rooms may then be searched e.g. ADL Kitchen

6.7.16 Complete relevant documentation.

6.7.17 Inform relevant people of outcome or further action required.

7.0 Non Immediate Searches

Reasons for a less immediate search may include: -

- Noted pattern of inappropriate/intoxicated behaviour in patient population.
- To raise the profile of security and act as a deterrent to the movement of banned/restricted items.
- To restrict the movement of restricted / banned items.
- To intercept banned/restricted items.
- To inform staff of the total security status of the ward/facility.

7.1 Where possible a non immediate search should be discussed with the inpatient facility manager.

7.2 The search should be thought through and planning must be given to the exercise in regard to manpower and timing.

7.3 Patients are NOT to be given fore warning of intended search until immediately prior.

[1] Pat Down - A search of a clothed person, using the flat of the hand and hand held metal detector

[2]Targeted Search - A planned area or pat down search where a particular individual or group of individuals are suspected of possessing restricted items

Belfast Health and Social Care Trust
caring supporting improving together

App 2

SEARCH REPORT

Name	Inpatient facility	Room

Staff name(s) 1) 2)	Date/ time search commenced……. Date / Time search completed……..

Type of search: Targeted / Routine, Person/ area[2] (circle as appropriate)
Reason for search

All staff note;

1. The patient consents to the procedure Yes No
2. Was the patient present during the search? Yes No
3. Did the patient declare any unauthorized item? Yes No
   (Record comments made at the time)
4. The patient understand that the search will commence
   With a "Pat Down Search." . Yes No

5. Items removed from the room;
   ….. …….
   ……
   …… ……

6.To whom has any evidence passed?……..

7. Are there any complaints by the patients? Yes / No
8. If Yes, are the details recorded in the patients notes Yes / No
9. Post search debrief Yes/ No

STAFF SIGNATURES;

PATIENT SIGNATURE: DATE:

(PRINT)

Belfast Health and Social Care Trust
caring supporting improving together

DAMAGE REPORT

Description of items removed	Precise location found	Searchers names	Tag number	Location item removed to	Reported to whom	Item handed to Date & Time

Damage prior to search	Damage caused during search

Signatures of searchers: Coordinator Signature:

Inpatient facility Manager report Inpatient facility Manager signature

PATIENT ADVISED OF ITEMS REMOVED OR DAMAGED

Patient Signature (Print)	Date:

APP3

Use of Hand Held Metal Detector

Training on the use of the hand held metal detector is provided for staff during their induction.

A hand held metal detector has been allocated to each inpatient facility – it should be utilised in all room and property searches.

The hand held metal detector can also be utilised following a pat down search being conducted where there is still suspicion that metal items may be secreted upon the person. Should this take place the patient should be informed as to why the hand held metal detector is being used and the action of the hand held metal detector. The patient will again be offered the opportunity to hand any banned item over before the search proceeds.

All metal objects should be removed from the patient before the search with the hand held metal detector takes place (staff should be aware of under wired bras).

The hand held metal detector should be operated by a staff member who is of the same gender of the person being search – another member of staff should observe the search.

The hand held metal detector should be turned on and tested by placing close to a metal object prior to being used in the search process.

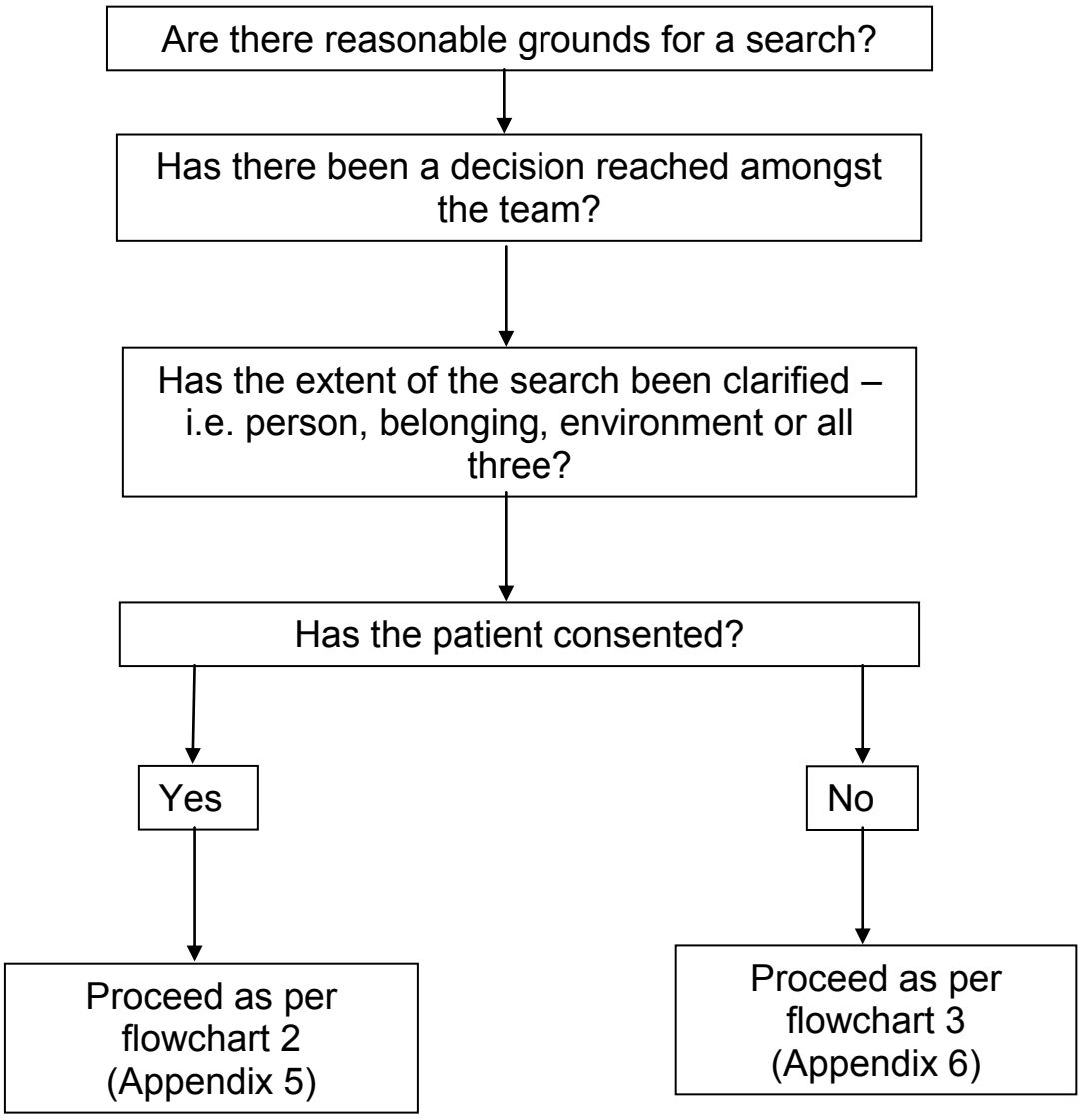
The hand held metal detector will be placed several centimetres from the patient's body, starting at the head and then working systematically from the top to bottom of the patient, across the front of the body and then the back. When searching the lower leg and foot area the patient should remove foot wear and raise their foot from the floor, so as not to pick up metal within the floor.

Should the hand held metal detector detect any metal objects it will sound with a beeping noise. Staff will ask the patient to remove any objects detected or these can be removed by the observing member of staff.

Any items of concern should be documented on the search form.

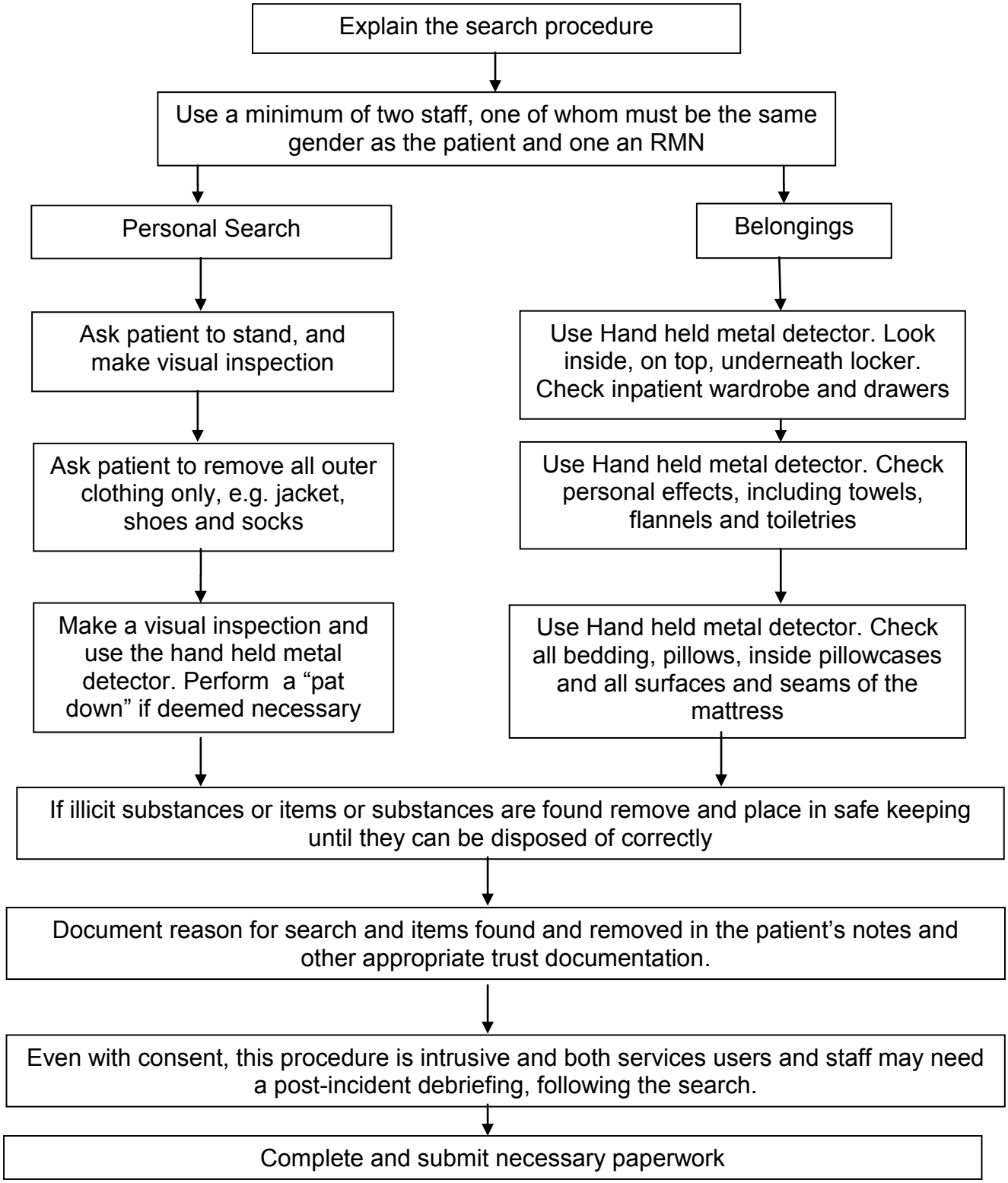
App 4

FLOWCHART 1: THE SEARCH PROCEDURE



Appendix 5

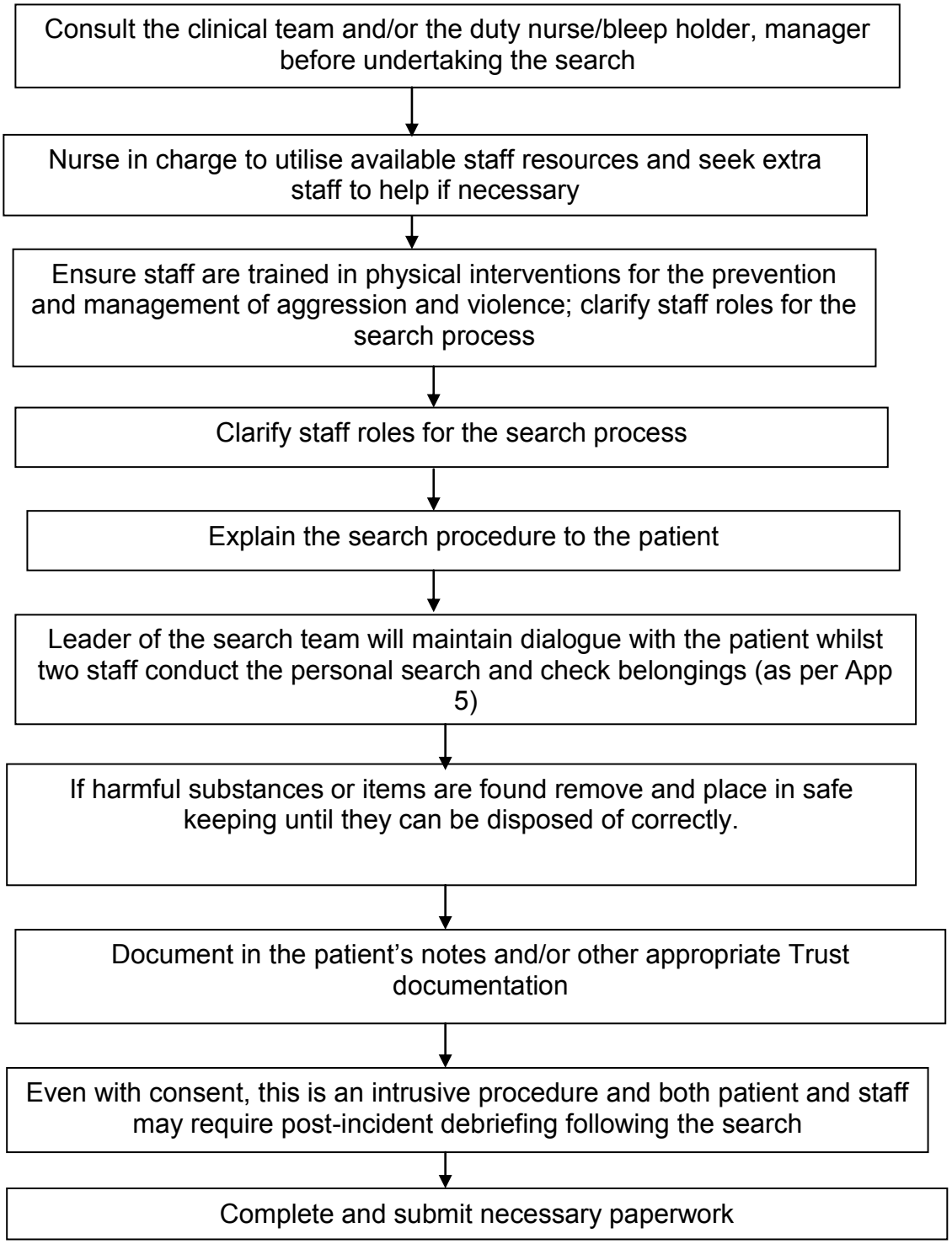
FLOWCHART 2: SEARCH WITH PATIENTS INFORMED CONSENT



NB: This flowchart relates only to searching of patient's suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

Appendix 6

FLOWCHART 3: SEARCH WITHOUT THE PATIENT'S CONSENT



NB: This flowchart relates only to searching of patient's suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

Appendix 7

Pat Down Search Procedure

1. Searches should be carried out in an area where there is room to carry out the search effectively. The patient's privacy and dignity should be maintained at all times where possible.

2. All searches of a patient's person must be carried by two staff members. One member of staff should be a registered nurse and of the same sex as the patient.

3. Where a staff member of the same gender is not available the search will be carried out using a handheld hand held metal detector with one staff member carrying out the search and the other acting as a witness.

4. Colleagues should be informed of the search and where it is taking place.

5. Staff should minimise the area of their body presenting a target by maintaining a side on stance when possible.

6. Staff should keep their head up and arms in a position where they are ready to be raised in defence and to reduce the risk of injury if attacked.

7. Staff should use their clinical judgement when considering placing their hands in the patient's pocket.

8. Any items removed should be recorded and the person informed of where they are being kept.

9. When the patient is discharged, all confiscated property should be returned to them.

Appendix 8

Pat down body search

1. Stand facing the patient.

2. Ask whether they are in possession of any restricted/banned items.

3. Ask all pockets to be emptied. If a coat/jacket is worn this should be removed after the pockets are emptied.

4. If the patient is in possession of any bags they should be asked to place these to one side for searching following the pat down search.

5. Patient to be searched using the hand held metal detector.

6. Staff to search items removed from pockets.

7. Staff to search any garments removed.

8. The patient should be asked to remove any headgear and pass to staff for searching.

9. If the patient's hair is long or thick they should be asked to run their fingers through their hair. This is again to prevent the risk of needle stick injury to staff.

10. Visual check of the patient's upper body including mouth ears and nostrils should be undertaken.

11. Should the patient be wearing a tie they should be asked to remove it and staff should search it using same method as for jackets/coats.

12. Any collars should be lifted and a visual check carried out before feeling around it.

13. Staff should pat their hands over the patient's shoulders

14. The patient should be asked to raise their arms level with their shoulders, keeping their arms straight, fingers open and apart and palms facing down. Staff should step slightly to one side, and search one arm by patting their hands along the upper and lower sides of the arm from shoulder to wrist. Staff should check between the fingers and look at the palm and back of the hand.

15. Repeat for the other arm.

16. Staff should pat down the front of the body of a male patient from neck to waist including the front of the waistband. Both sides of the body from armpit to waist including waistband should be checked.

In the event that a search is conducted on a female patient the breast area should be avoided

17. Staff should ask the patient to turn around and keep their arms in the raised position.

18. Staff should search the patient's back from neck to waist including the waistband and the seat of their trousers or skirt.

19. Staff should assume a kneeling position side on to the patient with the fore knee on the floor and furthest leg flexed and propping back thereby keeping a stable base.

20. Staff should check the patient's leg from crotch to ankle including the inside of the leg, the back of the leg and the outside of the leg. When searching the outside of the leg the search is from the waist to the ankle.
If the patient is wearing a skirt the search must be carried out by patning the hands down both sides of the leg from the outside of the skirt. (This makes it very difficult to search the tops of the legs and it may be necessary to use the hand held hand held metal detector).

21. Repeat for the other leg.

22. Stand up.

23. Staff should ask the patient to turn around and keep their arms in the raised position.

24. Staff should check the abdominal area of the subject.

25. Staff to use the same kneeling position and technique as before to search the front and sides of one leg.

26. Repeat for the other leg.

27. Staff should use their clinical judgement when considering retrieving hidden items.

28. Where staff suspect that something is hidden inside footwear, the patient should be asked to removed them for inspection. Staff should carry out a visual check of the sole and heel of the shoe by first tapping the heel of the shoe against the floor. The shoe should then be checked feeling for lumps from the outside and looking inside the shoe. **STAFF MUST NOT PUSH THEIR HANDS INTO THE SHOE**.

30. Staff should study the area around the patient for any items that may have been dropped before or during the search.

31. The patient should be asked to step to one side to check that they are not standing on anything he has dropped before or during the search.

App 9

Medium and Low Secure Specific Guidance

This guidance should be read in conjunction with the main document and other appendices.

1.0 Routine Searches[1]

1.1 All areas that patients have access to will be routinely searched on a quarterly basis

1.2 All patients and their property will be subject to routine search on admission.

1.3 Patients from Shannon Clinic and Clare Unit returning from unescorted leave beyond the secure area will be subjected to a search. The frequency should be dictated on the care plan

2.0 Visitors for Patients (Shannon Clinic only)

2.1 On entering, visitors will be advised of the restricted/banned items procedure within the unit and asked to store personal belongings and restricted items in the lockers provided (this will include the contents of their pockets).

2.2 The escorting nurse will meet the visitor(s) in the large reception area and re-iterate this. The escorting nurse should advise the visitor(s) of the search procedure and proceed to the airlock.
If a visitor refuses to cooperate with the procedure then access to the clinic will be denied. A full explanation will be given regarding same.

2.3 All items brought for patient should be searched (only sealed items will be permitted)
Escorting staff should request that the visitor removes any metal items from person and place in tray provided.

2.4 The escorting staff should then use the hand held metal detector to scan the visitor. **HANDS MAY NOT BE LAID ON TO SEARCH A VISITORS PERSON**

2.5 If illegal items are suspected on the visitor e.g. suspicious substances, weapons, etc. They should be refused entry and requested to leave clinic.

2.6 In the event of illegal items being found or a visit not being able to go ahead due to visitor's refusal to co-operate staff should inform the nurse in charge of inpatient facility, senior nurse co-ordinator, inpatient facility manager, RMO and the patient. An incident form should be completed

[1]Routine Search - A planned area search, to deter movement / or possession of restricted item(s)

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 73/16

Title:	Protocol for the Management of Substance Misuse in Adult Mental Health and Learning Disability Inpatient Wards		
Author(s)	Agnes Dee, Senior Clinical Nurse Manager Orla McCambridge, ST4, Home Treatment Team Patricia Minnis, Quality Co-ordinator		
Ownership:	Cecil Worthington, Director, Adult Social and Primary Care		
Approval by:	Standards and Guidelines Policy Committee Executive team Meeting	**Approval date:**	14/12/2016 01/02/2017 08/02/2017
Operational Date:	February 2017	**Next Review:**	February 2022
Version No.	V1	**Supercedes**	
Key words:	Alcohol, substance, contract, misuse		
Links to other policies	Belfast Health and Social Care Trust Admission/Discharge Policy Promoting Quality Care – Guidance on the Assessment and Management, DHSSPS, May 2012 Regional Guidelines on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland Belfast Health and Social Care Trust Observations within Mental Health Services Belfast Health and Social Care Trust Levels of Supervision/ Observations within Learning Disability Facilities Regional Guidance for the Personal Search of Patients (Therapeutic Searches) Belfast Health and Social Care Trust Patient Searches in Mental Health and Learning Disability Belfast Health and Social Care Trust Adult Mental Health and Learning Disability Absent Without Leave Policy Belfast Health and Social Care Trust Medicines Code Belfast Health and Social Care Trust Controlled Drugs Policy for Inpatient Areas Belfast Health and Social Care Trust Patient Absent without Permission Belfast Health and Social Care Trust Use of Restrictive Practices in Adults Use of Physical Interventions by staff from Mental Health and Learning Disability Services		

Date	Version	Author	Comments
01/10/13	0.1	A. Dee	Initial Draft – sent out for comment
08/10/13	0.2		Comments received
16/12/13	0.3		Comments received from MAH – procedure updated
03/06/14	0.4		Comments from Consultation received. Protocol updated
12/06/14	0.4		Approved at Mental Health Governance Committee
24/06/14	0.4		Approved at Learning Disability Hospital Management Team meeting
06/09/2016	0.5		Comments received from Pharmacy and amended
27/09/2016	0.6		Comments from Pharmacy and amended.

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast Trust Mental Health and Learning Disability Services seeks to promote and maintain a caring and safe environment for anyone admitted to any of the Trust's mental health or learning disability inpatient facilities, their carers, visitors and staff. In doing so, the Trust has a responsibility to maintain an alcohol and illicit drug free environment for all. The Trust is obligated by the law to ensure that no possession or supply of illicit drugs takes place within its premises. This document aims to ensure that there are robust systems in place to prevent such activities from taking place within the Belfast Health and Social Care Trust Mental Health or Learning Disability adult inpatient facilities.

1.2 Purpose

This protocol has been developed to ensure a standardised approach across all of Belfast Trust's mental health and learning disability inpatient facilities in the management of substance misuse including illicit drugs, non-prescribed medication and alcohol.

This protocol provides staff with guidance to prevent the use of illicit drugs, non-prescribed medication and alcohol in inpatient wards. This will include the offering of appropriate interventions to all patients who report substance misuse, are believed to be misusing substances or are at risk of misusing substances.

1.3 Objectives

This protocol aims to: -

- Prevent alcohol and illicit drugs from being brought into any Belfast Health and Social Care Trust Mental Health or Learning Disability inpatient facility;
- To ensure that staff respond to substance misuse with due regards to the requirements of the law;
- To reduce the risks of self harm or harm to others associated with substance misuse;
- Ensure that inpatient staff have the knowledge, skills and support to work with inpatients who misuse substances, or are at risk of such misuse and to offer prompt and appropriate care to address identified needs;
- Ensure that staff respond to substance misuse issues in a safe, effective and sensitive way with due regard to patients' wellbeing;
- Offer appropriate brief interventions and referral to specialist services to users who report substance misuse or who are believed to be misusing substances or are at risk of misusing substances (e.g. recently detoxified from drugs or alcohol).

2.0 SCOPE OF THE POLICY

This policy applies to all inpatients, staff and visitors to any Adult Mental Health or Learning Disability facility.

3.0 ROLES/RESPONSIBILITIES

All staff working within the mental health or learning disability inpatient facility have a responsible role to play in achieving the above policy objectives.

4.0 KEY POLICY PRINCIPLES

The misuse of drugs and alcohol by patients in an inpatient setting presents an enormous challenge to staff as this can seriously affect the ability of services to assess, treat and care for patients safely and effectively. Whilst the Trust provides care for individuals with substance misuse problems, it will not tolerate the use, possession and supply of substances on their premises. It is also against Trust policy for inpatients to use legal substances such as alcohol or non-prescribed medication on inpatient wards as using them will not only potentially render the patient less responsive to the care and treatment the Trust offers to them but also have adverse effects if taken with prescribed psychotropic drugs.

The Misuse of Drugs Act 1971 categorises drugs as class A, B and C (this list is ever changing). Offences under the Act include:

- possession of an illicit substance unlawfully
- possession of an illicit substance with intent to supply it, supplying or offering to supply an illicit drug (even where no charge is made for the drug)
- Allowing premises you occupy or manage to be used unlawfully for the purpose of producing or supplying illicit drugs.

The Psychoactive Substances Act became law in April 2016. This legislation is intended to control the supply and use of substances that were previously known as “legal highs” The Act defines a Psychoactive Substance as

“*a substance produces a psychoactive effect in a person if, by stimulating or depressing the person’s central nervous system, it affects the person’s mental functioning or emotional state.*”

The Act contains a number of exemptions including

- Controlled Drugs within the MDA 1971
- Medicinal products whether or not they have been prescribed
- Alcohol, or alcoholic products
- Nicotine or tobacco products
- Caffeine or caffeine products
- Food’, i.e. products ordinarily consumed as food or drink.

Simple possession of a Psychoactive Substance is not an offence but possession within a Custodial Institution or possession with intent to supply are offences.

The Trust's position with regards to psychoactive substances is the same as their position on dealing with drugs under the Misuse of Drugs Act 1971 and these are all classed as illicit drugs/substances

Although alcohol is exempted from the Psychoactive Substances Act, the use of alcohol is prohibited on hospital premises.

Inpatient wards should ensure that they have a poster (refer to **Appendix 1**) at the entrance to the ward informing Patients and visitors that the possession and use of illicit drugs on hospital premises is illegal and that alcohol is prohibited and all previously prescribed medication or over the counter formulations should be handed over to ward staff. This message should be included in the inpatient booklet/welcome pack and repeated in ward community meetings.

4.1 On Admission to Inpatient Setting

On admission to inpatient wards **all** patients should be advised of the Trust's position with regards to the possession and use of substances other than prescribed medication. Staff should also consider routinely informing carers/significant others.

Staff should use this opportunity to engage the patient in open dialogue and encourage them to disclose any substance misuse issues they may have. Any issue around substance misuse identified during assessment should inform the care plan. Staff should also encourage patients to self-refer to community substance misuse services or agree to a referral to dual diagnosis workers by a member of trained staff.

Patients who are known to have misused substances in the past should be provided with health promotion information about the effects of substance misuse on health and should be informed about the help they can receive from their ward team and, if appropriate, specialist dual diagnosis or substance misuse services.

4.2 Suspicion of Substance Misuse

When suspicion arises that a patient may be misusing illicit substances and/or alcohol, staff will accumulate evidence and plan a multi-disciplinary approach.

It is the responsibility of the nurse in charge to allocate a member of nursing staff to monitor the patient.

The member of nursing staff should check the patient's vital signs (heart rate, blood pressure, temperature, respiratory rate and oxygen saturation level) and compare to the baseline. Consideration should also be given to the use of the Glasgow Coma Scale and record on the NEWS chart if necessary. Nursing staff should contact the ward/duty doctor of the incident and request

attendance to the ward. In the event of any serious physical health concerns staff should send the patient to the Emergency Department, summon a crash team or dial 999 as per local procedure.

The duty doctor will further assess the patient's mental and physical state, including levels of toxicity, signs of withdrawal and potential for acute disturbance and review current treatment. A drug test may usefully inform the assessment/treatment of any patient who has a sudden and unexpected change in presentation regardless of whether they are a known drug user or not.

The Duty Doctor will agree a joint management plan with nursing staff to include:

- Management of any aggression or violence
- Review of medication
- Review of Observation levels
- Monitoring of the physical condition of the patient (Early Warning Signs monitoring)
- Alternative management if appropriate
- Transfer to the Emergency Department if there are concerns regarding physical state
- Discharge – in these circumstances this should be a consultant decision, either by the responsible Consultant or the duty consultant if out of hours.
- Transfer to the Psychiatric Intensive Care Unit or in the case of learning disability, an appropriate acute ward.
- A strategy meeting will be convened within 3 working days and all services involved in the service user's care will be invited.

4.3 Substance Misuse Contracts

If a patient repeatedly possesses or supplies substances despite this being part of his/her care plan, it might be necessary to draw up a contract with him/her specific for substance misuse linked to the care plan and risk assessment. Whilst these contracts are not legally binding on the patient, this is another attempt to get some commitment into adhering to the ward operational procedures and/or to engage in therapeutic interventions in relation to their substance use.

As part of the contract, it will be important to agree with the patient on less restrictive interventions first e.g. agreeing that they will be searched each time they come back from leave and they will have a urine drug screen done at random (Refer to **Appendix 2**).

4.4 Searches

As stated in the Regional Search Policy a search may be carried out where staff have reasonable grounds to believe that a patient has illegal substances and/or alcohol in their possession.

Police can be asked to come to the unit to remove drugs if a confrontation is expected or if patients are unwilling to comply with Trust policies regarding the

confiscation of illicit substances. This decision should be made by the multidisciplinary team.

Where a patient is found in possession of suspected illicit drugs in an inpatient area, they will be asked to surrender the substances to staff – (Refer to **Appendix 3)**. Staff should observe universal precautions when handling illicit substances i.e. use gloves and wash your hands after handling drugs.

Staff should then complete an incident form according to the BHSCT Procedure for Reporting and Investigation Adverse Incidents. If the incident is reported to the police, staff should quote the police reference number on the action taken section of the incident form.

4.5 Confiscation and disposal of illicit Substances

Please refer to section 6.8, and appendix 4 and 5 of the Belfast Trust Medicines Code.

4.6 Confiscation and disposal of Alcohol & Non-prescribed Legal drugs

Other substances, which the patient held lawfully, such as alcohol, medicines previously prescribed and medication bought over the counter cannot be destroyed without the patient's consent. The patient has a right for such items to be returned to them at the time of their discharge.

Once consent has been obtained from the patient, they should be given the option to have the alcohol or non prescribed medication removed by a relative or carer of an appropriate age.

If there is no agreement reached with the patient and staff believe that there is a risk to them or others in returning the property, they should consult with the patient's Responsible Medical Officer or the manager to gain agreement to remove the property from the patient.

If staff are not clear about confiscation or disposal of substances, they should seek advice from the Trust Pharmacy Department.

4.7 Informing the Police

Under the Misuse of Drugs Act 1971 and in particular section 8 those in charge of premises have a responsibility to inform the police if they believe that anyone is committing an offence on their premises.

All incidents involving possession or supply of illicit substances on BHSCT premises will be discussed by the multidisciplinary team and consideration given to reporting to the police. The patient or visitors should be fully informed of the decision to report to the police. Staff should co-operate with all police investigations and be available to attend court to give evidence if asked to.

4.8 Visitors to the Inpatient Facility

Staff should find a balance between providing safe care and facilitating appropriate visitor contact.

If there is considerable suspicion/evidence that a visitor is in possession of drugs or supplying drugs to inpatients, they will be asked to leave immediately and reported to the police. If they do not leave, staff should consider asking the PSNI for assistance, in order for the visitor to be safely removed from Trust premises.

If a visitor has been asked to leave the premises for possession or supply of illicit substances, the Nurse in charge in consultation with the multidisciplinary team may prohibit the visitor from visiting, and write to them informing them of such a decision. This decision must be reviewed regularly and consideration given to supervised visits.

4.9 Planned discharge from the ward

It is possible that some patients might still carry on using substances regardless of having taken part in/been given /offered.

- Information on posters
- Patient information booklet/welcome pack.
- Health promotional information about the effects of drugs on health.
- Appropriate help to deal with his/her drug and alcohol problems.
- Searches and drug screening.
- Care plans around substance misuse.
- Contracts and
- Police have been informed.

If there is considerable suspicion that a **Voluntary patient** continues to use drugs, and it is felt by the multidisciplinary team that their main problem is with substance misuse and that the mental illness can be managed better if the patient stops using substances then a **planned** early discharge may be an option. Normal discharge procedures apply.

It is crucial that as part of this process the multidisciplinary team considers the risk implications of the substance misuse in terms of increasing risk behaviours such as self-harm, suicide and violence prior to a decision to discharge. This should be clearly documented.

The discharge meeting within mental health services should have a follow up plan including 7 day follow–up appointment with mental health services (learning disability staff should refer to their own discharge plan/protocol). This might mean referring the patient to a drug and alcohol team if they are willing to engage with this service. Substance misuse services need to be fully informed of any mental health/risk issues and will then also be able to alert services if the person fails to engage on discharge.

Treatment plans and discharge arrangements for patients with substance

use problems need to take account of the external environment, to which they are returning and include the risk of relapse. Relatives and carers should (with the consent of the patient), be involved in these arrangements.

For **all detained patients and some Voluntary patients** who cannot be safely discharged to the community, a multidisciplinary review of their treatment and care will take place at the earliest opportunity as their needs may be more appropriately met elsewhere. This review may lead to their leave from the ward being temporarily withdrawn (if detained), and/or a limit on their visitors if appropriate and/or referral to a Psychiatric Intensive Care Unit or appropriate acute learning disability ward, for increased and more appropriate supervision.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy will be disseminated to all staff within Mental Health and Learning Disability Services.

5.2 Resources

No additional resources are required.

5.3 Exceptions

The scope of this policy applies to adult Mental Health and Learning Disability inpatient wards within Adult Social and Primary Care Directorate.

6.0 MONITORING

Adhoc audits will take place to ensure adherence to the implementation of this protocol

7.0 EVIDENCE BASE / REFERENCES

D.O.H (2006) **Dual diagnosis in mental health inpatient and day hospital settings:** *Guidance on the assessment and management of patients in mental health inpatient and day hospital settings who have mental ill-health and substance use problems*

Wallace C, Mullen P., Burges P (2000) **Nursing Times**, Nov 30, 2000; Vol 96, No. 48. “Wintercomfort Case”

Williams, R. (2000) Substance use and misuse in psychiatric wards. The Psychiatrist (2000) 24: 43-46. doi: 10.1192/pb.24.2.43. Professor of Mental Health Strategy The Royal College of Psychiatrists.

Misuse of Drugs (NI) Regulations, DHSS, 2002

http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/

8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with Mental Health and Learning Disability Services

9.0 APPENDICES / ATTACHMENTS

Appendix 1 Say No to Drugs Poster
Appendix 2 Patient Contract
Appendix 3 Process on discovering patient in possession of illicit drugs flowchart

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

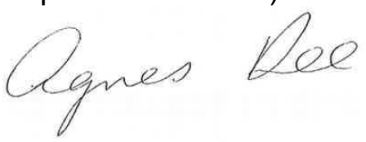
Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



_____ **Date: ___February 2017___**

Author

_____ **Date: ___February 2017___**

Director

Appendix 1

Belfast Health and Social Care Trust

Say "No" to Substance Misuse on the Ward!

Possession or supply of Illicit (Illegal) Substances

Any person found in possession, using or supplying illicit substances on the ward will be reported to the police and the substance will be confiscated and destroyed. Visitors found in possession or supplying illicit substances whilst on Trust premises will be reported to the police and their visiting rights will be reviewed. Prosecution will also be considered.

Alcohol and Medication Not Prescribed On the Ward

It is against BHSCT policy to use these substances and they will be confiscated. With your consent the substances will either, be destroyed, kept in a locked cupboard by staff to be given to you on discharge or to your Carer/family or friend of an appropriate age to take off the premises.

If you have drug or alcohol problems ask ward staff to assess you and advise you on the treatment options available. You will not be reported to the police for asking for help.

Thank you for helping us to maintain a safe environment for our Patients, Visitors and Staff.

Belfast Health and Social Care Trust

Appendix 2

Patient Substance Misuse Contract

BHSCT aims to maintain an alcohol and illicit drug free environment for patients, carers, visitors and staff. While we provide care for individuals with substance misuse problems we do not tolerate the use, possession and supply of substances on Trust premises. The misuse of drugs and alcohol by patients in an adult inpatient mental healthcare or learning disability setting can seriously affect the ability of our staff to assess, treat and care for patients safely and effectively.

Please be aware that prescribed drugs or those bought over the counter can also be harmful if used against medical advice. Trust staff may consider any substance, even unidentified, as presenting a possible cause of harm and treat it as a harmful substance.

We ask you to agree to:
o Abstain from drinking alcohol while an inpatient.
o Abstain from taking any drugs other than those prescribed by your ward doctor.
o Random urine drug samples taken to screen for substance misuse (**we will ask for your consent each time you are asked to give a sample**).
o Personal searches of yourself and your property by nursing staff in accordance with the Trust Policy for conducting Personal Searches (**we will ask for your consent each time before you are searched**).
By agreeing to sign this contract the understanding is that if you break the terms of the contract then agreed measures to help reduce your substance misuse will be instigated and there will be an immediate review of your care plan with your full involvement.

If you break the terms of this contract then any of the following measures may be instigated and there will be

- an urgent review of your care plan.
- Increased observation levels
- Regular drug screening
- Restrictions on leave
- Searching property
- Limiting or supervising visits
- Referral to other services e.g. drug and alcohol services, other community services or PICU/appropriate ward.

I agree to abide by this contract:

Signed by patient:	Date:
Witnessed by (any member of MDT):	Date:
Signed by the Responsible Clinician:	Date:

Appendix 3

What to do if you discover a patient in Possession or Supplying "Suspected Illicit Substances"

Patient found Using, Possessing or Supplying "Suspected Illicit Substances".

↓

Remind the Patient of Trust policy and ask him/her to hand in the "Suspected illicit Substance" to staff.

↓

Carry out room searches and personal external searches in line with Trust policy.

↓

Pay due regard to changes in the Patient's physical and mental health
(**This applies at any stage of this decision algorithm)

↓

Store the suspected substances safely according to the BHSCT Medicines Code

↓

Consideration to be given to reporting to local police.

↓

Complete an Incident form, destruction and removal form & Document in the Patient`s notes.

For regular use of illicit substances, discuss this with the MDT

↓

Consider the use of a patient contract. If the contract fails and risk assessment permits, consider **planned**
early discharge/transfer to an appropriate service.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 11/09

Title:	**Belfast Health & Social Care Trust Community Learning Disability Interim Financial Support Policy**			
Author(s)	Aisling Curran, Service Manager, Acting head of Community Learning Disability Anne Campbell, Assistant Service Manager, Residential and Supported Living			
Ownership:	Marie Heaney, Adult Social & Primary Care Director			
Approval by:	Adult, Social and Primary Care Directorate Governance Meeting Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting		**Approval date:**	12/12/2018 07/03/2019 04/04/2019 10/04/2019
Operational Date:	March 2019		**Next Review:**	March 2024
Version No.	1	**Supercedes**	Belfast Health & Social Care Trust Community Learning Disability Financial Support Policy (2014) (draft)	
Key words:	Cash, statements, bank, financial, learning disability			
Links to other policies	Adult Protection Policy and Procedures Gifts and Hospitality Policy Records Retention and Disposal Schedule			

Date	Version	Author	Comments
	0.1	A Curran A Campbell	Initial Draft
24/12/2018	0.2	A Curran A Campbell	Comments received and policy amended
20/02/2019	0.3	A Curran A Campbell	Further comments received and policy amended
25/02/2019	1	A Curran A Campbell	Further comments received and policy amended

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This interim policy and associated procedures detail the requirements within Community Services for the management of Service Users' finances.
It should be read in conjunction with:

- Regulation and Quality Improvement Regulations and Standards (2003)
- Regulation and Quality Improvement Safeguarding of Service User Finances within Residential & Nursing Homes & Supported Living Schemes(2016)
- Department of Health Policies and Circulars
- https://www.health-ni.gov.uk/publications
- The Mental Health (N.I.) Order 1986
- Department of Health Adult Safeguarding Prevention and Protection in Partnership (July 2015)
- Belfast Health & Social Care Adult Safeguarding Policy, 2013
- Gifts and Hospitality Policy, Belfast Trust, 2015
- Records Retention and Disposal Schedule, Belfast Trust, 2008
- RQIA February 2016 Safeguarding of Service User Finances within residential and nursing home and supported living schemes.
- General Data Protection Regulation (2018)
- Belfast Health & Social Care Trust "*Best Interest Decision Making A Guide for Social Workers*

1.2 Purpose

The policy aims to safeguard Service Users' financial interests and to provide direction and ensure appropriate governance arrangements are in place for staff in community learning disability services.

1.3 Objectives

a) To protect Service Users from financial abuse
b) To protect Service Users' financial interests
c) To provide direction and support for staff managing service user finances.
d) To ensure good governance of financial management arrangements.
e) To ensure that the requirements relating to Service User finances under the Mental Health (N.I.) Order 1986 are met

2.0 SCOPE OF THE POLICY

2.1 The interim policy applies to all situations in which service users in community Learning Disability services require support from Belfast Health & Social Care Trust staff with their finances.

2.2 Service users may need support with their finances because;

- They lack capacity to make some or all financial decisions.
- They have physical difficulties that hinder their ability to make financial transactions
- They require protection from financial exploitation.
- They require advice and support to enable them to make their own decisions about their finances.

3.0 ROLES/RESPONSIBILITIES

3.1 All staff working in the adult learning disability community services have a responsible role to play in achieving the above procedural objectives.

3.2 There are specific roles and responsibilities outlined in the procedure for: -

Co-Director for Learning Disability Services:
To ensure provision and distribution of comprehensive, up to-date procedure based on regional guidance;

3.3 **Service/Operations Manager:**
To ensure the procedure is consistently implemented across all community based residential and supported living facilities.
To work with the Managers in monitoring the frequency of the policy being put into action, identifying lessons learnt where appropriate and informing practice.

3.4 **Facility Manager**
To ensure that staff are conversant with and consistent in their application of the procedure and clear about their individual responsibilities;
To ensure all appropriate documentation is completed as per the procedure;
To work with the Operations Manager in monitoring the usage of the policy and identifying lessons learnt where appropriate and informing practice.

3.5 **Facility staff:**
To ensure they are conversant with the procedure;
To understand their individual role and responsibility in relation into implementation of the policy
To work with the Manager in monitoring the usage of the policy and identifying lessons learnt where appropriate and informing practice

4.0 KEY POLICY PRINCIPLES

4.1 The definitions and background of the policy:

The policy has been formulated to ensure there are appropriate governance arrangements in place for staff support of Learning Disability Service User finances across community services.

4.2 Key Policy Statement

The Policy sets out the standards and protocols for the management of Service Users' financial affairs in community learning disability facilities.

4.3 Policy statements:

Financial support to service users by Belfast Trust Health & Social Care Trust Community staff must only be provided in compliance with this policy.

Learning Disability Service Users should be encouraged to manage their own finances where possible.

The service will be delivered mindful of equality and human rights obligations in particular treating service users and their carers with respect and dignity and the provision of reasonable adjustments where required

Where a Service User has been formally assessed as not capable of managing their financial affairs, staff should ensure that all decisions about their finances are made in the Service User's best interests.

Staff have a duty to act if they suspect a Service User is being financially abused and must refer any such concerns for investigation under the Trust's Adult Safeguarding Policy.

5.0 IMPLEMENTATION OF POLICY

5.1 Consultation Process:

A working group was established with representatives across Learning Disability. The role of the working group was to update the previous draft policy in place (Belfast Health & Social Care Trust Community Learning Disability Financial Support Policy) as an interim measure until such time as the policy could be extended across both Mental Health & Learning Disability within the ASPC Directorate. Consultations regarding this interim policy were also held with the following –

- Rhoda McBride, Divisional Lead Social Worker
- Jacqui Austin, Senior Manager , Service Improvement & Governance
- Michael McGinn, Senior Manager, Finance
- Nicola Williams, Head of Governance, Audit & Client Accounting

A draft policy was circulated across Learning Disability services after the

December Governance meeting with a request for comments.

5.2 Resource(s) / Evidence Base:

a) Mencap Publication In Control Fact Sheets
Mencap Publication: Best Practice Guides Finance and Accounting

b) ARC Publication: Guidance on Money management 2010
ARC Publication : Managing my Money (2010)
ARC Publication: My Money Matters (2010)

5.3 References, including relevant external guidelines:

- Circular HSS (7) 57/2009. Misappropriation of Residents Monies- Implementation and Assurance of Controls in Statutory and Independent Homes. December 2009
- Regulation and Quality Improvement Safeguarding of Service User Finances within Residential & Nursing Homes & Supported Living Schemes (2016)
- The Mental Health (N.I.) Order 1986
- Safeguarding Vulnerable Adults, Regional Adult Protection Policy & Procedural Guidance (Sept 2006)
- Belfast Health & Social Care Adult Safeguarding Policy, 2013
- Gifts and Hospitality Policy, Belfast Trust, 2010
- Belfast Health & Social Care Trust Procedure for Handling of Petty Cash (2016)
- Records Retention and Disposal Schedule, Belfast Health and Social Care Trust. 2008
- Department of Health, Social Services and Public Safety- Reference Guide for Consent for Examination, Treatment and Care. 2003
- Belfast Health & Social Care Trust "*Best Interest Decision Making A Guide for Social Workers*

This policy should be implemented by all community staff that have responsibility for the management of service user finances.

All staff will require training on the policy and subsequent updates

6.0 PROCEDURES

6.1 This section details the actions to be carried out by staff when managing service user finances.

Monitoring

Service Users who Lack Capacity
In any aspect of his/her finances and it is proposed that a Trust member of staff should manage this aspect, this should be agreed at multi-disciplinary Best Interests meeting with confirmation that no other options are available and that the Service User would be at risk without Staff support. A Financial Support Plan (Appendix 1) should be drawn up which should state:

a) Corporate appointeeship or any other authority granted for the management of that Service User's finances.
b) The details of the financial support required.
c) The details of how this will be delivered.
d) Details of the monitoring arrangements.

The Service User should be consulted insofar as this is possible about their wishes in respect of their finances, making reasonable adjustments in terms of communication being inclusive and accessible. Due consideration should be given to this when drawing up the Financial Support Plan.

Carers should be consulted and involved and given the first choice of being Appointee where this is appropriate making reasonable adjustments in terms of ensuring that communication is inclusive and accessible and the significance is understood.

Financial Support Plans should be signed by the Care Manager/Team Leader/Manager of Facility providing the support. If appropriate the person's Carer should also sign the support plan to indicate their acceptance of the plan. In the event of Carer disagreement, consideration may be given to case discussion. The Service User should sign to say that the plan has been shared with him/her, and also by carers or family if possible and where appropriate.

It is the responsibility of the Community Key Worker / Facility Manager to ensure a copy of the Financial Support Plan is given to the Corporate Appointee which the Corporate Appointee then uses to manage the Service User's funds. A copy of the Financial Support Plan will also be retained in the service user's file.

Following receipt of the Financial Support Plan in Trust Finance Department, a period of one calendar month is required to set up redirection of benefits to the Trust.

6.2 Service Users who have capacity but require support with their finances
Where a Service User has capacity to manage their finances but requires

support to do this and is willing to accept support, a Financial Support Agreement (Appendix 2) should be drawn up. The Service User should be consulted about their wishes in respect of their finances, making reasonable adjustments in terms of communication being inclusive and accessible. Their views should be clearly central when drawing up the Financial Support Agreement. The Financial Support Agreement should:

a) Detail the finance support required
b) Detail how this will be delivered
c) Detail the monitoring arrangements.

The Financial Support Agreement must be signed by the Service User, the Service User's key worker and the Manager of the service providing the financial support. An Easy Read version of what is agreed should be available for the service user if they wish.

6.3 Carer Management of Finances

Where a Carer manages a Service User's finances either by agreement or because the service user lacks capacity, this is only an issue for the Trust if the Trust is also managing some aspect of the person's finances. This might be the case if a person is supported by Residential or Supported Living Services and the family act as appointee but leave money with Staff to spend on behalf of the Service User. In such circumstances a Financial Support Agreement (Appendix 2) should be drawn up with the carer agreeing what specific financial support staff will undertake. The Service User may be involved in signing the agreement. The monitoring arrangements for this should be as detailed in this policy with a minimum review on an annual basis.

6.4 Service Users in Commissioned Care Managed Residential and Nursing Home Placements where the Trust is Appointee

Where the Trust has had appointeeship transferred to it by a previous appointee and is receiving benefits for the Service User in question, paying private or voluntary residential/nursing home costs and transferring any remaining money to private or voluntary nursing home/residential home personal accounts, there is no need for Office of Care and Protection (OCP) involvement or for the drawing up of a Financial Support Plan (FSP) (Appendix 1). The Trust should ensure that the service provider has an adequate financial support policy in place.

The Service User's Key Worker approaches Trust Finance to request corporate appointeeship in circumstances where the Service User lacks capacity. In such circumstances the following applies:

1) If the Service User is only on benefits then a medical certificate is required to present to the Social Security Agency.
2) If the Service User has other income then a referral to the OCP is required to request this to be redirected. The OCP will requires a F8 Medical to undertake this on behalf of the Trust.
3) If the Service User has savings to be redirected then a referral to the OCP is required to request this to be redirected. The OCP will require a F8 Medical to undertake this on behalf of the Trust. It is noted if the

Service User's savings is less than the Regional Threshold the Trust does not require access to this money so therefore it remains in situ. However, if the Service User requires access to this money then the Trust will recommend transfer on behalf of the Service User. In situations where the Service Users savings are greater than the Threshold and the Service User resides in a Nursing & Residential facility, transfer will occur as there is a charge on savings above the Threshold. This is the responsibility of the Key Worker and/ or Care Manager.

4) The OCP will actively seek a relative to undertake this financial responsibility for the Service User. If the OCP can't find a suitable candidate they will request that the Trust will take on the responsibility
5) Once OCP become appointee for a Service User they will require instructions from the Key Worker as to where the Service User's Personal Allowance (PA) is to be allocated. It can be allocated to one of the following:
   a) Patient Bank (If it goes here the OCP will require information on to who and how this money will be accessed on behalf of the Service User)
   b) To the Home
   c) To Relative

d) If the PA is being paid into the facility the Trust expect the home to keep a ledger for the Service User. The Key worker is responsible for reviewing this ledger to satisfy the Trust that what has been paid directly by the Trust to the facility is reflected in the ledger and also that any expenditures are reasonable and in line with what it expected to deliver the Service User's needs.

6) The Care Manager and/or Trust Key Worker undertakes an annual Care Review with each Service User to review the care provided. In relation to management of Service User's finances, for Service Users who reside in a residential or nursing home facility, the care review includes:
   a) Confirmation of access to their Personal Allowance (PA).
   b) Confirmation of the following information from Finance
      i) Is the Service User's contribution being paid to the Trust
      ii) If there is a third party charge, is this being paid
   c) If the Trust is appointee for the Service User:
      i) Confirmation of where the PA is being paid to
      ii) If accessed by patient bank – confirmation of who is accessing it and how much has been requested since the time of the previous care review
   d) BHSCT commissions financial audits of statutory and non-statutory services. The care Manger and/or Key Worker should escalate any concerns to Trust Contracts Department and Senior Management as a financial audit or investigation may be required.

OPERATIONAL PROCEDURES

Withdrawal of Cash

If the support required includes the withdrawal of cash from a bank/post office account or ATM machine, the following arrangements should be made. See also Appendix 3 regarding withdrawal of cash from "Patient's Bank".

a) The Service User should, where possible, accompany the member of staff to withdraw cash.
b) A receipt for any withdrawals must be obtained and kept on record. If the machine does not issue a receipt, this should be noted on the record.
c) The PIN for the account should be kept in a safe belonging to the Trust (where such a safe is in place). The safe should also contain a list of who is authorised to access the PIN number.
d) The PIN and the debit card must not be stored together.
e) Account details, statements, books, debit card must be kept in a separate location from the PIN number. (Service User file, Service User's possession).
f) Monthly statements for the account must be obtained and audited on a monthly basis by the appropriate Manager of the service. An agreement needs to be drawn up in relation to monitoring the account.
g) To ensure the safekeeping of the debit cards, staff are required to record date, time, and signature when an ATM card is removed from and returned to the premises and signed by two staff where possible.
h) The amount of money withdrawn from the service users' bank account/post office account must concur with the anticipated weekly//monthly expenditure of the service user as indicated on the Financial Support Plan /Financial Support Agreement

Lodging of Cash/Cheques/Transfer of Funds

If the support required includes the lodging of cash/cheques or the transfer of funds from a bank/post office account or ATM machine, the following arrangements should be made.

a) The service user should, where possible, accompany the member of staff to lodge cash.
b) A receipt for lodgements must be obtained and kept on record.
c) Monthly statements for the community bank account must be obtained and audited against the financial log on a monthly basis by the appropriate Manager of the service
d) If staff support a service user to carry out internet shopping a hard copy detailing the transaction must be maintained and reconciled with the service users bank statement.
e) Staff are required to comply with the agreed guidance (Appendix 3) when transporting cash in their own vehicle.

Holding of Cash

a) Service user cash being held by the Trust should be kept in an individual cash box or purse in a locked cupboard or safe on Trust premises or in the service user's own home. On Trust premises, the key should be held by the senior member of staff on duty in Residential and Supported Living Services or by an administrative member of staff in Community Teams and Day Services. Where the cash box is held in someone's home, the service user should, where possible, hold the key. If this is not possible, the key should be kept out of sight in an identified location that is separate from the cash box. The location of the key should only be known to staff involved in supporting that service user. Where a service

user is living in a shared house, each service user must have their own individual cash box with the keys for each box inaccessible to the other service users.

b) Cash to be held should be in line with the agreed weekly expenditure identified in the Financial Support Plan or Agreement. The exception to this is when an amount of money has been placed in it immediately prior to a specific purpose. This must be sanctioned by a member of staff at Band 6 or above in Day Services and Community Teams or by the appropriate Manager of the service in Residential and Supported Living Services. This approval must be noted on the service user's ledger sheet.
c) Where staffing levels in a facility allow for 2 people to do so, 2 members of staff will sign for lodgements and withdrawals. If staffing levels do not permit, such as in Supported Living environments, where single staff call to a service user's home, one staff member will sign.
d) In domiciliary / supported living services where Service Users are supported by one member of staff and unable to sign, one member of staff may sign (note any issues should be picked up on audit/spot checks)

Supporting Service Users to Spend Money

If the support required includes the spending of money for the Service User, the following arrangements should be made.

a) The service user should accompany the member of staff, if possible, when his/her money is being spent.
b) An expenditure record must be maintained. This record should detail the date of the expenditure, a description of the expenditure and the amount spent. This record should also keep a running balance of the person's assets.
c) Receipts must be obtained and kept for all expenditure except personal spend / expenditure which the service user undertakes by his/herself and is generally for small purchases.
d) It is noted that most debit cards now include a contactless payment facility, allowing the user to make a payment for purchases up to £30 in one transaction without the need of a PIN.
e) Staff or relatives of staff should not sell goods or services to service users.
f) Staff must not use their own bank accounts or credit cards to facilitate a service user's transaction in any circumstances. Crisis and/or emergency situations can override this in exceptional circumstances and for a small amount of cash only e.g. use of petty cash. Permission to proceed in such cases is required from the appropriate Manager.
g) Staff must neither lend money to nor borrow money from a service user Crisis and/or emergency situations can override this in exceptional circumstances and for a small amount of cash only.
h) Where there are loyalty rewards or coupons for spend in certain retailers this must be clearly evidenced to benefit the service user only. Staff must not use their loyalty card in order to benefit or claim points.

Disposal of Service User's goods

a) All disposals should be discussed and agreed, where possible, by the

service user either individually or in consultation with their Carer. Reasonable adjustments should be made to support communication and ensure as full an understanding as possible with service user.

b) A record of all disposals must be kept in the Service Users file.
c) Service User's goods being disposed of, should not be either given to or purchased by staff.

Shared costs for Service Users

On occasion, Service Users share costs for particular services. This includes household grocery and household maintenance funds. Where this is the case the following protocol must be followed:

a) An individual Service Users' agreement must be drawn up, signed by the service user, recorded and stored within their care / support plan
b) Individual Service User contributions to a communal fund must be noted on the individual's ledger record.
c) Separate records must be kept to detail the spending and monitoring of the communal fund. Records must show each individual service user's contribution to the communal fund. All spending from this communal fund must be receipted.
d) Service users must contribute equally to and benefit proportionately from any communal fund.

MONITORING ARRANGEMENTS

a) The scheme/facility should maintain a ledger sheet (Appendix 4) in the agreed format for all service users detailing all financial transactions. This is in addition to sign in/sign out procedures for cash boxes/safes.
b) All receipts for financial transactions of any kind in any one-month should be kept in the one envelope. This is to make the monitoring of the records manageable.
c) The Key Worker's appropriate Manager must scrutinise the financial records for each client on a monthly basis. This should involve looking at monthly statements, receipts, cash box/safe records and the service user's ledger sheets. The appropriate Manager must ensure that there are no discrepancies in the documentation and that all transactions are reasonable. The appropriate Manager will sign the monthly statements, the cash box/safe record and the ledger sheets to show they have done this. The appropriate Manager must inform a Senior Manager of any discrepancies as soon as possible.
d) Where individual cash boxes are in place in Residential Facilities, two staff should carry out a daily check (where possible) of the cash held in service user's individual cash boxes and verify that this agrees with the ledger record for each service user. The two staff members must sign the ledger record to show that this has been done.
e) In Supported Living Services, the check will be conducted by one member of staff and monitored by the appropriate Manager on a monthly basis. Staff conducting these daily and monthly checks should note any discrepancies and report them to a more senior member of staff immediately. The senior member of staff should investigate the discrepancy and the outcome of the investigation and any action noted on

the service user's ledger sheet. This entry should be signed by the appropriate Manager of the service.

f) Operations Managers are responsible for general oversight of the financial policies and procedures and should discuss and monitor this regularly in supervision with Managers.
g) All staff must be made aware of the Trust's financial policy/procedures as part of their induction. Staff must sign the Trust's monitoring pro-forma to show that they have read and understood the policy. Staff must raise any concerns they have about mismanagement of finances with their line Managers or a more senior member of staff.
h) Managers should ensure that financial management issues are discussed on a regular basis at team meetings and updates given whenever required.
i) All signatures on financial records must be in full, dated and be legible.
j) Service user financial records should be kept in the service user's file in the service which has primary responsibility for managing the person's finances and the records should be kept in accordance with the Trust's policy on record retention.

Savings

In such circumstances where the Trust is the Corporate Appointee and where a service user accumulates £2500 in a current account, if there are no plans to spend that money within six months, the Key Worker should bring this to the attention of the Team Leader/Manager. The Team Leader / Manager should review the regular expenditure and if this is thought sufficient, advice should be sought from the appropriate Manager, and/ or OCP or any authority, about the best management of this money. If the money is to be transferred, the appropriate Manager and/ or OCP will issue instructions and authority for this. The Financial Support Plan should then be amended accordingly and the necessary actions taken.

Gifts

Staff should adhere to the Trust's Gifts and Hospitality Policy. In addition, staff members must not accept money from service users. Staff members must not accept gifts from service users unless the service user has bought these independently with personal spending money and the value does not exceed £50. Any such gifts must be declared by the staff member to their Line Manager who will decide if a gift can be accepted.

If a Service User who lacks capacity wishes to give a gift or money to a third party, staff must decide on the appropriateness of this. The appropriateness of this gift must be escalated and discussed with Senior Staff.

9.0 APPENDICES

The following Appendices are guides for Staff and Managers. Individual Service Teams may wish to develop their own versions of the templates provided.

- Appendix 1 Financial Support Plan

- Appendix 2 Financial Support Agreement
- Appendix 3 Guidance for Staff Transporting Cash in their own Vehicles
- Appendix 4 Ledger Sheet
- Appendix 5 Flowchart

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved **X**

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

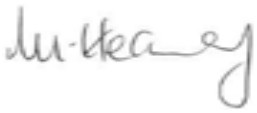
SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

28/02/2019

_____ **Date:** _____

Authors



28/02/2019

_____ **Date:** _____

Director

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 1

Financial Support Plan

This plan is to be used with service users who lack financial capacity and require an appointee
This financial support plan should be read in conjunction with ---------- care and support plans.

1. Service Users Details	
Service User Name	
Service Name	
Address	
DOB	
Key Worker Name	
Manager Name	
Senior Manager Name	

2. Current Arrangements for the management of service users finances.

- *This should detail the support required*
- *How this support will be delivered*

3. Human Rights Considerations / Financial Capacity

Human Rights Consideration

Belfast Health and Social Care Trust (BHSCT) aspires to be known as one of the safest, most effective and compassionate health and social care organisations and staff deliver services in accordance with this goal. In line with our Trust values to treat everyone with respect and dignity Belfast Trust is committed to the safeguarding and promotion of Equality, Good Relations and Human Rights in all aspects of its work.

This Financial Support Agreement (FSA) has been Equality Screened in terms of Equality and Good Relations in accordance with our Section 75 duties and in terms of our obligations under the Human Rights Act 1998.

Support staff will make every effort to ensure that respect for equality of opportunity, good relations and human rights, is part of their day to day work and is incorporated and reflected as an integral part of actions and decision making processes.

Support staff, when assisting ---------- (service user name) with the management of his/her finances must always consider the need to promote Equality of Opportunity, Good Relations and Human Rights whilst offering an appropriate level of support with financial management.

Details of this support is outlined in section 6 of this document and this FSA should be reviewed at least annually."

4. What Financial Support is required

Opening of a bank/post office account (Please detail suggested bank/branch and if cheque book/ cash card required etc.) ☐

Management of a current bank/post office account (withdrawals/lodgements) ☐

Opening a savings account (Please detail suggested bank/branch/type of account, access/cash card required etc.) ☐

Management of a savings account (including making withdrawals/lodgements) ☐

Spending service users' money on their behalf	☐

5. Authority • ***This should detail any authority and powers granted***

6. Appointeeship Details if Relevant
Rationale for appointeeship: Name of Appointee: Address of Appointee: Date Appointeeship Granted:

7. Please name the staff who will be managing the person's finances (minimum of two and a maximum of four names)

8.		**Income Sources** ***a) The benefits which I am entitled to are paid directly to me for my personal use.*** ***b) The BHSCT provide my care and support. This is paid from the Supported Housing budget. I do not pay for any care or support provided.***		
			Weekly/monthly *Please state*	£
	Supporting People –*This money is paid from the NIHE directly to the BHSCT to pay for my housing support*			£
	Salary			£
	State Pension			£
	Pension Credit			£
	Personal Independence Payment (PIP) – Care Component			£
	Personal Independence Payment (PIP) – Mobility Component			£
	Income Support			£
	Incapacity Benefit			£
	Job Seekers Allowance			£
	Housing Benefit – *paid directly by NIHE to landlord*			£
	SDA			£
	Employment & Support Allowance			£
	Other			£
	TOTAL			£

9. Anticipated Weekly/Monthly Expenditure

a) If utility bills are paid in equal amounts by each tenant when the bill is received this should be noted.

b) Please note if any of these bills are paid by direct debit.

	Amount Per Week	**Amount Per Month**
Supporting People - *This money is paid from the NIHE directly to the BHSCT to pay for my housing support*	£	£
Electricity	£	£
Gas/Oil	£	£
Rent/Rates –*paid directly by NIHE to landlord*	£	£
TV Licence Fee	£	£
Sky TV	£	£
House Insurance	£	£
Groceries	£	£
Telephone	£	£
Care Line	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending	£	£
Gardener	£	£
Window Cleaner	£	£
House Cleaner	£	£
Launderette	£	£
Taxi's	£	£
Clothes	£	£
Other- Leisure etc Social Outings- (meals)	£	£
TOTAL	£	£

10. Savings (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

Lodgement Arrangements (e.g. post/in branch/lodgement slips)

Withdrawal Arrangements (e.g. cash card/pass book etc.)

Current savings on (Date) Amount

11. Banking Management (Currents Accounts) (if relevant)

Name of Bank/Post Office Account	
Address of Bank/Post Office Account	
Account Number	
ATM Debit Card	☐Yes ☐No
Pass Book	☐Yes ☐No
Cash Card/Pass Book Where is this held?	
Who has access to it?	
Pin Number *The pin number must be stored separately from debit card* Details to be kept in safe on Trust premises and locked cash box in users home	
Who has access to it?	

12. Cash Box/Safe Arrangements (if relevant)		
	Where is the cash box/ money wallet held?	
	Who holds the key/safe code?	
	Where is the key kept?	
	Who has access to the key/safe code?	

13. Monitoring
The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.

Signatures:	
Family Member/NOK:	**Date:**

Manager:	**Date:**
Key Worker:	**Date:**
Community Team Leader:	**Date:**

This Financial Support Plan has been discussed and shared with me and I am in agreement with it. ☐

Service Users signature: _____

Date: _____

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 2

Financial Support Agreement

This agreement is to be used with service users who have capacity, but require support with financial management

1. Service Users Details	
Service User Name	
Service Name	
Address	
DOB	
Key Worker Name	
Manager Name	
Senior Manager Name	

2. Current Arrangements to assist the service user in the management of services users finances • ***This should detail the support required*** • ***How this support will be delivered***

3. Human Rights Considerations / Financial Capacity

Human Rights Consideration

"Belfast Health and Social Care Trust (BHSCT) aspires to be known as one of the safest, most effective and compassionate health and social care organisations and staff deliver services in accordance with this goal. In line with our Trust values to treat everyone with respect and dignity Belfast Trust is committed to the safeguarding and promotion of Equality, Good Relations and Human Rights in all aspects of its work.

This Financial Support Agreement (FSA) has been Equality Screened in terms of Equality and Good Relations in accordance with our Section 75 duties and in terms of our obligations under the Human Rights Act 1998.

Support staff will make every effort to ensure that respect for equality of opportunity, good relations and human rights, is part of their day to day work and is incorporated and reflected as an integral part of actions and decision making processes.

Support staff, when assisting ---------- (service user name) with the management of his/her finances must always consider the need to promote Equality of Opportunity, Good Relations and Human Rights whilst offering an appropriate level of support with financial management.

Details of this support is outlined in section 6 of this document and this FSA should be reviewed at least annually."

4. Please name the staff who will be assisting the service user to manage their finances (minimum of two and maximum of four names)

5.		**Income Sources** ***a) The benefits which I am entitled to are paid directly to me for my personal use.*** ***b) The BHSCT provide my care and support. This is paid from the Supported Housing budget. I do not pay for any care or support provided.***		
			Weekly/monthly *Please state*	£
	Supporting People –*This money is paid from the NIHE directly to the BHSCT to pay for my housing support*			£
	Salary			£
	State Pension			£
	Pension Credit			£
	PIP – Care Component			£
	PIP – Mobility Component			£
	Income Support			£
	Incapacity Benefit			£
	Employment & Support Allowance/Job Seekers Allowance			£
	Housing Benefit – *paid directly by NIHE to landlord*			£
	SDA			£
	Other			£
	TOTAL			£

6. Anticipated Weekly/Monthly Expenditure ***a) If utility bills are paid in equal amounts by each tenant when the bill is received this should be noted.*** ***b) Please note if any of these bills are paid by direct debit.***		
	Amount Per Week	**Amount Per Month**
Supporting People - *This money is paid from the NIHE directly to the BHSCT to pay for my housing support*	£	£
Electricity	£	£
Gas/Oil	£	£
Rent/Rates –*paid directly by NIHE to landlord*	£	£
TV Licence Fee	£	£
Sky TV	£	£
House Insurance	£	£
Groceries	£	£
Telephone	£	£
Care Line	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending	£	£
Gardener	£	£
Window Cleaner	£	£
House Cleaner	£	£
Launderette	£	£
Taxi's	£	£
Social outings-(Meals, transport etc)	£	£
Other-(Clothes)	£	£
TOTAL	£	£

7. Savings (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

Lodgement Arrangements (e.g. post/in branch/lodgement slips)

Withdrawal Arrangements (e.g. cash card/pass book etc.)

Current savings on (Date) Amount

8. Banking Management (Currents Accounts) (if relevant)

Name of Bank/Post Office Account _____

Address of Bank/Post Office Account _____

Account Number _____

ATM Debit Card ☐Yes ☐No

Pass Book ☐Yes ☐No

Cash Card/Pass Book
Where is this held? _____

Who has access to it? _____

Pin Number *The pin number must be stored separately from debit card*
Details to be kept in safe on Trust premises and locked cash box in users home

Who has access to it? _____

9. Cash Box Arrangements (if relevant)

Where is the cash box held? _____

Who holds the key? _____

Where is the key kept? _____

Who has access to the key? _____

10. Monitoring

The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.

Signatures:	
Family Member/NOK:	**Date:**
Manager:	**Date:**
Community Team Leader:	**Date:**
Community Member:	**Date:**

This Financial Support Agreement has been discussed and shared with me and I am in agreement with it. ☐

Service Users signature: _____

Community Learning Disability Team Leader signature _____

Date: _____

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 3

Guidance for Staff transporting Cash in their own vehicles

This guidance aims to:

- Guide and protect staff when transporting cash from Patients' Bank to Service Users' own home.
- This guidance should be adhered to in order to minimise risks associated with transporting cash.

    - Letter or email correspondence to be made with Patients Bank 24hors in advance of cash withdrawal required
    - Article 15 payments required from Patient's Bank need to be signed by appropriate manager
    - Staff collecting cash from Patient's Bank need to bring identification
    - Staff will collect the agreed cash amount from Patients' Bank where possible once weekly.
    - Staff to be vigilant and aware of others when transporting cash.
    - Cash should be placed securely in zipped bag in car boot.
    - Should staff identify any concerns in relation to safety when transporting cash, they should contact their Line Manager immediately.
    - Any incidents regarding cash should be reported to Line Manager, PSNI and Trust's Finance Department and recorded on DATIX
    - Incidents reported will be investigated and lessons learned and shared at local level.

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 4

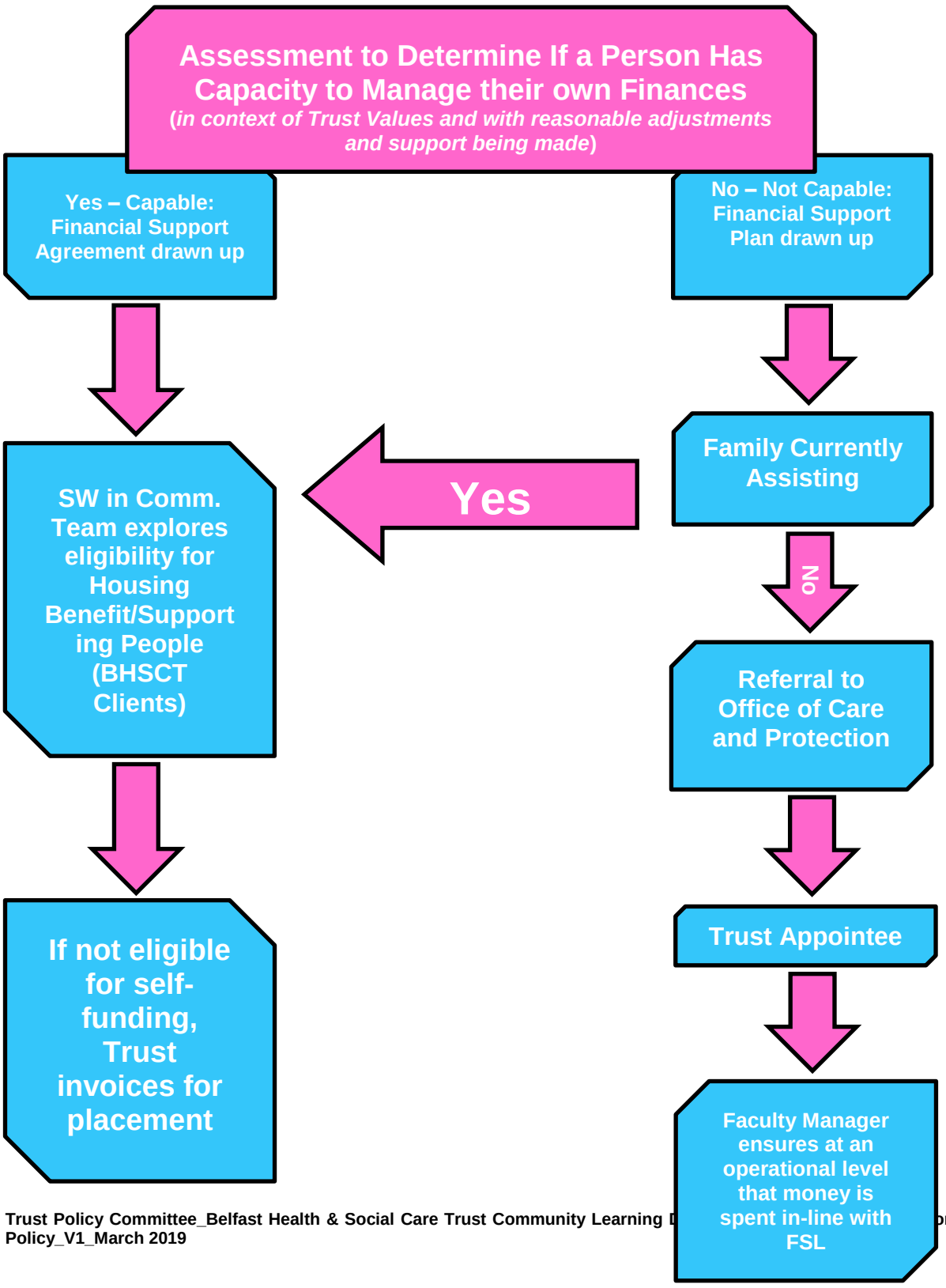
Ledger Sheet
SERVICE USER'S CASH FLOW SHEET (Supported Housing)
Name of Service User: _____ Page No. _____

DATE	REASON FOR TRANSACTION	RECEIPT NO.	AMOUNT RECEIVED	AMOUNT WITHDRAWN	BALANCE	SERVICE USER/STAFF SIGNATURES	

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 5

Management of Finances in LD Residential and Supported Living Facilities



Belfast Health and Social Care Trust
caring supporting improving together

Policy Code: BHSCT/PtCtCare (01) 2021

Title:	**Management of Patient's Handed In Property**			
Policy Author(s)	Brona Shaw, Senior Manager for Patient Experience [redacted] Una St Ledger, Nursing Development Lead, Acute Services [redacted]			
Responsible Director:	Brenda Creaney, Director of Nursing and Patient Experience			
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☒	Non Clinical Trust Wide ☐	
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**				
Approval process:	Standards and Guidelines Committee Executive Team Meeting		**Approval date:**	13/04/2021 07/06/2021
Operational Date:	June 2021		**Review Date:**	June 2026
Version No.	3	**Supercedes**	V2 – February 2008 – May 2014	
Key Words:	Patients' property, valuables, cash, safekeeping			
Links to other policies	BHSCT Medicines Code (2017) BHSCT Controlled Drugs Policy-Inpatient Areas (2017) SG 01/11 BHSCT Patients' Finances and Private Property - Policy for Inpatients within Mental Health and Learning Disability Hospitals (2015) SG 09/15 BHSCT Management of Residents' Finances and Private Property, Older Peoples Residential Homes (2017) SG 72/16 BHSCT Guidance on Actions to be Taken after a Patient's Death in Hospital (2018) SG 04/09 BHSCT Finance Department. Patients' Private Property: Written Procedures for Acute Hospitals. BHSCT MCA Guidance (November 2019) PHA information leaflet 'Laundry advice for patients and visitors' HFMA (2016) Patients' Monies and Belongings. 3rd Edition. Bristol: Healthcare Financial Management Association. Mental Capacity Act (NI) (MCA, NI) (2016): Deprivation of Liberty Safeguards (DOLS) (2019)			

CONTENTS

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

This policy sets out the Belfast Trust policy and procedures for the management and safekeeping of patients' property in wards and departments. The safe custody of patients' finances and personal property is an important part of patient care and every effort must be made to protect the interests of patients, staff and the Trust.

Belfast Trust has a responsibility to provide a secure environment for patients' valuables and personal property handed-in for safekeeping and for the safekeeping of property of patients lacking capacity and of deceased patients.

The Trust will not accept liability for the loss of or damage to property brought onto the Trust's premises unless it is handed-in for safekeeping.

Disclaimer posters should be displayed prominently in all departments and patient areas but this does not remove the Trust's duty of care to take reasonable steps to ensure the safety of patients' property.

1.2 Purpose

- To set out the Trust's policy on the management and safeguarding of patients' valuables and personal property and details procedures to be followed with regard to property at every stage of the patient journey.
- To provide clear standardised guidance on policy and practices for staff about their responsibilities on the receipt, documentation, custody, transfer, return and disposal of patients' personal property.
- To safeguard the interests of patients and protect staff and the Trust.
- To comply with the HFMA (2016) Patients' Monies and Belongings practical guide.

1.3 Objectives

- Ensure a standardised approach to the custody of handed-in property throughout the Belfast Trust.
- Ensure patients and/or their carers will be informed of the measures to be taken to protect their property before and/or at the time of their admission.
- Ensure patient's property is properly accounted for by providing accuate and written evidence of custody of property.
- Provide safeguards and assurance for patients and relatives
- Ensure the interests of patients, staff and the Trust are protected
- Reduce liability of the Trust to loss or damage to patient property

2.0 SCOPE OF THE POLICY

This policy applies to all Belfast Trust employees, paid and unpaid, bank and agency staff, and departments who have responsibility for the handling, recording, custody and return of patients' personal property.

The policy covers admission to inpatient general wards and departments, outpatient departments, emergency departments, transfer within departments and/or patient discharge to home/other organisations.

This policy **does not apply** to patients' property in: Mental Health and Learning Disability services; Trust Residential Homes for older people; or patients' own homes. Please refer to:

- BHSCT Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals (2015) SG 09/15
- BHSCT Management of Residents' Finances and Private Property, Older Peoples Residential Homes (2017) SG 72/16

3.0 ROLES/RESPONSIBILITIES

Chief Executive - has overall responsibility for the provision of a safe and secure environment for patients and their property whilst on Trust premises.

Finance Director - has responsibility for implementing the Trust's financial policies, including those relating to patients' money and other property.

Non-Executive Directors - are responsible for supporting, scrutinising and where appropriate challenging the Executive Board on issues relating to security management and matters relating to the protection of patients' property whilst on NHS premises.

Executive Director of Nursing and Patient Experience and **Deputy Director of Nursing** - are responsible for the writing of the Patient Property Policy, ensuring it is disseminated appropriately and that systems are in place to monitor compliance.

Divisional Nurses - are responsible for contributing to the establishment of a range of quality controls and quality assurance processes to ensure high quality, safe and effective service delivery within the Division.They are responsible for the promotion of a safeguarding culture across the Division in partnership with Safeguarding Leads, to meet the needs of vulnerable adults and children, and people with issues involving mental capacity and should ensure that all staff are aware of the potential issues relating to Safeguarding in relation to patient property.

Directorate Managers and Senior Nurses - are responsible for ensuring this policy and its procedures are disseminated to all staff and implemented in their areas of responsibility. They are responsible for ensuring that:

- Staff are aware of the Patient's Property Policy and Procedures.
- Providing staff with guidance regarding implementation of this policy.
- Monitoring the implementation of the Policy and Procedures within their service area.

Registered Ward Sister/Charge Nurse/Midwife in charge of the ward - is responsible for ensuring inspection of the 'Patients'/Clients' Valuables Record and Receipt Property Book' and the ward's safe/secure storage areas on a

weekly basis to ensure that no property is being held for a patient who has been transferred, discharged or died, and that an efficient system operates. If property is reported missing, the Ward Sister/Charge Nurse/Midwife must instigate a prompt local search and document the outcome.

Cash Office Cashiers -are responsible for managing the receipt, custody and return of handed-in property according to Trust Finance procedures and policy.

Security Manager - will support the ward/department sister/charge nurse/midwife in the investigation of reported theft of property.

All Trust employees, paid and unpaid, and bank and agency staff - in all departments have a responsibility to adhere to this policy.

4.0 CONSULTATION PROCESS

This policy was developed in consultation with:

- Ward managers and service leads
- Bereavement Coordinator
- Infection Prevention and Control Lead Nurse
- Implementation Lead for Mental Capacity Act
- Senior Finance Officers
- Patient and Client Support Services
- Divisional Nurses
- Risk & Governance and Patient Liaison Managers
- Legal Services, Business Services Organisation
- Police Service of Northern Ireland

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Definitions

Patients' property can be defined as anything owned by the patient that is of monetary, personal and/or sentimental value to the patient. Loss or damage to property can cause considerable distress and inconvenience to patients and cost to the Trust. For the purposes of the policy patients' property will be divided into two broad types: valuables and other property and can include, but is not limited to, the following.

Valuables

- Watches, rings and other jewellery
- Cash
- Debit/credit cards
- Bank/building society pass books and check books
- Driving license, passports and similar documents
- House/car keys

- Portable electronic devices (laptops, tablets), mobile phones

Other property

General items other than valuables, for example

- Clothing and footwear
- Handbag/wallet
- Toiletries
- Books
- Own medications
- Aids - spectacles, contact lenses, hearing aids (specify left and/or right) dentures (specify top and/or bottom set), prostheses, mobility aids.

5.2 Key Policy Statement(s)

- Patients must be encouraged to bring only essential items into hospital and have all other property taken home by the next-of-kin for safekeeping.
- Patients are responsible for ensuring the storage and safekeeping of their property unless they have handed it in for safekeeping.
- Patients are encouraged to hand in for safekeeping any valuables that have not been sent home.
- The Trust will not accept liability for the loss or damage to any property brought into hospital that has not been handed-in for safekeeping and for which an official receipt is not obtained.
- Where a patient is deemed to lack capacity staff should take valuables and property in for safekeeping.
- The Trust is responsible for making patients aware of the terms of this policy and for its correct application.
- On appointment staff will be made aware of their responsibilities in the care of handed-in patient property.
- Notices relating to the liability of the Trust in respect of patients' private property should be displayed prominently in all areas, such as, waiting and treatment areas, accident and emergency departments and wards.

5.3 Policy Principles

5.3.1 Patient admission

- Patients and next-of-kin should be given information at pre-admission clinics and in appointment and pre-admission advisory letters not to bring items of value or money into hospital.
- Patients should be informed of the patient property policy on admission and encouraged to send non-essentials and valuables home for safekeeping. Only a small sum of money should be kept for personal use.
- Patients and next-of-kin should be made aware that the Trust will not accept liability for personal property brought onto its sites that have not been handed-in for safekeeping and for which a receipt has not been issued. Patients should be encouraged to hand in valuables for safekeeping that have not been sent home.
- Patients should be advised that all property retained by themselves or next-of-kin on admission are at their own risk.

- If a patient declines to hand in valuables for safekeeping, this must be noted in the nursing notes and signed by two members of staff, one of whom is a registered nurse/midwife.
- Care should be taken that patients' spectacles, hearing aids and dentures are available for their use. Dentures should be stored in labelled denture pots. Patients' own personal mobility aids such as walking frames, crutches and wheel chairs should be labelled with the patient's name and details, available for their use and transferred or discharged with patients. Culturally important items of property should be available to remain with patients.
- Due to limited storage facilities staff should advise parents to leave children's car seats and prams, that are not required for use, at home for the duration of the hospital admission.

5.3.2 Receiving, recording, depositing of handed-in property

- When handing in money and valuables to the cash office for safekeeping, Trust processes and procedures should be explained to patients so that they understand how their property will be managed.
- Property handed-in should be examined and recorded in an itemised fashion in the 'Patients'/Clients' Valuables Record and Receipt Property Book' by two members of staff, **one of whom should be a registered nurse/midwife** and where practicable in the presence of the patient or their next-of-kin/personal representative.
- The pre-numbered form in the 'Patients'/Clients' Valuables Record and Receipt Property Book' should be completed for all patients handing over property for safekeeping for the duration of their stay.
- This form should be used to detail 'valuables' such as money, bank/building society cards and jewellery. Clothes and other such items of low value should not be documented on this form with the exception of patient transfers/discharges/deaths.
- Care should be taken that valuables **(section 4.1)** are described sufficiently in non-value adding terms and are not identified according to materials or designer brands.
- **Money/cash** refers to any coins and notes and **<u>should be</u>** itemised (including currency) and counted, and a record of the total amount made (for example, two £20 notes, one £10 note, five £1 coins, three 50pence coins = Total Amount of £56.50).
- **Jewellery <u>must be</u>** described in terms of type and amount (for example, 'three yellow metal chains', 'two white solid metal bracelets', ' one yellow metal ring with 3 clear stones', 'one wrist watch with yellow rimmed round face and black strap', 'two identical white metal earrings'). Descriptions such as 'gold', 'silver' or 'diamonds' must not be used.
- **Debit/credit cards <u>should be</u>** listed according to the issuing bank/building society, type of card (for example, Visa, Mastercard) and name of account holder as shown on the card. The card number should not be recorded.
- **Bank/building society pass books and check books** (record name of bank, account holder name, amount and date of last balance shown. For chequebooks record the cheque number of the first unused cheque in the

book). Itemise pension books. Also itemise any tickets (lottery, events, travel), vouchers and certificates of monetary value.

- **Driving license, passports and similar documents** (document name of holder, country of issue, type of document (paper, card or booklet, whether it has a photograph) and year of expiry).
- The patient should sign and date the completed form in the 'Patients'/Clients' Valuables and Receipt Book'. Where the patient is not capable of signing the form, the next-of-kin may sign in their place. The form should then be signed and dated by two members of staff, **one of whom should be a registered nurse/midwife**, having checked that the details of the property listed is accurate and acknowledging receipt of the property. The top copy of the form should be given to the patient (or next of kin where appropriate) as a receipt.
- **Cash and jewellery** must be placed in a standard Property Envelope, checked with the patient/next-of-kin by the two members of staff, and the envelope sealed. The envelope should be signed by these officers, as evidence of this check.
- The property should be transferred promptly (and within 24 hours) to the Cash Office or Drop Safe in the standard Property Envelope along with the second copy of the 'Patients'/Clients' Valuables and Receipt Book' form. The Cash Office should sign and date the bottom of the form, acknowledging receipt of the property and retain the second copy of the form for their records.
- Outside of office hours, the property must be stored securely at ward/departmental level until the Cash Office reopens or until such as times as it can be safely deposited in the Drop Safe.
- The third copy of the form should be retained in the 'Patients'/Clients' Valuables and Receipt Book' as the ward's permanent record.
- Only one 'Patients'/Clients' Valuables and Receipt Property Book' should be in use at any given time in a ward/department and be properly referenced. Pages must be used sequentially. New books can be obtained from the Cash Office.
- The book must be kept in a secure place and available at all times for inspection by authorised staff.
- If errors are made, forms should not be removed from the 'Patients'/Clients' Valuables Record and Receipt Property Book'. In such cases forms should be cancelled with two diagonal lines across the form with 'cancelled' written in between the lines and signed by the author. Correction fluid such as Tipp-ex should not be used. All amendments should be made in ink. A new form should then be started if required.

5.3.3 Short-term custody of property

- **This procedure should <u>only be used</u> for the short-term custody of property and <u>must not be</u> used in place of the procedure (section 5.2) for sending handed-in property to the Cash Office**.
- On occasions, patients' property may need to be held for safekeeping for a short period of time, if it cannot be handed over to the next-of-kin for safekeeping (for example, when a patient is undergoing theatre/day procedure/endoscopy/outpatient/radiology procedures). In such instances,

staff should itemise and document the handed-in property in the 'Patients'/Clients' Valuables Record and Receipt Property Book' **(as outlined in section 5.2** (or follow the procedure set out in the Theatre/Endoscopy/Cataract Care Pathway. Property should be returned as soon as possible after treatment).

- The form should be signed by the patient or next-of-kin and **two members of staff, one of whom should be a registered nurse/midwife** and the property placed in a standard Property Envelope'. The top copy of the form should be given to the patient/next-of-kin**.**
- Cash and jewellery valuables handed-in for short-term safekeeping must be placed in a Property Envelope **(as outlined in section 5.2)** and stored in a secure area in the ward/department that should not be readily identifiable as holding patients' property.
- The ward sister/charge nurse should ensure that short-term custody property is only held on the ward/department for short periods of time (not exceeding a maxium of 24 hours). Property should be returned to the patient/next-of-kin at the earliest opportunity. The patient/next-of-kin will sign the bottom half of the second copy of the form, acknowledging the return of the items detailed on the form. The patient/next-of/kin will return their top copy of the form to nursing staff and this should be destroyed.
- The second and third copy of the form should remain fast in the 'Patients'/Clients' Valuables and Receipt' property book as the ward's permanent copy.
- In the event that the property remains handed over for longer periods of time it must be lodged as soon as possible with the Cash Office **(as outlined in section 5.2)**.

5.3.4 Patients lacking capacity

- It must be assumed that all patients have the capacity to make a decision about the safekeeping of their property.
- Situations may arise, where a patient lacks capacity to make decisions about their property, either on admission (for example patient brought unconscious into the emergency department or has cognitive impairment) or at any time during their stay (for example, a patient's level of consciousness decreases, becomes increasingly confused/disorientated, or enters into a coma). In such situations, the Trust automatically assumes responsibility of the property.
- Staff must follow procedures in assessing and recording capacity in line with the Mental Capacity Act (NI) (MCA, NI) (2016): Deprivation of Liberty Safeguards (DOLS) (2019) and the Belfast Trust's MCA Guidance (November 2019).
- If a patient has been assessed and deemed by staff to lack capacity, personal property and valuables should be taken into safekeeping in the patient's best interests and recorded and catalogued **(as set out in section 5.2)**. Actions taken by staff to protect a patient's property can be considered to be related to their 'care and treatment' and may thus be protected from liability, provided there is no negligence in the handling of the property.

- Before taking a patient's property into safe custody, staff should consider whether property can be handed over to next-of-kin or in the case of longer-term lack of capacity if there is anyone with authority to make decisions on behalf of the patient.
- If the patient has an 'Enduring Power of Attorney' or if a 'Controller' has been appointed by the 'Office of Care and Protection' they should be consulted regarding what to do with the patient's property. The 'Enduring Power of Attorney' or 'Controller' should be encouraged to remove from the premises any non-essential property, especially valuables, or otherwise to hand it over for safekeeping.
- Where an 'Enduring Power of Attorney' or 'Controller' are not immediately available staff may decide to take part or all of the patient's property into safe custody, if this is in the best interests of the patient.
- The receiving, recording and depositing of the valuables to the Cash Office for safekeeping procedure should be undertaken **(see section 5.2**.)
- The property will be placed into safekeeping until the patient regains capacity to decide what should be done with it, or until the property can be given to the 'Enduring Power of Attorney' or 'Controller.'
- Where jewellery is left on the patient, this should be recorded in the 'Patients'/Clients' Valuables Record and Receipt' Property Book.'
- Where items are handed over for safekeeping by the attorney or deputy, their signature is required wherever the patient's signature is required in the 'Patients'/Clients' Valuables Record and Receipt' Property Book.'
- Explanation for the absence of the patient's signature must be documented in the Book' and in the patient's nursing notes**.**

5.3.5 Patients clothing

- Patients should have a space to store their clothing. Only minimal essential clothing should be brought into hospital.
- In the following circumstances clothing and/or the absence of clothing along with other property including valuables will be itemised in the 'Patients'/Clients' Valuables Record and Receipt Property Book' at the time of admission:
  - ❖ Emergency admissions
  - ❖ All internal and external transfers
  - ❖ Admissions of confused, disorientated or unconscious patients
  - ❖ Deceased patients

- Patient's clothing requiring laundering should be placed in a property bag.
- If clothing is soiled or patient has a suspected/known infection, clothing should firstly be placed in a water soluble bag, followed by a patient property bag. The PHA information leaflet 'Laundry advice for patients and visitors' should be given to patients/next-of-kin for guidance. Patients/next-of-kin should be advised to empty contents of property bag/water soluble bag into the washing machine, taking care not to touch contents. (The solubility of such bags is compromised by the limited volume of water used by domestic machines).
- Soiled clothing should not be stored for a prolonged period at ward level due to the infection risk. Advice should be sought from the Infection

Prevention and Control Team on an individual basis on how to handle specific items.
- In emergency situations damage to clothing may be unavoidable as clothing may have to be cut off to provide essential treatment. Consent should be sought where the patient is conscious. Where the patient is not conscious next-of-kin should be sensitively informed.
- Patients/next-of-kin should be sensitively asked if they wish to take soiled/cut off clothes home or to have staff dispose of it. This should be documented in the nursing notes.

5.3.6 Patients own medication

- For guidance on patients' own medication on admission, please refer to:
  - ❖ BHSCT Medicines Code (2017)
  - ❖ BHSCT Controlled Drugs Policy-Inpatient Areas (2017) SG 01/11

5.3.7 Management of illicit substances and items

- Please refer to the BHSCT Hospital Medicines Code (2017) (section 6.7) for guidance on illicit substances brought into hospital.

5.3.8 Patients' property seized by police

- On occasions, police may require to seize patients' property for evidence. Staff must ensure the police officer's name, service number and police station base are recorded and that an inventory of the seized property is documented in the 'Patients'/Clients' Valuables Record and Receipt Property Book.'

5.3.9 Patient Transfer or Discharge

- Patients' property must be accounted for in transfer/discharge handover procedures.
- When a patient is transferred from the emergency department to a ward, or from one ward/department to another ward/department or site within the Trust, or to another organisation - nursing staff must ensure all property, that had not been handed-in, is listed in the 'Patients'/Clients' Valuables Record and Receipt Property Book' before the patient leaves, and that it is documented to which ward/department the patient is transferred.
- The receiving ward should sign the book as a receipt and be given a copy of the record.
- The record/receipt form should state if any handed-in valuables are held in the Cash Office for safekeeping.
- The receiving ward should treat the transferred patient as a new admission and document any property to be handed-in, in their 'Patients'/Clients' Valuables and Receipt Property Book.'
- Where patients are capable of looking after their own property and have requested that handed-in property be returned to them, the normal standard procedure for patient discharge will apply.

- The transfer of patients to other organisations outside of the Trust is to be treated as discharge, except in circumstances of emergency transfers.
- If an emergency transfer is required and discharge procedures cannot be followed a record should be entered in the patient's nursing notes and Transfer Form stating that property remains in the safekeeping of the Trust site Cash Office and can be released through normal discharge procedures at the earliest possible time. This should be signed by the registered nurse and another member of staff.
- When a patient is discharged from the Trust, any property handed-in for safe keeping should be returned to the patient as soon as practicable, preferably at or before the time of discharge.
- Nursing staff will contact the Cash Office. As money is usually returned to the patient as a cheque, the Cash Office require sufficient notification and time to make the necessary arrangements.
- When the cheque/property is available for return, a Withdrawal Form will be completed by the Cash Office. This form will be signed by the patient as acknowledgment of receipt of the returned property.
- If notice cannot be given, the Cash Office will post the property to the patient's home address. A copy of the Withdrawal Form should be sent by the Cash Office with the cheque in order that the patient may be able to acknowledge receipt of their property.
- If the patient lacks capacity to make a decision about their property, handed-in property will **only be** returned to their next-of-kin, 'Enduring Power of Attorney' or 'Controller'.

5.3.10 Management of property when a patient is on leave

- Where an in-patient has a period of leave from a ward/department they should be strongly encouraged to take all of their personal property that has not been handed-in for safekeeping with them.

5.3.11 Return of handed-in (deposited) property

- Patients discharged from hospital can reclaim property held by the hospital for safekeeping, by producing their receipt, given to them at the time their property was handed-in.
- Where it is known that the patient is to be discharged at a weekend or on a bank holiday, and property is required by the patient, the cashier should be contacted in advance to make sure that arrangements are made for the property to be obtained prior to the date of discharge.
- A patient may make a request to have some or all of their handed-in property returned to them while they are still an in-patient. In such circumstances the normal process for releasing property shall be completed.
- The Cash Office **must be** informed when patients are transferred between wards or discharged.

5.3.12 Deceased patients

- Dentures should be placed in the mouth, if possible, as part of the Last Offices procedure. Otherwise, dentures should be sent to the Mortuary

with the body in an appropriate denture container labelled with the patients' details. The location of the dentures should be recorded on the 'Body Transfer Form.' BHSCT Guidance on Actions to be Taken after a Patient's Death in Hospital (2018) SG 04/09

- Remove all jewellery unless requested by the next-of-kin not to do so or unable to remove. Jewellery left on the body should be recorded on the 'Body Transfer Form' and catalogued **(as outlined in section 5.2)**. Rings remaining on the body should be taped in place.
- Cultural items of property left on the body should be recorded on the 'Body Transfer Form.'
- Ensure the patient's property and valuables present on the ward/department at time of death is listed in the 'Patients'/Clients' Valuables Record and Receipt Property Book' and signed for by two staff, one of whom is a registered nurse/midwife.
- Place the patient's property in a Belfast Trust purple property bag and return to the next-of-kin. Ask the next-of-kin taking the property to sign the 'Patients'/Clients' Valuables Record and Receipt Property Book'.
- Check if any valuables are being held by the cash office and inform the cash office as soon as possible upon the death of the patient.
- Where cash or valuables have been deposited in the Cash Office for safe custody inform the next-of-kin how to access it, giving contact details for the Cash Office, and that it can only be given to the next-of-kin as confirmed by a solicitor.
- If the next-of-kin are not present at the time of death property shall be stored in a safe place on the ward until arrangements can be made for its collection.

5.3.13 Lost, missing, damaged property

- If a patient's handed-in property is reported missing the ward/department sister/chargenurse/midwife or nurse/midwife in charge will be informed immediately and an enquiry launched.
- If the property cannot be found the Trust security manager should be informed. The ward supported by the security team will carry out an investigation.
- It is the responsibility of the ward sister/charge nurse/midwife or nurse in charge to inform the police if the loss is suspected to have resulted from criminal action. The incident should be reported using the Trust's Datix incident reporting system and the senior manager informed.
- Where accidental damage or loss occurs to handed-in patient property this must be reported immediately to the ward sister/chargenurse/midwife or nurse/midwife in charge.
- If not already aware, the patient and/or their next-of-kin should be advised of the damage or loss to their property as soon as is practicable.
- The ward sister/chargenurse/midwife will complete a WO1 Form and return this to the Finance Department for accidental damage or loss of handed-in property. http://intranet.belfasttrust.local/directorates/finance/Documents/WO1%20Form.doc.

- If property that had not been handed over for safekeeping is reported damaged or lost, an investigation should be commenced and the security manager alerted if criminal action suspected. The patient and/or next-of-kin should be reminded that the Trust will not accept liability for the damage or loss.

5.3.14 Unclaimed property

- Patients' property may be left behind following discharge, transfer or death.
- Valuables should be documented in the property book and deposited with the Cash Office as soon as possible for safekeeping (**see section 5.2**).
- Clothing and non-valuables should be stored in a sealed bag, clearly labelled with the patient's details, in a dedicated space, such as a cupboard. Soiled clothing should not be stored as it is an infection risk.
- Ward/department staff should make all reasonable efforts to trace the patient/next-of-kin to arrange collection.
- If contactable the patient/next-of-kin should be informed that uncollected/ unclaimed personal property may be disposed of after 12-weeks and this should be documented. However, **advice should be sought** on a **case by case basis** before disposing of property in case there are any extenuating circumstances in the particular case. Care should be taken to ascertain whether articles are of value and expert advice sought about the value. Items of value should be reported to the Senior Financial Accountant and Head of Corporate Governance. Property held in safekeeping must be reviewed regularly by the Cash Office staff to ensure that items belonging to discharged/deceased patients are not overlooked.

5.3.15 Disability and cultural awareness and competence

- Essential aids such as glasses, hearing aids, dentures and mobility aids should be available for patients use to preserve dignity and effective communication, nutrition, mobility and independence.
- Sign Language interpreters and alternative formats for information should be available as reasonable adjustments for people with disabilities.
- Staff must be cognisant of religious rituals or cultural norms in regard to items of patient property. Some items of property may be considered essential to remain with the person or the deceased.
- Staff should engage with the patient or their family/carers to ensure a culturally competent response in this regard.
- All staff must attend mandatory equality, good relations, human rights and disability training.
- The Making Communication Accessible resource is available for all staff to help them communicate responsively and sensitively with patients and carers who may have a disability.
- An ethnic minority interpreter should be made available for people who are not proficient in English and property-related information should be available in different languages.

5.3.16 Exceptional Circumstances including Covid-19

- During extraordinary exceptional circumstances, such as the Covid-19 pandemic and/or other catastrophic situations, it may be necessary to deviate from this policy and to follow the relevant Policy/Standard Operating Procedure for such events **(See Appendix 1 Covid-19 SOP).**

5.4 Dissemination

This policy applies to all paid and unpaid staff, healthcare professionals and security and finance staff working within the BHSCT. The policy should be disseminated at team meetings and will be available via the Trust Hub Policies and Procedures page.

5.5 Resources

Patients and/or their next-of-kin shall be informed of the measures to be taken prior to or at the time of admission by:

- Pre-elective day case/admission advisory information letters/booklets
- Trust Patient Property Leaflet/Booklet 'Keeping your things safe when you go into Hospital' – disseminated to elective patients prior to admission (electronically/or hard copy) and to patients and families on admission to hospital. Available also on Trust public facing website. **(See Appendix 2).**
- Information contained in ward/department patient information booklets
- Verbal information given by staff involved in the admission process
- Personal property disclaimer notices posted in hospital wards and departments and waiting areas **(see Appendix 3).**

All staff in all departments and new staff at local service level induction, need to be made aware of and familiarise themselves with the policy and procedures for managing patients handed-in property.

Updates of patient property issues should be discussed at ward meetings and briefings.

5.6 Exceptions

This policy applies to all Belfast Trust employees, paid and unpaid, bank and agency staff, and to all departments with responsibility for the handling, recording, custody and return of patients' personal property. This includes admission to inpatient general wards and departments, outpatient departments, emergency departments, transfer within departments and/or discharge to other organisations. The policy **does not apply** to Mental Health and Learning Disability services; Trust Residential Homes for older people; or patients' own homes, where existing polices and procedures are in place.

6.0 MONITORING AND REVIEW

- Adherence with this policy and the effectiveness of the policy will be monitored via the Trust's Internal Auditors and auditing processes.

Reported breaches of the Patients' Property policy should be formally investigated through the Trust's risk management and governance arrangements. Please see an example of an audit tool in the table below.

- As a measure of good practice Lead Nurses and Governance Leads should regularly review Datix and complaints data in relation to patients' property and undertake improvement actions in alignment with this policy.
- A monitoring framework is set out in the table below.

What is monitored	Person performing monitoring	Frequency	Process
Patient/family issued copy of Trust Patient Property Leaflet/Booklet	Ward Sister/Charge Nurse	Weekly	Audit against a checklist form
Check contents of ward safe/property storage areas	Ward Sister/Charge Nurse	Weekly	Audit against a checklist form
Check all entries in Property book recorded as per policy	Ward Sister/Charge Nurse	Weekly	Audit against a checklist form
Monitor compliance as part of Lead Nurse's improvement checks	Lead Nurse	Monthly	Provide evidence of monitoring to internal audit team/ DN
Monitor compliance with policy and property-related complaints/incidents	Divisional Nurse (DN)	Quarterly	Data and improvements discussed at Assurance meetings
Ward/Department compliance with policy	Internal Audit	Annual Review	Finance Director/Internal Audit Department schedule audit

7.0 EVIDENCE BASE / REFERENCES

This policy has been informed by:

- HFMA (2016) Patients' Monies and Belongings. 3rd Edition. Bristol: Healthcare Financial Management Association.
- Mental Capacity Act (NI) (MCA, NI) (2016): Deprivation of Liberty Safeguards (DOLS) (2019).
- Belfast Trust's MCA Guidance (November 2019)
- PHA information leaflet 'Laundry advice for patients and visitors'
- BHSCT Medicines Code (2017)

- BHSCT Controlled Drugs Policy-Inpatient Areas (2017) SG 01/11
- BHSCT Patients' Finances and Private Property - Policy for Inpatients within Mental Health and Learning Disability Hospitals (2015) SG 09/15
- BHSCT Management of Residents' Finances and Private Property, Older Peoples Residential Homes (2017) SG 72/16
- BHSCT Guidance on Actions to be Taken after a Patient's Death in Hospital (2018) SG 04/09

8.0 APPENDICES

Appendix 1 Covid-19 SOP
Appendix 2 Patient Property Leaflet/booklet- 'Keeping your things safe when you go into Hospital'
Appendix 3 Personal Property Policy Disclaimer Notice
Appendix 4 Handed-In Property Policy Procedures Flowchart

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **the Mangagement of patient's handed in property** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement. Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to

undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by

the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

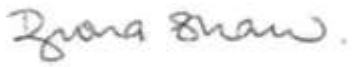
13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).



09/04/2021

_____ **Date:** _____

Authors

09/04/2021

_____ **Date:** _____

Director

Appendix 1

Standard Operating Procedure for managing personal property of patients with suspected or confirmed Covid-19 status

On hospital admission

- Ascertain what needs to stay with patient as soon as possible at admission
- Send home all non-essential items, especially valuables, with next-of-kin at admission or as soon as possible after admission.
- Advise patient/family that valuables cannot be sent off the ward to the Cash Office and that property is retained on the ward by them at their own risk. The Trust will not accept liability for loss or damage of property on the ward.
- Two members of staff (one of whom must be an RN) list the property and sign in patient's nursing notes what property was sent home at admission and to whom the property was given. Document and sign in patients' notes if patient choses to retain valuables at their own risk.
- All property returned home should be sealed in a clear bag or in a patient property bag labelled with the patient's details and the date and not opened for 72hours (3days).
- **Orange waste bags must never be used for patient's property as there is a risk of property being discarded.**

During hospital stay

- Discourage next-of-kin from bringing up personal property especially valuables.
- Hospital gowns can be provided to reduce the need for changes of clothing.
- Glasses, hearing aids and dentures should be labelled and stored in appropriate cases and transferred or discharged with patients. Culturally important items of property can remain with patients.
- Advise patients that if they keep mobile phones and tablets it is at their own risk.
- Advise virtual visiting can be accommodated with ward devices.
- Property returned home should be sealed in a property bag labelled with patient's name and the date and not opened for 3 days.
- Document as outlined in the 'on hospital admission' section.
- Patients/next-of-kin should be asked if they wish to take clothing home at their own risk or to have staff dispose of it.
- Clothing taken home should firstly be placed in a water soluble bag, followed by a patient property bag. The property bag should be kept sealed and not opened for 3 days (72 hours).
- Advise that contents of property bag/water soluble bag should be emptied into washing machine, taking care not to touch contents Neither the property bag or the water soluble bag **should not** be put in the washing machine). The water soluble bags used in healthcare are not suitable for use in domestic machines and may result in damage. These bags may be disposed of in household waste.
- Advise that hands should be washed after handling property.

Patient Transfer between departments of Belfast Trust and to and from other Trusts

- Patients' property must be accounted for in transfer/discharge handover procedures.
- Large amounts of property should not be transferred with patients from other Trusts to the Belfast Trust or from Belfast Trust to other Trusts or between wards and departments in the Trust to prevent loss of property and risk of cross infection and because of limited storage facilities. Next-of-kin should already have been asked to collect and take home property before patient transfer.
- When a patient is transferred with property from the emergency department to a ward, or from one ward/department to another ward/department or site within the Trust, or to another organisation - nursing staff must ensure all property is listed in the Patient's Nursing Notes before the patient leaves, and that it is documented to which ward/department the patient is transferred and to whom the property was handed over to. The receiving ward nurse should sign in the patient notes that they have received the property.
- NISTAR will only transfer small items of property with patients during critical care transfers and will record that it has been handed over to the receiving unit on their report form.

On Discharge

- **Negative COVID-19 status at discharge -** standard patient property bags should be used
- **Positive/Suspected COVID-19 status at discharge -** patient property should be placed in a sealed clear bag or hospital property bag labelled with the patient's name and the date and the patient/next-of-kin instructed not to open for 3 days (72hours).

In the event of Patient Death

- Property should not be sent to mortuary.
- Dentures should be placed in the patient's mouth
- Ensure property and valuables are listed in Patients' Nursing Notes and signed for by two staff, one of whom is a registered nurse.
- Ask next-of-kin if they wish clothing to be returned or disposed of by ward staff.
- Place property in sealed clear bag or patient's property bag labelled with patient's name and the date. Return to next-of-kin. Two nurses (one an RN) document and sign in nursing notes and document to whom the property was returned.
- If clothing taken home - advise to empty contents of property bag/water soluble bag into washing machine, taking care not to touch contents (neither the patient property bag or water soluble bag **<u>should not</u>** be put in the machine). Wash hands after handling property.

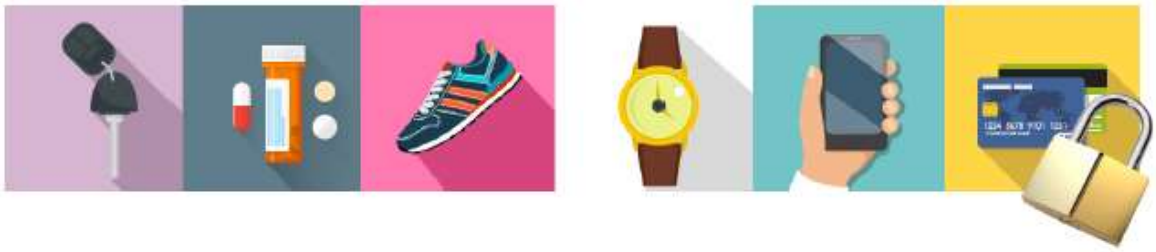
Appendix 2

Patient Property Leaflet/booklet- 'Keeping your things safe when you go into Hospital'

HSC Belfast Health and Social Care Trust

caring supporting improving together

Keeping your things safe when you go into Hospital



Welcome to the Belfast Health and Social Care Trust.

This booklet has important information for you and your family about keeping your things safe when you go into hospital.

What to bring with you to hospital

- A list of your medicines your doctor has prescribed.

- Your 'hospital passport' or 'This is me' book, if you have one.

- Your walking stick or anything you use to help you walk.

- Your glasses, hearing aids or dentures. Make sure they are labelled and in their cases.

- Toiletries. For example, your toothbrush, toothpaste, soap, face cloth, towel and wet wipes.

- Nightwear, dressing gown, underwear and slippers.

- Comfortable clothes to wear during the day.

- A small amount of money to buy newspapers or magazines.

2

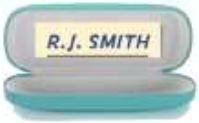
What YOU can do to keep your things safe

Do not bring valuables into hospital.
Valuables are things that cost a lot of money or are important to you. For example, car keys, mobile phones, jewellery or photos.

If you come into hospital in an emergency you may have valuables with you. Please send these home with a family member as soon as possible.

Only bring things you really need.
You will have a bedside cabinet. It does not lock. The cabinet is not very big and does not have room for a lot of things.

Leave big things at home
For example, if you are in hospital with a child then leave their car seat and pram at home.



Label all your things.
Please make sure all your things have your name on them. This will help to keep them safe.

Look after your things.

- If you choose to keep your mobile phone or other valuables with you on the Ward **you** need to keep them safe.
- Staff can only look after your things if you hand them in for **safekeeping**.
- If you find you cannot look after your things, please tell us.

Do not wrap dentures and hearing aids in tissues. Please use their cases to keep them safe.

3

Tell staff if there are any big changes to valuable things you have with you on the ward.

We cannot keep a list of the clothes you have in hospital. This is because the clothes you have with you can often change.

Insure your things
Make sure you have insurance for things you bring into hospital. For example, your mobile phone.

Insurance is when you pay a company money so that if valuable things are lost, broken or stolen they can be replaced.

What WE do to keep your things safe

We will try to keep your property safe and stop it getting lost, stolen or damaged.

We can put things into safekeeping
We will not take responsibility for your property unless you give it to us for safekeeping.

Safekeeping is when you give us things to keep safe. We put them in a locked office.

The locked office is not on the Ward.

If you are not able to make decisions for yourself when in hospital, staff can

- keep your things in safekeeping
- or ask your carer, family member or someone who makes your decisions for you to take your things home to keep them safe.

4

Damaged or dirty clothes

Sometimes clothes have to be cut-off when we help you. Sometimes clothes get blood on them.

We will ask you if you want to take these clothes home or if you want us to get rid of them.

If you want to take them home there is a leaflet to help you wash the clothes safely. This can be found at www.publichealthagency.hscni.net.

COVID-19

When you are going home we will tell you if we think there might be COVID-19 on your ward.

If we think there might be COVID-19

- **do not open your bag of clothes and other things for 3 days.**

How do I get my things back from safekeeping?

Speak to the Ward Nurse if you need your things back from the locked office to

- send them home
- or to take them home with you when leaving hospital.

Any money you put into safekeeping will be given back to you as a cheque. This can take time.
A cheque can be posted to your home address if you do not want to wait.

5

Lost property

We always try to give things back to the right person. We want to help you find anything you have lost before you go home.

Pack carefully
Check you have packed all your things before you leave hospital.

If you lose something.
Tell us if you lose something. We will help you look for anything you have lost. If we can't find it, we will investigate.

Please remember that staff and the Trust can only keep things safe if you hand them in for safekeeping.

If we find your lost property
We will try to contact you if you leave something behind and we find it.

You have 12 weeks to pick up anything you leave behind.

If you do not collect dirty clothes they will be destroyed. This is because they are an infection risk. This means they could make people sick.

If you are unhappy with our investigation
If you are unhappy with our investigation to find your lost property please contact the Complaints Department.

6

Complaints Department

Complaints Department
Belfast Health and Social Care Trust
7th Floor, McKinney House
Musgrave Park Hospital
Stockman's Lane
Belfast
BT9 7JB

Telephone
(028) 9504 8000
Monday – Friday, 9am-4pm

Textphone
18001 028 950 48000

Email
complaints@belfasttrust.hscni.net

We can give you this information in larger print or have it translated for you.

Please contact the ward for more information.

made with photosymbols

Appendix 3

Personal Property Policy Disclaimer Notice

Personal Property Disclaimer Notice

Important!

Please help us to help you

The Belfast Trust would like to remind patients and visitors that the Trust cannot accept responsibility for the loss, theft, or damage to any items of property brought onto or left on these premises.

We recommend that Valuables and Money should not be brought into hospital and/or should be sent home for safekeeping.

The Trust will not accept liability for personal property or money unless it is handed in for safe custody and a written confirmation is obtained as a receipt.

Working together · Excellence · Openness & Honesty · Compassion

HSC Values

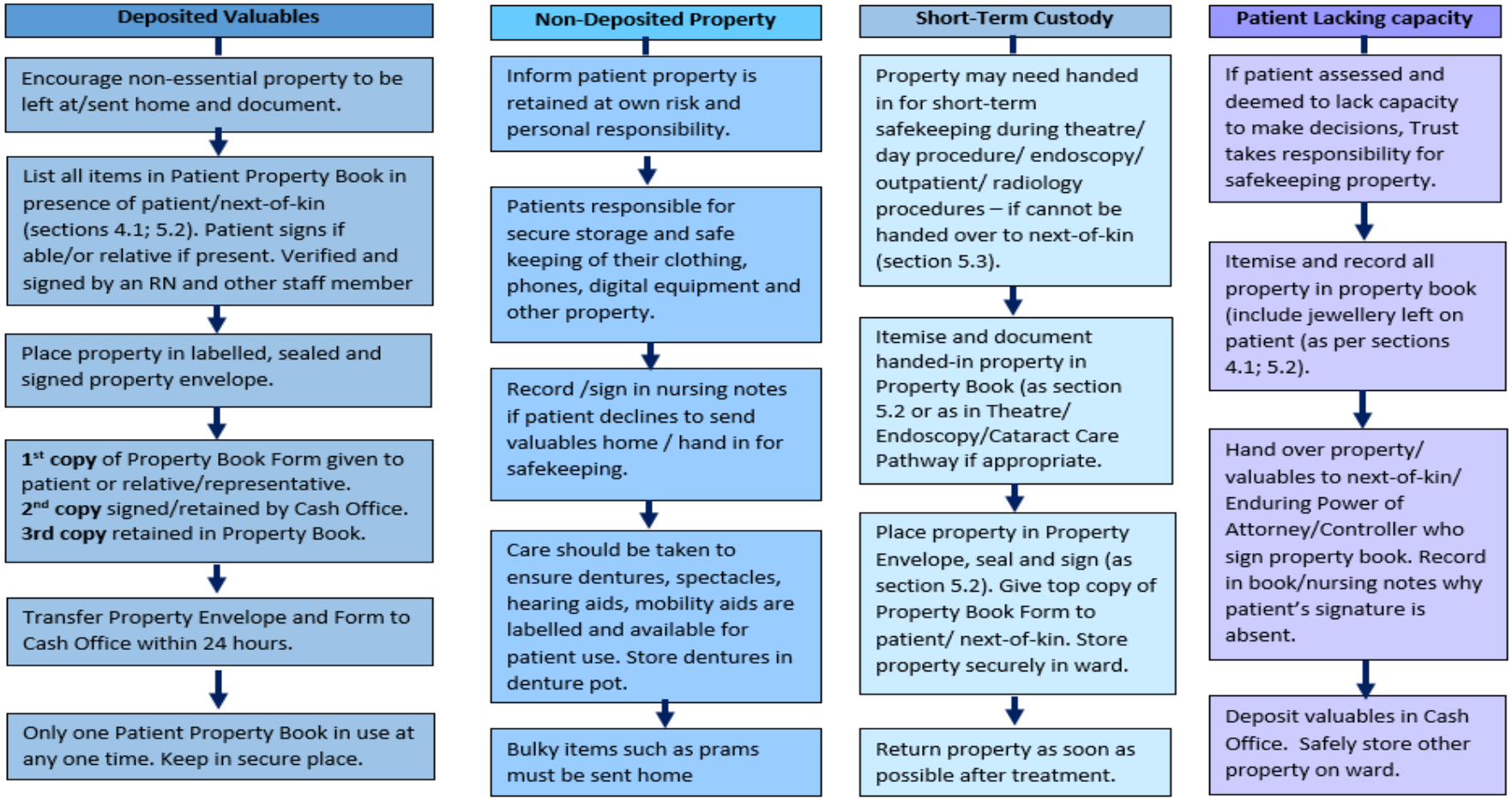
HSC Belfast Health and Social Care Trust

caring supporting improving together

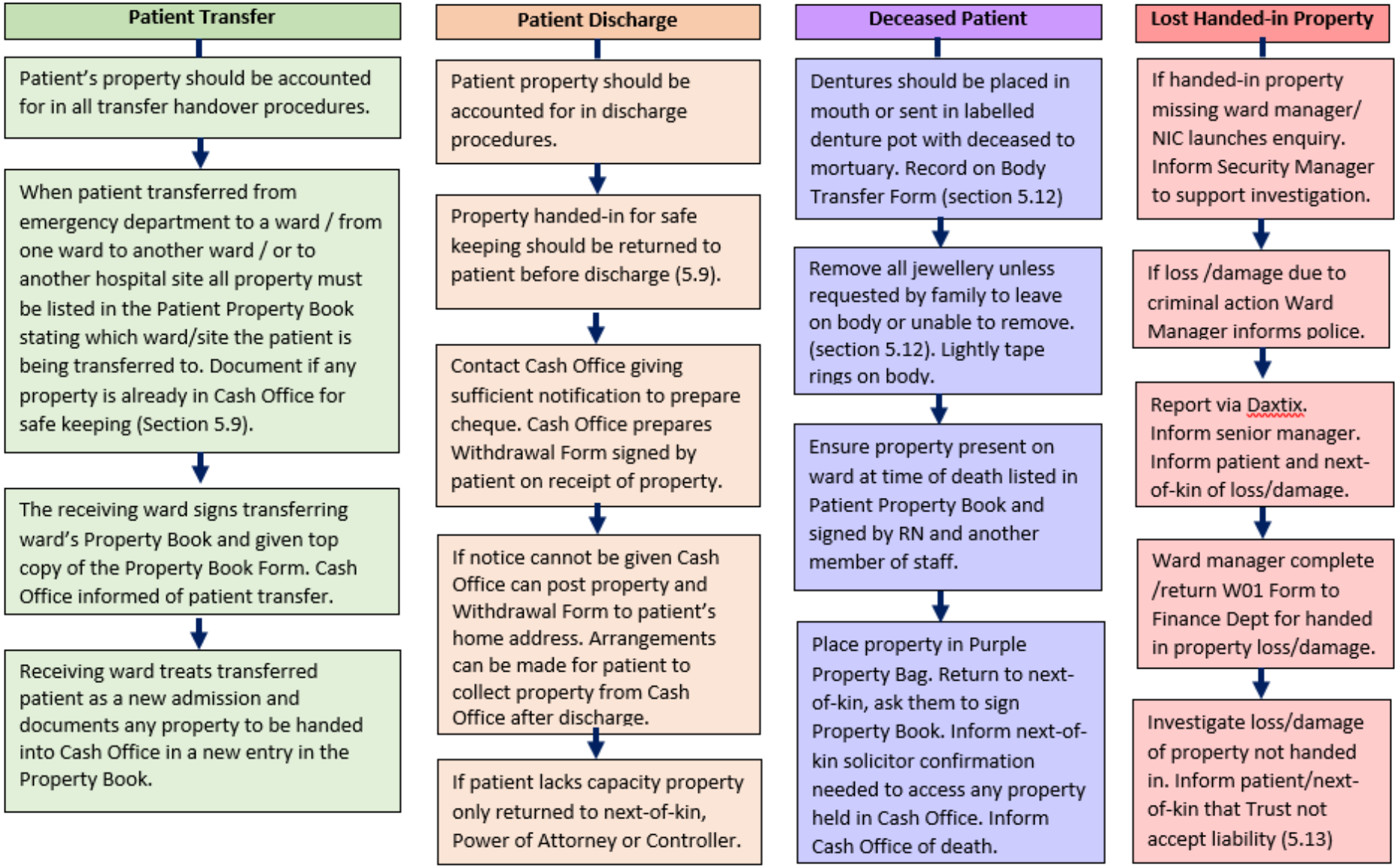
This notice is to be displayed prominently in all Trust areas and departments

Appendix 4

Patient's Handed-in Property Policy Procedures Flow Chart



Patient's Handed-in Property Policy Procedures Flow Chart



Belfast Health and Social Care Trust
caring supporting improving together

Policy Code: BHSCT/SHWH/MH (01) 2021

Title:	**Procedure for Search of Patients, their Belongings and Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh)**			
Policy Author(s)	Davy Martin, Lead Nurse Tel: [redacted] Noel McDonald, Operations Manager, Recovery Services Tel: [redacted] Johnny Killough, Charge Nurse, Ward L, Mater Hospital Tel: [redacted] Paul McCabe, Senior Clinical Nurse, Acute Mental Health Services Tel: [redacted] Seamus Coyle, Nurse Development Lead Tel: [redacted] Garvin McKnight, Charge Nurse, Sixmile, Muckamore Abbey Hospital [redacted]			
Responsible Director:	Moira Kearney, Interim Director of Mental Health and intellectual Disability			
Policy Type: (tick as appropriate)	*Directorate Specific ☒	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐	
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**				
Learning Disability Governance Mental Health Governance	29/09/2020 09/09/2020			
Approval process:	Standards and Guidelines Committee Executive Team Meeting		**Approval date:**	09/06/2021 25/08/2021
Operational Date:	August 2021		**Review Date:**	August 2026
Version No.	2	**Supercedes**	V1 – June 2016 – June 2019	

Key Words:	Search, risk, pat, necessary
Links to other policies	BHSCT use of restrictive interventions for adult and children's services (2015) TP 59/09 BHSCT Patient privacy and dignity within the hospital setting (2016) SG 17/08 BHSCT Adult protection policy and procedure BHSCT Learning Disability admission and discharge policy (DRAFT) BHSCT Acute Mental Health Admission and Discharge Policy Shannon Clinic Regional Secure Unit Admission/Discharge Procedure BHSCT Mental Health and Learning Disability Services Banned/ Restricted Items Procedure BHSCT Mental Health and Learning Disability Physical Interventions Procedure BHSCT Observations within Mental Health Services BHSCT Adult Mental Health and Learning Disability Services Absent Without Leave Procedure (AWOL) BHSCT Levels of Supervision/Observations within Learning Disability Inpatient Services BHSCT Protocol for the Management of Substance Misuse in Mental Health and Learning Disability Inpatient facilities

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

Belfast Health and Social Care Trust Mental Health and Learning Disability Services seeks to promote and maintain a caring and safe environment for all patients admitted into any of its inpatient facilities. It is recognised that a small number of patients/visitors may attempt to bring dangerous or illegal items into the inpatient facility, thus compromising the safety of themselves, other patients, visitors, and staff. Staff may feel it is necessary to search patients, their belongings, or the surrounding environment where there is a clear concern around their own, visitor or staff safety. Any searches taken should be reasonable and proportionate to the circumstances in which it is conducted.

A search is defined as:

"any scrutiny of personal possessions or of an individual that exceeds the expected norms of any clinical environment."

Personal Search – this is the systematic mechanical, visual or "pat down" inspection of a patient which ordinarily takes place with consent but may be undertaken in some instances without consent. A personal search takes place with outer clothing removed i.e. coats/jackets/ jumpers/shoes/ socks.
Where a hand held metal detector is used an explanation will be given as to how it works and procedure used.

Personal Property Search – this is considered to be anything exceeding usual routine checks of property during the admission process or return of a patient to the inpatient facility.

Unit Search – this is the systematic search of the environment, to seek out a missing object, potential stolen goods or hazardous/potentially hazardous items or substances that may jeopardise individual safety or the integrity of the inpatient facility. In the event a unit search is deemed necessary patient movement may be restricted.

1.2 Purpose

This procedure has been developed to ensure a standard approach is taken in implementing this procedure across all of its mental health and learning disability inpatient facilities as outlined in the Regional Guidelines for the Search of Patients, their belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Settings.

This procedure provides staff with standard guidance when considering the implementation of any search of a patient, visitor or the environment.

1.3 Objectives

This procedure aims to: -

- Provide staff with standard guidance where a search of any patient, visitor or the environment is being considered;
- Reduce the likelihood of patients having access to items, which may be harmful or inappropriate to themselves or others
- To maintain a safe environment for all patients, visitors and staff within the mental health or learning disability inpatient facility.

This procedure should be read in conjunction with: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Settings, March 2014
- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, November 2011
- Mental Health (NI) Order 1986
- Management of Aggression Guidelines
- BHSCT Compliments and Complaints Policy
- BHSCT Patient Privacy and Dignity Policy
- BHSCT Obtaining Consent for Examination, Treatment or Care in Adults and Children
- BHSCT Adult Protection Policy and Procedure
- BHSCT Patient Property
- BHSCT Learning Disability Services Admission and Discharge Policy
- BHSCT Mental Health Services Admission and Discharge Policy
- Shannon Clinic Regional Secure Unit Admission/Discharge Procedure
- BHSCT Restrictive Practices Policy
- BHSCT Mental Health and Learning Disability Physical Interventions Procedure
- BHSCT Observations within Mental Health Services
- BHSCT Levels of Supervision/Observations within Learning Disability Inpatient Services
- BHSCT Adult Mental Health and Learning Disability Services Absent Without Leave Procedure (AWOL)
- BHSCT Protocol for the Management of Substance Misuse in Mental Health and Learning Disability Inpatient facilities

2.0 SCOPE OF THE POLICY

This procedure applies to all patients, both voluntary and detained, admitted to an adult mental health or learning disability inpatient facility,

visitors and staff. Those working within a low or medium security facility should also refer to Appendix 9.

A search of personal property is considered to be anything exceeding usual routine checks of property during the admission process or return of a patient to the inpatient facility.

There will be no intimate body searches

3.0 ROLES AND RESPONSIBILITIES

All staff working within the mental health or learning disability inpatient facility have a responsible role to play in achieving the above objectives. There are specific responsibilities highlighted as follows: -

Co-Directors for Mental Health and Learning Disability are responsible for:

- Ensuring the provision and distribution of the procedure;
- Ensuring the monitoring of implementation of the procedure.

Service Managers for Inpatient Facilities in conjunction with their Assistant Services Managers/Senior Nurse Managers are responsible for: -

- Ensuring the procedure is circulated to all staff within their service area;
- Ensuring the procedure is consistently implemented across all inpatient facilities;
- Ensuring the monitoring of implementation of the procedure;
- Acting where there are concerns the procedure is being misused or misinterpreted or where there is the possibility of a more serious service issue;
- Ensure that the necessary training to implement this procedure is in place.

Inpatient facility Sisters/Charge Nurses are responsible for: -

- Ensuring the procedure is circulated to all staff;
- Ensuring staff within their inpatient facility are consistent in the application of the procedure;
- Ensuring a banned/restricted items list is developed for their respective inpatient facility and displayed on the ward;
- Ensuring that the patient welcome pack/booklet advises of the facility's banned/restricted items and of the possibility being searched;
- Ensuring staff are clear about their role and responsibilities;
- Ensuring that all staff implementing this procedure have relevant training;
- Informing their Line Manager/Duty Officer on each occasion the procedure is implemented and its outcome;
- Ensuring incident report is completed where a search has taken place without consent from the patient;

- Ensuring the update of care plans, risk assessments and other relevant documentation.

Multidisciplinary Team members are responsible for: -

- Ensuring they are clear as to their role and responsibilities in the implementation of this procedure;
- Ensuring they are competent to carry out the implementation of this procedure;
- Highlighting any concerns they have as to their competency to implement this procedure;
- Complete incident report where a search has taken place without consent from the patient;
- Updating all relevant documentation including the patient's care plan, risk assessment, search report etc.

4.0 CONSULTATION

This Policy has been developed following consultation with: -
Mental Health and Learning Disability Services
Service User Advocates
Carers Advocates

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 All patients have the right to receive care in a safe environment. However it is recognised that a small number of patients/visitors may attempt to bring dangerous or illegal items into the inpatient facility which may compromise the safety of themselves, other patients, visitors and staff.

5.2 The decision to search a patient and/or their belongings can only take place if there are reasonable grounds to believe that this is necessary. Any searches taken should be reasonable and proportionate to the circumstances in which it is conducted. The search procedure should be referred to within the patient's welcome booklet/pack.

5.3 Each inpatient facility will have a banned/restricted items list in place which will be displayed on the inpatient facility's notice board. This list will consist of any dangerous/illegal/inappropriate items that are felt could compromise the safety of patients, visitors or staff. This list should be contained within the inpatient facility's patient welcome booklet/pack.

5.4 Search of Patients

All patients and where appropriate their carers/relatives should be made aware of banned/restricted items and the ward's search procedure on admission or as soon as is practicable following admission. This should be done both verbally and in writing.

Consideration may need to be given to the involvement of an advocate or interpreter.

Patients should be asked if they are in possession of any banned/ restricted item during the admission process. Any such items should be removed by staff from the patient. Depending on the item and the patient's wishes if appropriate, it may either be taken into the care of staff until their discharge, given to a relative for safe keeping until their discharge or handed over to the PSNI. Where an illegal item/ substance has been found this should be signed and countersigned in the patient's notes by two members of staff.

The decision to search a patient and/or their belongings can only take place if there are reasonable grounds to believe this is necessary i.e. where there is reasonable suspicion that they are in the possession of hazardous/potentially hazardous items or substance that may jeopardise individual safety or the integrity of the inpatient facility. The patient's risk assessment should be reviewed. Indicators that may lead to a decision to search could include where: -

- The patient has a known relevant history of carrying and/or hiding an offensive item/harmful substance;
- The patient has expressed the view that they intend to injure themselves or another person with an implement;
- Information has been received from other patients, staff or visitors that a patient has a dangerous item in their possession;
- A patient is acting in a threatening/unpredictable manner and where there is reason to believe that the patient is in possession of an item that is potentially dangerous to themselves or others.

It should be noted that this list is not exhaustive and professional judgement will remain a key factor in any decision taken.

A multidisciplinary discussion should take place as to the need for a search, ideally involving their Named Nurse. The reason for such a decision should be clearly documented in the patient's notes. All risks should be considered prior to any search being undertaken both to the patient and to staff. If necessary the PSNI should be called however this should only be in exceptional circumstances to prevent harm to the patient or others or to prevent a breach of the peace from occurring.

The reasons for the search and those conducting the search should be explained to the patient and documented in their progress notes, daily inpatient facility round and the search report (App 2). Consideration should be given to the need for the need for alternative modes of communication. Once a patient has been informed of the intended search they should not be left unsupervised.

The patient's consent must always be sought and recorded in the search report (App 2). Please see 4.5 for guidance regarding those patients without capacity to consent. If a patient does not consent to be searched: -

- Medical staff should be consulted. Outside of the hours of 0900 hours and 1700 hours the Duty Doctor and Senior Manager on Call should be consulted;
- A member of staff should remain with the patient and ensure they have no contact with other patients until the search has been completed;
- An incident form should be completed;
- If the situation dictates urgent intervention, the search team should follow management of aggression procedures;
- Any search carried out without consent must be conducted with the minimum force necessary.

The manner in which the search is conducted should ensure the greatest possible privacy and respect of the dignity of the patient. Full consideration must be given to the patient's human rights relating to the patient's race, gender, sexual orientation, spiritual beliefs, disability and age to ensure this is protected. If the patient's request cannot be facilitated the search must be postponed until that choice can be provided. A member of staff should remain with the patient and ensure they have no contact with other patients until the search has been completed.

The searching of a patient or their property should be conducted in a private area i.e. bedroom by two members of staff (one of whom must be a Registered Nurse and of the same gender as the patient). The patient should be offered the opportunity to be present during any search of belongings unless clinical assessment has indicated that it is not safe.

In the case of personal searches patients should be asked to remove their outer clothing i.e. coat, cardigan. A visual inspection will be completed with consideration being given to the use of the hand held metal detector. "Pat Down" searches may only be performed where significant concern remains (App 7 and 8). Staff members carrying out a patdown search must wear gloves at all times. Staff must not place themselves at risk by searching clothing or other items, which are not completely visible. If pockets or hidden areas are to be searched, the staff member should first ask the patient to turn these areas out for inspection.

Items removed from the patient should be put into appropriate bags. The patient will be informed in writing or in another appropriate manner of any items removed from them and who has custody and responsibility for these. This will also be recorded on the search report (App 2)

5.5 Capacity to Consent

Consent should be sought prior to a search being undertaken. Where a patient has been assessed as lacking capacity to give consent, consultation with a responsible person, relative, or independent

advocate should take place prior to the search unless it is considered there is an immediate risk.

The identified person should be available to support the patient during the search unless not reasonably practicable to do so. Details of the capacity assessment specific to the search should be recorded on the search report (App 2) and other relevant documentation i.e. care plan, progress notes etc.

An incident form should be completed where a search has taken place without consent.

Where a patient under the age of 18 years is being cared for on an adult inpatient facility and the need for a search arises, the local Trust policy in relation to searching children/adolescents must be adhered to.

5.6 Post Incident Management

Staff should take time to speak to patients and if appropriate their carer following the search (this may not be straight after the event) to re-iterate the reason for the search and discuss the outcome of the search. Patients wishing to make a complaint should be referred to the Trust's Complaints Policy.

Where appropriate a physical examination to take place of the patient following the search i.e. where restraint has been used.

The multidisciplinary team should review the incident at the earliest opportunity following the search, review and if needed update the patient's care plan and other relevant documentation.

5.7 Visitors

Visitors should be made aware of any banned/restricted items during their initial visit to the inpatient facility. Where there is reasonable suspicion that a visitor has banned/restricted items on their person/property staff should supervise visits, halt the visit or refuse the visitor entry to the inpatient facility. If the visitor to the inpatient facility refuses to leave, staff should summon the PSNI if necessary.

Should a visitor wish to make a complaint, they should be advised of the Trust's Complaints policy.

Any such instance should be deemed an incident and staff should ensure that an incident form via DATIX is completed as per the reporting of adverse incidents policy.

5.8 Dissemination

This procedure will be disseminated to all managers and staff working within a mental health or learning disability inpatient facility.

5.9 Resources

Training resources will be required to ensure the full implementation of this procedure.

5.10 Exceptions

This procedure will not apply to CAMHS or Children's Learning Disability Services.

6.0 MONITORING AND REVIEW

A search report must be completed following each search. A record will be kept in patient record. Each facility will have clinical oversight of searches. Trends/concerns/learning will be reported through local governance arrangements. This will be completed by Senior Nurse Manager AMHIC, Security Lead Shannon Clinic and Assistant Service Manager Muckamore Abbey Hospital.

A six monthly audit of implementation of the policy will take place.

7.0 EVIDENCE BASE/REFERENCES

Mental Health (NI) Order 1986
Nursing and Midwifery Council (NMC) The Code (2015)
Human Rights Act 1998
Regional Guidelines for the Search of Patients, their Belongings, and the Environment of Care within Adult Mental Health/Learning Disability Inpatient Settings, 2014
Deprivation of Liberty Safeguards – DHSSPS Interim Guidance 2014
Use of Physical Interventions for Adult and Children's Services
Reference Guide to Consent for Examination, Treatment or Care, DHSSPS, March 2003
NICE Guidance NG10: Violence and Aggression: Short Term Management in Mental Health, Health and Community Settings
NICE pathway: Anticipating, reducing the risk of and preventing violence and aggression in Adults

8.0 APPENDICES

Appendix 1 – Search Procedure General Guidance
Appendix 2 – Search Report
Appendix 3 – Use of Hand held metal detector
Appendix 4 – Flowchart relating to Search of Patients Procedure
Appendix 5 – Flowchart relating to Search of Patients with Consent
Appendix 6 – Flowchart relating to Search of Patients without Consent

Appendix 7 – Flowchart relating to Pat down Search Process
Appendix 8 – Guidance as to the Search of Patients
Appendix 9 – Medium and Low Secure Specific Guidance
Appendix 10 – Monthly monitoring report by facility
Appendix 11 – Six monthly audit of policy implementation

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Procedure for the Search of Patients, their Belongings and the Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh)** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy haspotential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** 28/05/2021

Policy Author

_____ **Date:** 08/09/2021

Director

APPENDIX 1

Search Procedure General Guidance

1.0 Searches – general guidance

1.1 All searches will be planned prior to them taking place.

1.2 In all cases the person's consent should be sought before any search is attempted.

1.3 Staff should always wear gloves when carrying out a search of a person or area.

1.4 In all cases a search of areas or person will only be conducted where there are two members of appropriately search trained staff.

1.5 Evidence should be appropriately bagged, tagged, and logged using the correct evidence bags.

1.6 Unauthorised/banned items should be appropriately stored/disposed of in accordance with the Belfast Trust Medicines Code.

1.7 Restricted items should be removed and recorded and stored safely. A note of same should be made in the patient's records.

1.8 Where a patient/visitor wishes to make a complaint, the complaints procedure will be followed.

1.9 A search report should be completed and forwarded to the search leader.

1.10 The search coordinator will always inform the nurse in charge of the inpatient facility of the outcome of any searches

1.11 Thereafter the nurse in charge of the inpatient facility will inform appropriate personnel of any issues arising

2.0 Patient Search (includes belongings, bedroom etc)

2.1 In all cases the person's consent should be sought before any search is attempted.

2.2 Once a patient has been informed that a search is intended, the patient should not be left unsupervised until the search has been completed.

2.3 If the patient wishes to observe, there should be an additional member of staff to observe the patient.

2.4 Details of the search and any findings must be documented in the patient's clinical notes and highlighted as appropriate.

2.5 Pat down searches[1]

2.5.1 Pat down searches will be conducted in a private area to ensure the greatest possible privacy and respect of the dignity of the patient.

2.5.2 A member of staff who is the same gender will always carry out pat down searches of female patients.

2.5.3 Pat down searches of male patients, where possible should be carried out by a staff member of the same gender but can be conducted by either male or female staff. However staff will ask for the patient's permission if a search is to be carried out by a member of the opposite sex.

2.5.5 Where a person is non-consenting to a pat down search a member of medical staff/duty doctor should be contacted before any search is attempted.

2.5.6 A patient's bedroom search will always be preceded by a pat down search of that patient.

2.6 Searches Requiring the Removal of Clothing

2.6.1 There **must be reasonable evidence** for believing that the patient is secreting on their person an illicit substance or item, which could adversely affect the safety and/or security of them, others or the unit.

2.6.2 Personal searches that require the full removal of the patient's clothing will only be instigated on the instruction of a member of medical staff/duty doctor.

2.6.3 Searches requiring the removal of clothing should be undertaken on the inpatient facility and in a private place. The patient should be kept under observation on the inpatient facility in an area away from the other patients until the situation has been resolved.

2.6.4 The patient will be informed that a search requiring the removal of clothing is required.

2.6.5 The patient will be escorted to a single room, which has been prepared for the procedure.

2.6.6 Two nursing staff of the same gender as the patient will conduct the search(one will be a qualified nurse).

2.6.7 The patient will be reassured at all times.

2.6.8 Staff conducting the search should wear disposable gloves.

2.6.9 The patient should never be completely naked at any time.

2.6.10 All clothing above the waist will be removed and searched. A visual check of the patient's upper body will be made. The patient should then be allowed to re-dress.

2.6.11 All clothing below the waist will be removed after a visual check of the lower body; the patient will be allowed to re-dress.

2.6.12 Removed clothing must be thoroughly searched, paying particular attention to seams, linings, cuffs, collars, waistbands, shoes, and pocket items.

2.6.13 An incident form outlining the reason for the search must be completed. The form should outline who authorised the search and why. An entry should be made in the patient's notes.

2.6.14 **THERE WILL BE NO INTIMATE BODY SEARCHES**

2.7 Non Consent Searches

2.7.1 The staff team carrying out the search must first get the consent of a member of medical staff. The patient should remain on special observations and not in contact with other patients until the search can take place.

2.7.2 The incident should be recorded on an incident form.

2.7.3 Should the situation dictate urgent intervention, the team conducting the search should follow the Trust's Use of Physical Interventions in Adult and Children's Services guidance

3.0 Targeted Searches[2]

3.1 Targeted searches will be carried out where staff suspect that a particular patient(s) has on their person or in their room, restricted items

3.2 All patients returning from AWOL will be searched

4.0 Room Searches of More than One Bedroom

4.1 Patients whose rooms have been identified for targeted search will be asked to accompany staff. The patients must be informed of the reasons for the search.

4.2 A nurse trained in search procedure must stay with patients at all times

4.3 The rooms are searched as stated above in Section 2.

5.0 Large Scale Searches

A large-scale search may be required at anytime for various reasons i.e.

- A breach of security is suspected or known;
- To intercept illicit substances or potential weapons;
- To raise the profile of security and act as a deterrent to the movement of items into the establishment, or through the patient population;
- To inform staff of the security status of the unit.

The reason for the search should determine the immediacy of action required.

6.0 Immediate Searches

6.1 Reasons for an immediate search may include:

- Known sharps/ignitables missing
- Significant amount of drugs/alcohol suspected/known to be on the unit
- Reason to believe that there may be an item which may be used to cause self harm or injury to others.

6.2 Under these circumstances there should be as little delay as possible

6.3 The senior nurse co-ordinator should be contacted to discuss decision

6.4 As much manpower as possible should be summoned whilst maintaining adequate resources in other wards

6.5 Staff not trained in search may be drafted to participate under guidance / supervision.

6.6 A staff member should be identified to co ordinate search plan

6.7 Search Plan

Ultimately the search coordinator will give direction on how a search will be conducted. Below is a framework, which may be used as a guide

6.7.1 First patient is searched.

6.7.2 Moving to the next.

6.7.3 Searched patients may be allowed to return to searched bedrooms to ease tension but may not circulate with unsearched patients.

6.7.4 Search may run over shifts, oncoming shift should be asked to assist and search teams to discreetly search TV lounge, inpatient facility WC, these rooms to be locked of initially. These will become " clean rooms"

6.7.5 Patients to be gathered in central area for community meeting and informed of intended search. No patient should be left unattended / unsupervised from this point until search completed.

6.7.6 As each patient leaves room, room should be locked.

6.7.7 All other patient access rooms should be locked off

6.7.8 Corridors may be locked off to limit access / patient movement.

6.7.9 Each patient in turn should accompany staff to their bedroom for a person search and room search.

6.7.10 The patient where possible should have the option to observe the room search, but if they choose not to remain in their bedroom they may not circulate with the unsearched population and should only have access to "clean rooms".

6.7.11 All other patients to remain in the central area with staff observing.

6.7.12 Search should be systematic and be completed as quickly as possible so that the status quo can be regained. Where a search will take place across shifts, the members of staff going off shift should be asked to stay behind where possible.

6.7.13 Once all patients and bedrooms have been searched central dining area should be searched.

6.7.14 At this point patient may be allowed to circulate in the central area, with no access to other unsearched area e.g. ADL kitchen, Resource room

6.7.15 Other side rooms may then be searched e.g. ADL Kitchen

6.7.16 Complete relevant documentation.

6.7.17 Inform relevant people of outcome or further action required.

7.0 Non Immediate Searches

Reasons for a less immediate search may include: -

- Noted pattern of inappropriate/intoxicated behaviour in patient population.
- To raise the profile of security and act as a deterrent to the movement of banned/restricted items.
- To restrict the movement of restricted / banned items.
- To intercept banned/restricted items.
- To inform staff of the total security status of the ward/facility.

7.1 Where possible a non immediate search should be discussed with the inpatient facility manager.

7.2 The search should be thought through and planning must be given to the exercise in regard to manpower and timing.

7.3 Patients are NOT to be given fore warning of intended search until immediately prior.

[1] Pat Down - A search of a clothed person, using the flat of the hand and hand held metal detector

[2]Targeted Search - A planned area or pat down search where a particular individual or group of individuals are suspected of possessing restricted items

APPENDIX 2

Search Report

Patient Details (if applicable)

Name		**Unique identifier**	
Inpatient facility		**Bedroom**	

CLINICAL AREA SEARCH		**Room name/number**	

DATE/TIME search commenced:		**DATE/TIME search completed:**	

Type of search	**Tick**	**Reason for search**	**Targeted /Routine T / R**	**Rights Explained Y / N / NA If not why?**	**Consent Obtained Y / N / NA**	**MDT discussion prior to non consensual search Y / N / NA**	**Physical Intervention required Y / N / NA**	**Patient offered opportunity to be present (if area search) Y / N / NA**	**Did they remain? Y / N**
Hand held metal detector									
Personal pat down search									
Patients bedroom									

Post Search

**Related Datix reference number*		
*Post incident Debrief carried out **Y / N***	*MDT review occurred / planned DATE*	*Has the complaints procedure been invoked **Y / N***

Search Team Details **Staff Name / Print**	**Staff Signature**	**Registered Y/N**	**Gender M/F**	**Role (Searcher / Observer)**	**Training up to date Y/N (If No give explanation)**

Description of items removed	**Declared by patient - or - Precise location found**	**Location item removed to**	**Reported to whom**

Damage prior to search	**Damage caused during search**

Inpatient ward sister/charge nurse report

Signature: _____

Patient advised of items removed or damaged

Patient signature: _____ **PRINT** _____ **Date**: _____

APPENDIX 3

Use of Hand Held Metal Detector

Training on the use of the hand held metal detector is provided for staff during their induction.

A hand held metal detector has been allocated to each inpatient facility – it should be utilised in all room and property searches.

The hand held metal detector can also be utilised following a pat down search being conducted where there is still suspicion that metal items may be secreted upon the person. Should this take place the patient should be informed as to why the hand held metal detector is being used and the action of the hand held metal detector. The patient will again be offered the opportunity to hand any banned item over before the search proceeds.

All metal objects should be removed from the patient before the search with the hand held metal detector takes place (staff should be aware of under wired bras).

The hand held metal detector should be operated by a staff member who is of the same gender of the person being search – another member of staff should observe the search.

The hand held metal detector should be turned on and tested by placing close to a metal object prior to being used in the search process.

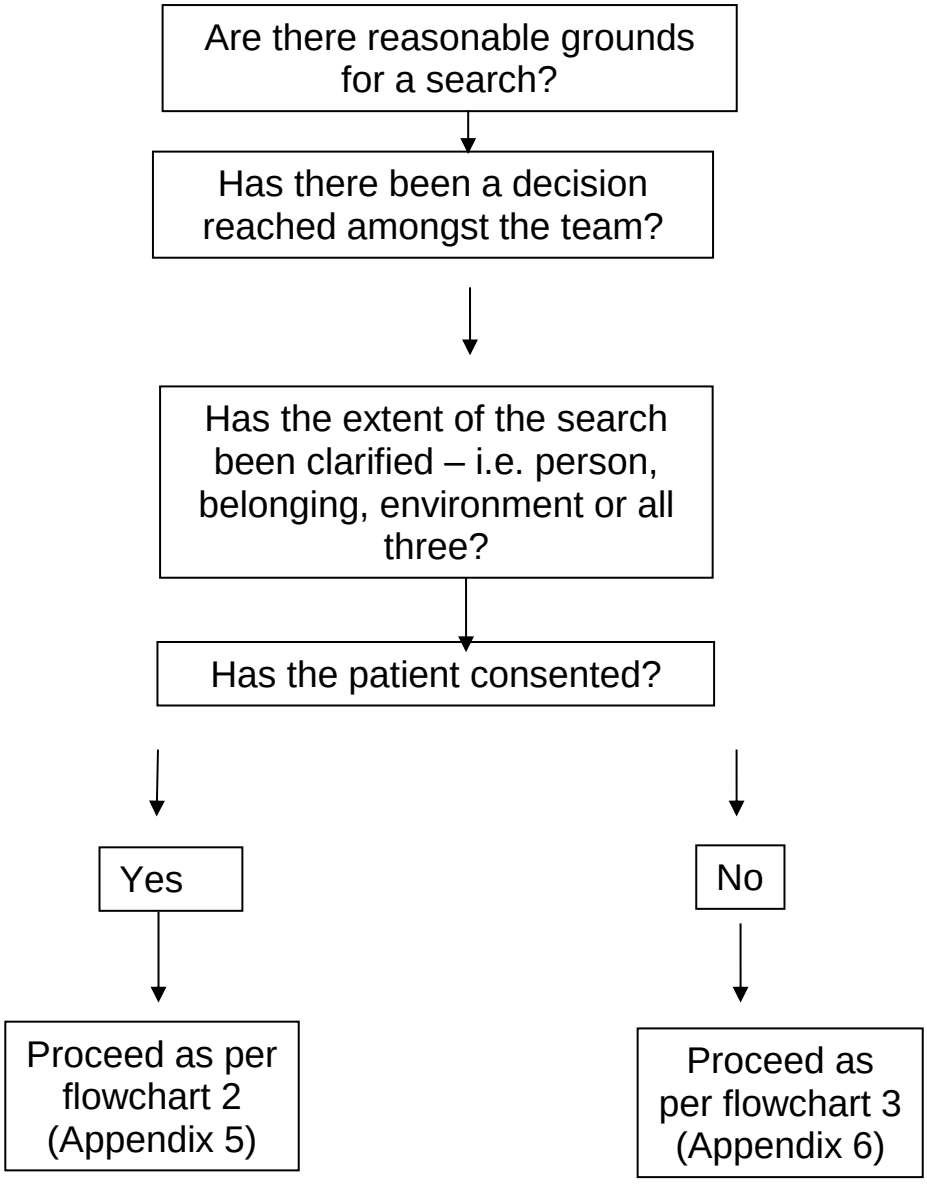
The hand held metal detector will be placed several centimetres from the patient's body, starting at the head and then working systematically from the top to bottom of the patient, across the front of the body and then the back. When searching the lower leg and foot area the patient should remove foot wear and raise their foot from the floor, so as not to pick up metal within the floor.

Should the hand held metal detector detect any metal objects it will sound with a beeping noise. Staff will ask the patient to remove any objects detected or these can be removed by the observing member of staff.

Any items of concern should be documented on the search form.

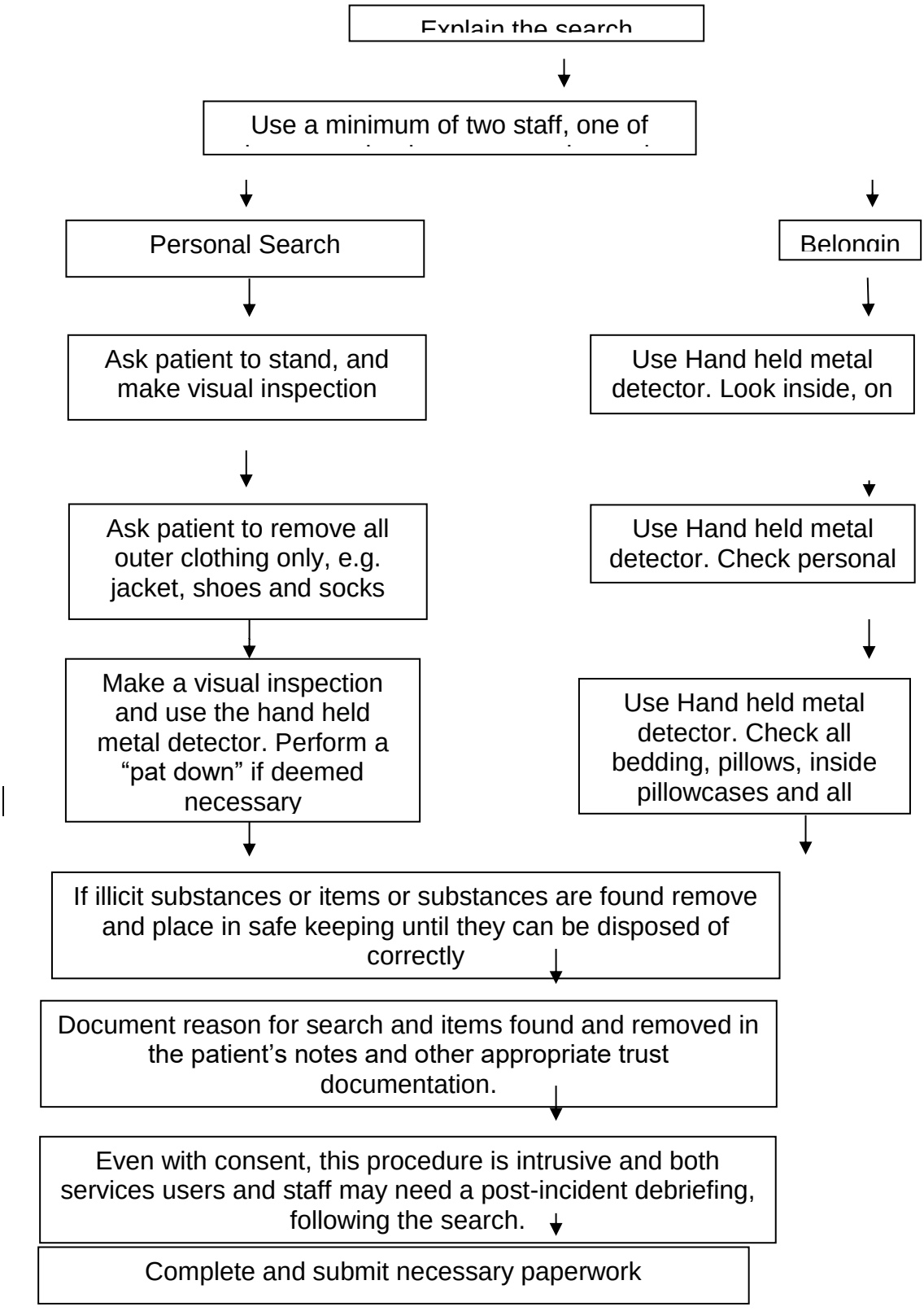
APPENDIX 4

FLOWCHART 1: THE SEARCH PROCEDURE



APPENDIX 5

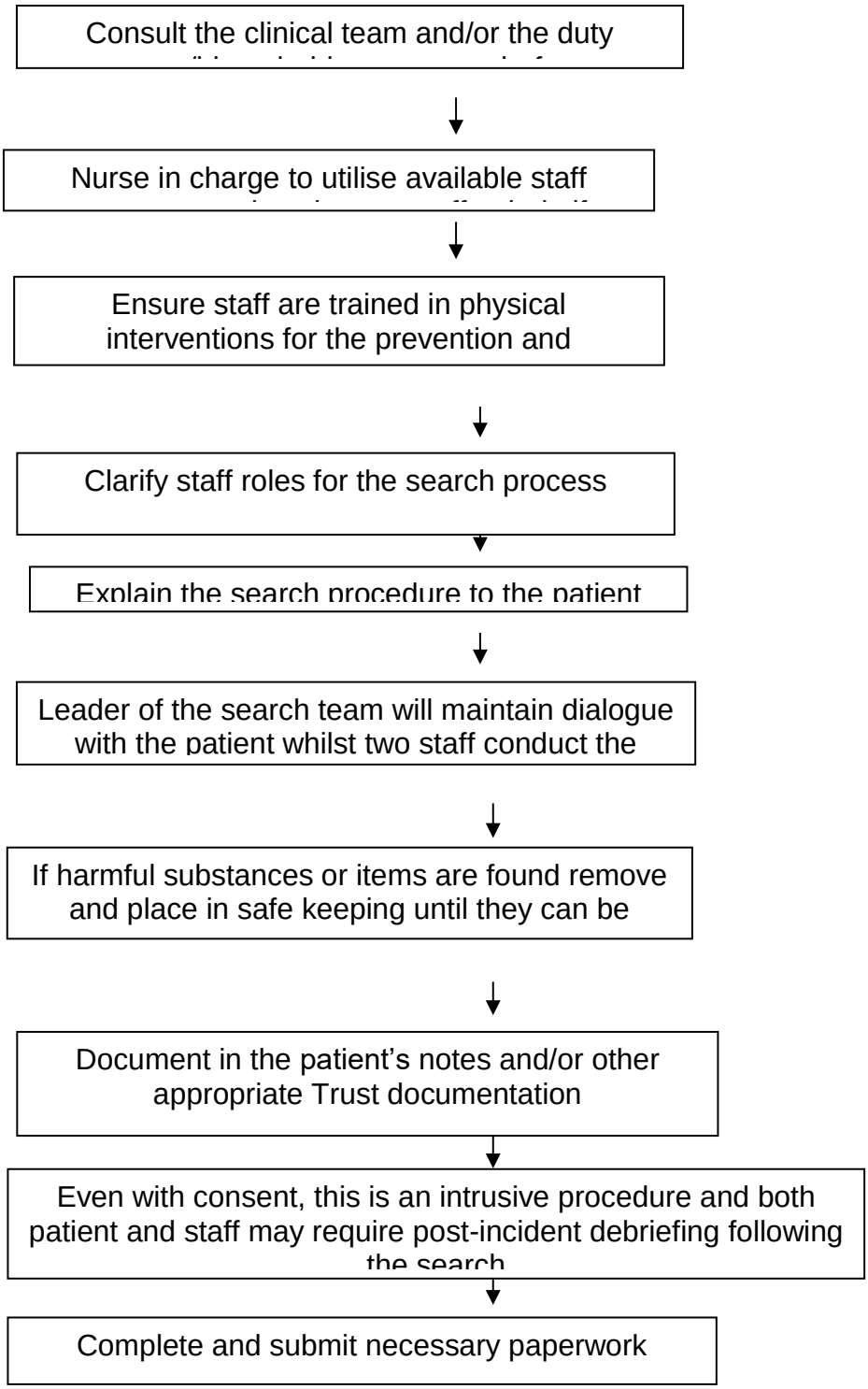
FLOWCHART 2: SEARCH WITH PATIENTS INFORMED CONSENT



NB: This flowchart relates only to searching of patient's suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

APPENDIX 6

FLOWCHART 3: SEARCH WITHOUT THE PATIENT'S CONSENT



NB: This flowchart relates only to searching of patient's suspected of secreting dangerous or illicit items. If objects or dangerous items are being used in a physically violent way, the immediate area may need to be evacuated and the local police called to assist immediately.

APPENDIX 7

Pat Down Search Procedure

1. Searches should be carried out in an area where there is room to carry out the search effectively. The patient's privacy and dignity should be maintained at all times where possible.

2. All searches of a patient's person must be carried by two staff members. One member of staff should be a registered nurse and of the same sex as the patient.

3. Where a staff member of the same gender is not available the search will be carried out using a handheld hand held metal detector with one staff member carrying out the search and the other acting as a witness.

4. Colleagues should be informed of the search and where it is taking place.

5. Staff should minimise the area of their body presenting a target by maintaining a side on stance when possible.

6. Staff should keep their head up and arms in a position where they are ready to be raised in defence and to reduce the risk of injury if attacked.

7. Staff should use their clinical judgement when considering placing their hands in the patient's pocket.

8. Any items removed should be recorded and the person informed of where they are being kept.

9. When the patient is discharged, all confiscated property should be returned to them.

APPENDIX 8

Pat down body search

1. Stand facing the patient.

2. Ask whether they are in possession of any restricted/banned items.

3. Ask all pockets to be emptied. If a coat/jacket is worn this should be removed after the pockets are emptied.

4. If the patient is in possession of any bags they should be asked to place these to one side for searching following the pat down search.

5. Patient to be searched using the hand held metal detector.

6. Staff to search items removed from pockets.

7. Staff to search any garments removed.

8. The patient should be asked to remove any headgear and pass to staff for searching.

9. If the patient's hair is long or thick they should be asked to run their fingers through their hair. This is again to prevent the risk of needle stick injury to staff.

10. Visual check of the patient's upper body including mouth ears and nostrils should be undertaken.

11. Should the patient be wearing a tie they should be asked to remove it and staff should search it using same method as for jackets/coats.

12. Any collars should be lifted and a visual check carried out before feeling around it.

13. Staff should pat their hands over the patient's shoulders

14. The patient should be asked to raise their arms level with their shoulders, keeping their arms straight, fingers open and apart and palms facing down. Staff should step slightly to one side, and search one arm by patting their hands along the upper and lower sides of the arm from shoulder to wrist. Staff should check between the fingers and look at the palm and back of the hand.

15. Repeat for the other arm.

16. Staff should pat down the front of the body of a male patient from neck to waist including the front of the waistband. Both sides of the body from armpit to waist including waistband should be checked.
In the event that a search is conducted on a female patient the breast area should be avoided

17. Staff should ask the patient to turn around and keep their arms in the raised position.

18. Staff should search the patient's back from neck to waist including the waistband and the seat of their trousers or skirt.

19. Staff should assume a kneeling position side on to the patient with the fore knee on the floor and furthest leg flexed and propping back thereby keeping a stable base.

20. Staff should check the patient's leg from crotch to ankle including the inside of the leg, the back of the leg and the outside of the leg. When searching the outside of the leg the search is from the waist to the ankle.
If the patient is wearing a skirt the search must be carried out by patting the hands down both sides of the leg from the outside of the skirt. (This makes it very difficult to search the tops of the legs and it may be necessary to use the hand held hand held metal detector).

21. Repeat for the other leg.

22. Stand up.

23. Staff should ask the patient to turn around and keep their arms in the raised position.

24. Staff should check the abdominal area of the subject.

25. Staff to use the same kneeling position and technique as before to search the front and sides of one leg.

26. Repeat for the other leg.

27. Staff should use their clinical judgement when considering retrieving hidden items.

28. Where staff suspect that something is hidden inside footwear, the patient should be asked to removed them for inspection. Staff should carry out a visual check of the sole and heel of the shoe by first tapping the heel of the shoe against the floor. The shoe should then be checked feeling for lumps from the outside and looking inside the shoe. **STAFF MUST NOT PUSH THEIR HANDS INTO THE SHOE**.

30. Staff should study the area around the patient for any items that may have been dropped before or during the search.

31. The patient should be asked to step to one side to check that they are not standing on anything he has dropped before or during the search.

APPENDIX 9

Medium and Low Secure Specific Guidance

This guidance should be read in conjunction with the main document and other appendices.

1.0 Routine Searches[1]

1.1 All areas that patients have access to will be routinely searched on a quarterly basis

1.2 All patients and their property will be subject to routine search on admission.

1.3 Patients from Shannon Clinic and Clare Unit returning from unescorted leave beyond the secure area will be subjected to a search. The frequency should be dictated on the care plan

2.0 Visitors for Patients (Shannon Clinic only)

2.1 On entering, visitors will be advised of the restricted/banned items procedure within the unit and asked to store personal belongings and restricted items in the lockers provided (this will include the contents of their pockets).

2.2 The escorting nurse will meet the visitor(s) in the large reception area and re-iterate this. The escorting nurse should advise the visitor(s) of the search procedure and proceed to the airlock.
If a visitor refuses to cooperate with the procedure then access to the clinic will be denied. A full explanation will be given regarding same.

2.3 All items brought for patient should be searched (only sealed items will be permitted)
Escorting staff should request that the visitor removes any metal items from person and place in tray provided.

2.4 The escorting staff should then use the hand held metal detector to scan the visitor. **HANDS MAY NOT BE LAID ON TO SEARCH A VISITORS PERSON**

2.5 If illegal items are suspected on the visitor e.g. suspicious substances, weapons, etc. They should be refused entry and requested to leave clinic.

2.6 In the event of illegal items being found or a visit not being able to go ahead due to visitor's refusal to co-operate staff should inform the nurse in charge of inpatient facility, senior nurse co-ordinator, inpatient facility manager, RMO and the patient. An incident form should be completed

[1]Routine Search - A planned area search, to deter movement / or possession of restricted item(s)

APPENDIX 10

Monthly monitoring report by facility

Facility: _____

Month: _____

	Number of searches conducted	% of searches connected to incident	% of searches with concerns regarding completion of documentation	% of searches were physical intervention was required	Items found during search	% of searches following which a debrief was conducted	% searches following which wellbeing of patient ascertained

* Any trends/concerns/learning arising from searches must be reported through local governance arrangements

APPENDIX 11

Six monthly audit of policy implementation

Facility: _____

Time period: _____

Evidence of Clinical Oversight of Searches	Is search equipment in situ and working?	% staff trained in search	Is there signage display for banned/restricted items displayed?	Is search mentioned in patients' pack?	Is search mentioned in carers' pack?

* Auditors to be appointed by local areas. Any concerns/learning identified to be fed up through local governance arrangements.

Belfast Health and Social Care Trust
caring supporting improving together

Policy Code: BHSCT/ASPC/LD (03) 2021

Title:	**Patients' Finances and Private Property – Policy for Adult Inpatients within Learning Disability Hospitals**				
Policy Author(s)	Gillian Traub, Interim Co - Director Muckamore Abbey Hospital Tel: [redacted] Owen Lambert, Service Manager Muckamore Abbey Hospital Tel: [redacted] Nicole Crossan, Patient Finance Liaison Officer Tel: [redacted]				
Responsible Director:	Moira Kearney, Interim Director of Mental Health and Intellectual Disability				
Policy Type: (tick as appropriate)	*Directorate Specific ☒	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐		
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**					
Learning Disability Governance Committee	13/09/2021				
Approval process:	Standards and Guidelines Committee Executive Team Meeting		**Approval date:**	05/10/2021 13/10/2021	
Operational Date:	October 2021		**Review Date:**	October 2026	
Version No.	2	**Supercedes**	V1 – April 2015 – April 2018		
Key Words:	Learning Disability, Finance, Private Property, Inpatients, Hospital				
Links to other policies	BHSCT Patient Property (2008) SG 05/08 BHSCT Records Retention and Disposal Policy (2017) SG 25/08 BHSCT Records Management Policy (2018) TP 13/08 BHSCT/SHWH/MH (01) 2021 Procedure for Search of Patients, their Belongings and Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh)				

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

All staff have a responsibility to ensure that patients' finances and private property are safeguarded and that their money is used in a way which reflects their wishes as appropriate and is in keeping with their treatment or person centered plan.

1.2 Purpose

This policy provides staff with guidelines regarding the handling of patients' finances and private property across the BHSCTin-patient learning disability wards. This policy should be read in conjunction with:

- BHSCT Patients' Property Policy
- BHSCT Records Retention and Disposal Policy
- BHSCT Records Management Policy
- Regional Guidelines for the Search of Patients, their belongings and the environment of care within Adult Mental Health/Learning Disability Inpatient Settings
- BHSCT Patient Searches in Mental Health and Learning Disability Inpatient Facilities

1.3 Objectives

This document aims to:

- Establish clear guidance for staff in relation to the handling of patients' finances and private property;
- Safeguard the interests of patients;
- Guide and protect staff when dealing with patients' finances and private property

2.0 SCOPE OF THE POLICY

This policy applies to all patients in a learning disability inpatient ward and to all staff working within inpatient Learning Disability Services within the Belfast Health and Social Care Trust.

3.0 ROLES AND RESPONSIBILITIES

3.1 Service Managers (SM)

Service Manager's are responsible for inpatient wards within Learning Disability. They must ensure that this Policy and its Procedures are disseminated to all staff and implemented.

As required, Service Managers / Co-Directors, in conjunction with Corporate Appointee, can commission independent benefits advice to be made available to patients and/or their families to ensure patients are in receipt of optimum benefit entitlement.

3.2 Assistant Service Manager (ASM)

ASM's are responsible for inpatient wards within Learning Disability must ensure that:

- Staff are aware of the Management of Patient's Finances and Private Property Policy and Procedures;
- They provide staff with training and guidance regarding the implementation of this policy.
- Monitor the implementation of the Policy and Procedures within their service area.

3.3 Charge Nurses/Ward Sisters (hereafter referred to as Ward Manager)

Ward Managers are responsible for a Learning Disability inpatient ward must ensure that:

- The Policy and its procedures are made available to all staff;
- Staff have an understanding of the policy and its procedures and have completed the policy template confirming this;
- This policy is fully implemented within their area of responsibility;
- This policy forms part of the ward's local induction;
- Any updates or issues arising in relation to this policy are discussed at ward meetings or supervision sessions;
- Any issues not resolved should be escalated to their line management.
- Patient monies held by the Trust are actively managed in the best interests of the individual patient.
- Address and record any queries and complaints received from patients or their family or advocate in regards to the management of their finances. If the complaint cannot not be resolved at ward level it should be escalated to the Service Manager.

3.4 Community Social Worker

- It is the responsibility of the patient's community Social Worker/Care Manager, on admission and discharge, to ensure that the patient is receiving all benefits that they are entitled to – this can be done in conjunction with the Benefits advice officer at the Social Security Agency.

3.5 Hospital Social Worker

- It is the responsibility of the patient's hospital social worker/key worker to ensure on a continuing basis while in hospital that the patient is receiving all and only the benefits they are entitled to. This can be done in conjunction with the Trust's Patient Finance Liaison Officer and the Appointee.

3.6 Appointee

- Ensure appropriate documentation is in place and retained to confirm appointeeship for relevant patients.
- Communicate with Social Security Agency regarding patient savings and change of circumstances which may impact on Benefits entitlement.
- Reconciliation of Benefits between entitlements and amounts received via Patients Private Property Accounts.

3.7 Patient Finance Liaison Officer

- In conjunction with the Hospital Social Worker and / or Benefits Agency, ensure that patients without capacity are receiving all benefits they are entitled to.
- Ensure that long term patients for whom we manage their monies, have funeral plans and wills in place as appropriate.
- Ensure that patient finances are pro-actively managed to meet or enhance patients' needs via a Financial Support Plan.

3.8 Finance Team

- Safeguard the security and optimum return of monies deposited to Patients Private Property Accounts including the use of interest bearing bank accounts where appropriate.
- Ensure that an individual computerised financial ledger is accurately maintained for each patient for whom the Trust holds monies.
- Issue Transaction and Fluctuation Reports to relevant managers for monitoring purposes.
- Report balances held in respect of all patient's to RQIA on a quarterly basis.

- Seek permission from RQIA when a patient balance is approaching £20k for the Trust to continue to hold and manage these funds.

3.9 Staff Member

- All staff have a responsibility to ensure that finances and private property held by the Trust are safeguarded for all patients, while they are on the ward.
- If a staff member has any concerns regarding the way in which a patient's money is being used they should immediately inform the Ward Manager or Assistant Service Manager.
- Where the patient lacks capacity to understand their affairs, staff must ensure that all purchases on their behalf are appropriate for their needs and individual to them in keeping with their treatment or person centred plan.

4.0 CONSULTATION

Learning Disability senior management team
Finance Staff
TILII

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Key Policy Statements

The Trust has legislative authority to manage individual patient finances up to £20k. Above this limit, permission must be sought from RQIA to retain the balances.

The Trust will actively manage patient monies in the best interests of the individual and make referrals to the Office of Care and Protection (OCP) as appropriate.

The Trust will support patient's as far as possible to be involved in the management of their finances and private property through the use of accessible and inclusive communication, where necessary reasonable adjustements will be made to support this.

Where possible, patients will be able to go out of hospital to make their purchases.

Staff will not ask for or have access to a patient's PIN number for their bank cards.

No patient should be purchasing items from their own finances which should be provided by Public Funds (e.g. essential food items, standard furniture etc.).

All patients' finance records must be retained for seven years.

5.2 Patient Capacity for Management of their own Finances

Capacity in relation to financial matters is presumed unless the contrary is proven with the burden of proof is on those seeking to prove absence of capacity. If a Patient has been assessed as having the capacity to manage their own finances they are deemed to be "Capable". If a Patient is assessed as not having the capacity to manage their own finances they are deemed to be "Incapable".

There are two clear legal propositions of capacity (Masterman-Lister 2002 Court of Appeal (England and Wales):

1. What is relevant is capacity for the particular transaction to be affected

2. What is required is the capacity to understand the nature of the transaction when it is explained.

English High Court case (Fehily v Atkinson 2016):

- A person needs the mental capacity to recognise the issues that must be considered, to absorb, retain, understand process and weigh the information in the balance in reaching a decision. A person may have capacity for one type of decision but not another.
- Capacity may vary over time and should be assessed at the specific time when the decision was made.
- The key issue is whether the person has **the ability to understand the transaction, not whether he actually understood it.**

Capacity can:

- Vary over time
  - At what point in time is capacity being considered? Possibility of fluctuating capacity
  - What is the available evidence in relation to capacity at that point in time? How can the picture at that time be reconstructed?

- Vary in respect of different issues
  - What is the nature, size and complexity of the transaction in question?
  - What is the individual's capacity in respect of that particular transaction?

There are three outcomes in relation to capacity of the patient to manage their own finances:

1. Capable
2. Incapable
3. Temporarily Incapable

5.2.1 Capable Patients

The Cash Withdrawal Limit section of the Financial Capacity Assessment (Appendix 1) should be discussed and agreed with capable patients. The limits should be reviewed regularly with the patient. This must be signed by two members of the MDT for example a nurse and a medical officer or two nurses (Band 5 or above).

On an annual basis the cash office will seek an update from each ward on each patient's capability status and cash withdrawal limit. In the intervening period, the patient's named staff are responsible for informing the Cash Office of any change in the capability status of a patient and / or their cash withdrawal limit. The Cash Office must enter the information about a patient's agreed withdrawal limits onto their computerised Patients' Private Property system so that it can be referenced by Cash Office staff at all transactions.

Should a capable patient wish to withdraw more than their agreed limit, this request must be respected and signed off by an appropriate person as per the authorisation levels.

Patients, whilst capable in the management of their own financial affairs, may still seek the help of staff to support them with management of their finances. A Financial Support Agreement (Appendix 2) should be drawn up if the patient agrees to this.

5.2.2 Temporarily Incapable Patient

If the Financial Capacity Assessment (Appendix 1) indicates that the patient may not have capacity temporarily to manage their financial affairs and that the situation could resolve with treatment and therapeutic intervention, the temporarily incapable section of the Cash Withdrawal Limits section should be signed by two members of nursing staff (Band 5 or above) or the Medical Officer at point of admission.

5.2.3 Incapable Patient

If the Financial Capacity Assessment (Appendix 1) indicates that the patient's capacity status is incapable the incapable patient section on the Cash Withdrawal Limits section of the Financial Capacity Assessment (Appendix 1) should be completed with a maximum withdrawal of up to £250.00 per week.

If the Trust are Corporate Appointee a Financial Support Plan (Appendix 3) must be drawn up by the Patient Finance Liaison Officer in conjunction with Corporate Appointee, MDT and family (if appropriate). If the Trust are not Corporate Appointee a Financial Plan (Appendix 3) can be drawn up if the patient and / or their Appointee is agreeable to this.

When the Trust is the Corporate Appointee, the Patient Finance Liaison Officer is to ensure a copy of the Financial Support Plan (Appendix 3) is given to the Trust Finance Department. A copy of the Financial Support Plan (Appendix 3) will also be retained in the patient's MDT file.

When it is established that a patient will be remaining in hospital for a longer period of time and that community appointeeship (where applicable) has been relinquished and the Hospital Appointee is taking on the role, it is the responsibility of the Ward Manager / Named Nurse to contact the Hospital Appointee requesting them to make arrangements to have patient benefits transferred into a Patient Private Property Account. This should only occur after a full discussion with the MDT and a LD Financial Capacity Assessment (Appendix 1) has been completed.

5.2.4 Assessment of Financial Capacity

An assessment of financial capacity should be undertaken by a designated member of staff which includes the assessment itself, the outcome and the agreed cash withdrawal limit (Appendix 1); this will be recorded on the electronic patient record.
Where an assessment of temporarily incapable is made, this should be reviewed in light of change in circumstances and / or in respect of the particular transaction being undertaken.

5.3 Patient Property and Cash on Admission to Hospital

5.3.1 Patients' Property and Cash to be lodged to the Cash Office on Admission

When a patient is admitted to hospital, they may bring with them:

- Items of value / property
- Cash
- Bank cards (Note: under no circumstances should staff ask or allow a patient to make known the PIN Number of such bank cards)
- Loyalty cards

In the instance of this occurring, these items should be removed as soon as practically possible for safe keeping to the Cash Office.

Note: This section does not relate to clothes or items of low value which may remain with the patient during their admission.

The pre-numbered Patients' / Clients' Private Property Receipt Book form (Appendix 4) should be completed where cash and / or property is to be lodged to the Cash Office. The patient should sign and date the form when completed as appropriate. Where the patient is not capable of signing the form, a relative may sign in their place. The form should then be

signed and dated by two members of staff, one of whom should be a registered nurse. The top copy of the form should be given to the patient (or relative where appropriate). Staff must also reflect these transactions on the Property Record (Ledger) (Appendix 5).

Staff must place the cash and / or property in an envelope and attach the Patients' Private Property Label (Appendix 6). The Patients' / Clients' Private Property Receipt Book form (Appendix 4) form should be brought to the Cash Office still attached to the Patients' / Clients' Private Property Receipt Book and brought along with the property in the envelope. Ward Staff and Cash Office Staff will check and agree the contents of each envelope when it arrives in the Cash Office and will both sign the envelope label (Appendix 6) to validate each other's agreement to the contents. The Cash Office will sign and date the bottom of the form, acknowledging receipt of the property. The Cash Office will then take the second copy of the form for their records. The third copy of the form should be retained in the Patients' / Clients' Private Property Receipt Book (Appendix 4) permanently as this is the ward's permanent record. The process should be repeated when patient's property is being removed from the Cash Office for return to the patient.

Staff should take cognisance of the following when completing the Patients' / Clients' Private Property Receipt Book form (Appendix 7):

- Tippex must not be used when making alterations to the form – all alterations must be made with black ink and signed by the person making the change.
- Jewellery and any other valuables should be described in non-value adding terms, for example, white/yellow coloured metal with white stone rather than silver/gold with diamond.
- Forms must not be removed from the book if an error is made. In such cases forms should be cancelled with two diagonal lines across the form with "cancelled" in between and a new form should then be started.

5.3.2 Patient's Property and Cash not being lodged to Cash Office on Admission

Any cash in a patient's possession on admission that is not to be lodged to the Cash Office should be entered onto a Cash Sheet ("Ledger") form (Appendix 4).

Any property in a patient's possession on admission that is not to be lodged to the Cash Office should be entered onto a Patients' / Clients Private Property Form (Appendix 8); this details a full inventory of the patient's property on admission. Any property items that are handed in for safe keeping in the property drawer on the ward should be documented on a Property Record (Ledger) (Appendix 5).

5.3.3 Patients who have no Cash on Admission

If a patient is admitted to hospital with no money and purchases are required, the Ward Manager should consider the following:

- Discussion with family regarding access to money for the patient
- Access to the patient's community Bank Account – note that this will be dependent on whether the patient is deemed to have capacity or not.
- Article 15 Payment (Appendix 9)
- Emergency Cash Float

5.3.4 Financial Capacity

All patients should have a Financial Capacity Assessment (Appendix 1) completed within 2 weeks of their admission; see section 3.2.4 for specified detail.

A Financial Support Agreement (Appendix 2) or a Financial Support Plan (Appendix 3) should be discussed and agreed within 4 weeks of the patient's admission in conjunction

with the MDT, Patient Finance Liasion Officer, the patient (if appropriate) and family (if appropriate).

5.4 Patient Property and Cash During a Stay in Hospital

5.4.1 Safe Keeping of Cash

If a patient receives cash from a relative or visitor, this should be documented in the ward Patients' / Clients' Private Property Receipt Book (Appendix 4) and the top copy given to the relative or visitor – the receipt book should carry two staff signatures one of which is on the authorised signatory list. If the cash is to be lodged to the Patient Private Property Account in the Cash Office, this should be completed as soon as possible in line with Cash Office opening hours. Where cash cannot be lodged immediately, it should be securely locked in the cash drawers, witnessed by two members of staff and documented on the Cash Sheet ("Ledger") (Appendix 7).
The keys for cash drawers should be held by the Nurse in Charge of each shift and should not be attached to any keys including medicine keys.

An upper limit of cash to the value of £250.00 may be held on the ward for any individual patient. The exception to this is when an amount of money has been placed in the cash drawers to be spent within a 24-hour period or over a weekend for a specific purpose e.g. weekend leave, shopping trip.

Withdrawals of monies from the Cash Office should, as far as is practicably possible, have a specific purpose e.g. Clothing / Shoes / Personal Spend. Excess money above the agreed £250.00 limit for any individual should be lodged in their Private Property Account. This will be monitored by the Assistant Service Manager, as part of their monitoring visits.

A Cash Sheet ("Ledger") (Appendix 7) must be used on every ward for each patient. Each ledger should record:

- The date of the transaction
- Incomings
- Outgoings
- Expenditure Details
- Balance

The signature of the staff member adding / withdrawing funds to the individual cash drawers should be recorded and be countersigned by a second member of staff. These staff must assure themselves that balances are correct, any discrepancies are noted and adjusted. All signatures should be in full in black ink and should be legible. If the ledger is signed by one nurse and the patient or their family, a second staff member's signature is not required.

Cash held at ward level should be checked by two nurses at the start and end of each handover, preferably by one nurse coming on shift and one nurse going off shift. Any discrepancies should be referred to the Assistant Service Manager immediately for investigation.

5.4.2 Safe Keeping of Property

Any **new** belongings of significant value acquired during the patient's stay, even if not handed in for safekeeping, should be documented on the Patient's / Client Private Property Form (Appendix 8) e.g. laptops, smart phones, game consoles. This should be checked and recorded by two members of staff, one of whom must be a registered nurse on a quarterly basis or sooner if required.

When a member of staff accepts any item for a patient which is to be placed into a property drawer this is accepting responsibility for safe keeping of the item. All items must be recorded on the Property Record (Ledger) (Appendix 5). Any personal jewellery or other items must have a brief description recorded on the ledger, in non-value adding terms, where possible (e.g. yellow coloured metal, watch). Property Drawer contents and records must be checked on a weekly basis, or sooner if required, by two members of staff; one of whom should be a registered nurse.

5.4.3 Cash Withdrawal and Expenditure

Cash withdrawals will be limited to what has been agreed with or for each patient (based on capacity) on the Cash Withdrawal Limits section on the Financial Capacity Assessment (Appendix 1), however the amounts can be changed should a patient's circumstances change.

In the case of patients who are capacitous, flexibility must be provided for them to increase the amount on the Cash Withdrawal Limits section on the Financial Capacity Assessment (Appendix 1), should they request this. However, it is recommended that withdrawals are limited in order to keep the cash float in the Cash Office to a minimum and also to minimise cash held at ward level.

Cash will be issued up to the agreed amount on the Cash Withdrawal Limits section on the Financial Capacity Assessment (Appendix 1), but the Cash Office will contact the Ward Manager about exceptionally high withdrawal requests. A request for expenditure will be processed only after considering whether the patient has sufficient funds available. Accounts should never become overdrawn unless there are known arrangements in place to recoup the deficit.

Authorisation Levels

For patients who are incapable or temporarily incapable the ward manager can approve withdrawal up to the maximum amount as detailed in the Cash Withdrawal Limits section on the Financial Capacity Assessment (Appendix 1).
For amounts above the withdrawal limit the following authorisation is required:

Amount	Authorisation Level
Up to £250	Ward Manager
Up to £500	Assistant Services Manager
Up to £2,000	Service Manager
Up to £4,000	Co-Director
Above £4,000	Co – Director & Director

5.4.4 (a) Withdrawal Process

A patient deemed to be capable may withdraw their agreed limit of money, as set out in the Cash Withdrawal Limits section on the Financial Capacity Assessment (Appendix 1), using Withdrawal Form 1 (Appendix 10).

When money has been withdrawn from the Cash Office for a capacitous patient and is subsequently held on the ward, the Cash Sheet ("Ledger") (Appendix 7) must be completed. Thereafter, when monies are withdrawn from the ward by the capacitous patient, he / she must sign the Cash Sheet ("Ledger") (Appendix 7) as evidence of receipt of the monies.

A patient who is not deemed to be capable has access to their money using Patients Private Property Withdrawal Form 2 (Appendix 11). This form will be signed by two members of staff who must both be on the authorised signatory list for that ward. When the

money is returned to the ward, this must be documented on the Cash Sheet ("Ledger") (Appendix 7).

5.4.4 (b) Loyalty Cards

If staff are going to be involved in assisting patients with shopping, they must never use their own loyalty cards where patients' monies or Trust monies are being used. However, if the patient wishes to bring their own loyalty card/s on a shopping trip for their own usage, then they should be permitted to do so.

5.4.4 (c) Receipts for Expenditure

If the patient is capacitous in relation to handling their own money he / she should, where possible, sign the Cash Sheet ("Ledger") (Appendix 7) to evidence receipt of monies from the cash drawer. Capacitious patients do not need to keep their monies in the cash drawer however they can avail of this if they so wish. No receipts are required.

Where a patient is deemed to lack capacity, all receipts for expenditure should be attached to the Cash Sheet ("Ledger") (Appendix 7). If there are residual monies left after purchases, this should be documented on the Cash Sheet ("Ledger") (Appendix 7) and the monies placed back into the cash drawer.

Staff have a responsibility to ensure all expenditures are adequately receipted when making purchases on behalf of patients deemed to lack capacity. If receipts are not present at the time of the Assistant Service Manager Monthly Audit, an investigation should be commenced.

5.4.4 (d) Online Purchases

Staff are not permitted to make online purchases for goods on behalf of patients. Where possible and if the patient has capacity, an account with access to a debit card should be set up in the patient's own name or payment should be arranged by using a cheque following withdrawal request from the Cash Office.

5.4.5 Transaction and Fluctuation Reports

Cash Office Staff will issue a monthly transaction report to each Ward Manager which will detail all incoming monies and outgoing expenditure. This should be reviewed by the Ward Manager for any discrepancies and signed on the day that the report is reviewed, the Assistant Service Manager will audit this as part of their monthly checks.

Cash Office Staff will issue a monthly fluctuation report to the Assistant Service Manager for all patients within their respective wards who will view, sign and date the fluctuation report and report any discrepancies to the Service Manager for review.

5.4.6 Staff Signatures

Each ward will provide the Cash Office with a list of staff signatures on an annual basis. The Ward Managers must notify the Cash Office of any amendments to the list during the year. The Ward Manager must retain a list of these signatures. The Cash Office must only process transactions in line with the current Authorised Signatory List (Appendix 12).

5.5 Article 15 of the Health and Personal Social Services (NI) Order 1972

Article 15 gives provision for an extraordinary payment to be made to a patient in certain instances, and should be issued if the following circumstances arise:

- A patient has no access to their own money whilst in the Hospital and the Hospital cannot get access to their money via a third party, i.e. relative.
- A patient has no money and has no right to benefits, i.e. overseas patient.

- Failure to provide access to finances to a patient may cause them distress to such an extent that there is a risk of harm to self or others.

If any of the above applies, then the hospital Social Worker completes an Article 15 'ADHOC Payments for Clients not Receiving Regular Payments' form (Appendix 9) which must be signed by the relevant senior manager who is on duty (Assistant Service Manager). A staff member who is on the Authorised Signatory List (Appendix 12) can bring the Article 15 (Appendix 9) request to Cash Office and the money will be released. A copy of the Article 15 (Appendix 9) request will be retained by the Cash Office and this will be signed by the staff member who is receiving the money. If possible this money should be recouped from the patient when they get access to their own finances again.

Remand Prisoners who are admitted to a Learning Disability In-Patient Unit are entitled to £20/week. The Ward Manager should put in place the necessary arrangements to have this paid into a Patients Private Property Account for the patient for the duration that they remain on remand status.

5.6 Appointeeship for Benefits

Where a patient is in receipt of benefits, and lacks capacity, under Social Security Regulations, an Appointee can be appointed. A Corporate Appointee, such as the Trust, can be appointed. Where that authority is sought, documentation from the Social Security Agency should be requested as evidence. There is a responsibility to ensure that any change of circumstances is notified to the Social Security Office. The responsibility is only forward looking and is not retrospective in respect of any funds held by the patient prior to an appointeeship being made.

A reconciliation between notification of benefits received to benefit amounts actually received via the patients Private Property Accounts should be carried out by the Appointee and held in the Cash Office.

5.7 Article 116 Mental Health (Northern Ireland) Order 1986

The Trust can hold patient funds up to £20,000. Where the funds are greater than £20,000, the Trust can only hold those funds with the consent of the RQIA. It is necessary to proactively seek the consent of the RQIA.

5.8 Article 107 Mental Health (Northern Ireland) Order 1986

Under this provision, the Trust has a duty to notify the Office of Care and Protection where certain criteria are met. There is a procedure for application which involves medical evidence regarding capacity and an application form which requires specific proposals in relation to the patient funds. The court will appoint a controller who will normally be a family member. It will not be the Trust who will be appointed as Controller, but the Trust has a statutory duty to refer where the conditions of the provision are met.

5.9 Deceased Patients' Property

Nursing staff must not give property / cash directly to relatives.

Any property / cash belonging to deceased patients and held at ward level should be lodged in the Cash Office, using the Patients'/Clients' Private Property Receipt Book Form (Appendix 4). This avoids the possibility of issuing property to the wrong person. Property / Cash should be gathered, an inventory created and signed by two staff, one of whom should be a nurse.

Next of Kin should be informed that property / cash are being retained by the Cash Office until such times as the processes below have been completed;

- Letters of Administration are sent to the Next Of Kin by the Cash Office Staff where the patient's estate (including monies and property / valuables) is in excess of £10,000 and the administration is directed by the courts.
- Forms of Declaration are sent to the Next of Kin by the Cash Office staff where the patients' estate (includes property / cash) is less than £10,000. Upon receipt of these back to the Cash Office (signed by a family solicitor), the Cash Office Staff will then proceed to forward all monies to the Next of Kin.
- Once the Cash Office Staff are in possession of either of the above Letter of Administration or Form of Declaration, a copy will be forwarded to the Ward Manager who will notify the Next of Kin in respect of property / cash so that a decision can be reached with them in respect of disposal of said items. A record should be retained in the patients MDT Notes of any items disposed of, including clothing and equipment.

Both of the situations described above refer to patients where there is no known will – where there is the existence of a will, Grant of Probate must be applied for, and in such cases staff should follow the steps described above until the Grant of Probate is obtained.

5.10 Patient Property and Cash on a Trial Resettlement or Discharge

5.10.1 Trial Resettlement and Discharge

This only applies to patients who are deemed to lack capacity in relation to managing their own financial affairs, who are being resettled and ultimately discharged.

If a patient has capacity they will be supported by their key worker and the staff from their new accomadation to develop a personal budget and finance plan to assist them in managing their finances, with support agreed based on what is required.

5.10.2 Trial Resettlement

The Appointee can release the following, until such times as the patient is in receipt of all of the benefits they are entitled to living in the community:

- Rent for Supported Living, where relevant, and if the patient is eligible to pay, i.e. has more in their personal account than the threshold for payment allows.
- Daily Living Cost monies - the facility to which the patient is being resettled must request in writing from the Care Manager/Social Worker the amount that is required for the patient. The facility should as far as is practicable indicate why the monies are being requested.
- The Care Manager / Social Worker will sign the request and forward to Corporate Appointee for payment of a cheque to the facility. The Cash Office will forward the cheque to the facility. The cheque will have to be paid into the facility's business account as the patient will not have a personal account at this stage. Each facility will have a responsibility for ensuring that it has robust internal accounting procedures for patients' personal spend.
- A Financial Support Plan (Appendix 3) should be completed by the Community Key Worker / Community Placement.
- If a patient is on trial resettlement and additional monies are required for personal spend, this should be requested by the Community Social Worker via e-mail to the Cash Office. The Cash Office will then issue a cheque or a bank transfer to the appropriate bank account i.e. facilities bank account or the patient's personal bank account. The facility is responsible for ensuring safe keeping of receipts.
- Payment to other facilities for placements in Residential and Nursing accommodation. The Care Manager or in the absence of the Care Manager, the Social Worker, identifies the cost of the trial resettlement placement and forwards the finance form

(Commencement of Placement) (Appendix 13) which includes the cost of the placement and senior manager authorisation to the finance department.

- If a request for expenditure is significantly higher than was planned in the resettlement meeting, then Finance will require authorisation for the exceptional item of expenditure in line with authorisation levels noted in this policy.

5.10.3 Discharge

As part of the resettlement / discharge process, discharge planning meetings take place which consists of MDT discussions.

When BHSCT are Corporate Appointee Financial Planning should be discussed as part of the discharge planning meetings. The Financial Planning Meeting Template (Appendix 14) should be completed which will reflect discussions and agreements on any potential required spend to aid resettlement and enhance the patient's quality of life.

All inpatients can avail of financial planning discussions if they and / or their appointee wish.

If the patient is resettled on a permanent basis, the following should happen with immediate effect:

- Multi-Disciplinary Team to determine whether an OCP referral is required. If required, this referral should be completed by the Community Social Worker.
- At the discharge meeting a final
- agreement on the patient's financial capacity should be noted. This should be documented in the person's care plan and medical notes to ensure that there is timely referral to the Office of Care and Protection or release of patient's monies as appropriate.
- If appropriate, savings will be transferred to the relevant Trust.

5.11 Dissemination

This policy will be disseminated to all staff working within learning disability inpatient facilities as part of their induction and circulated to existing staff by email and discussed at team meetings

5.12 Resources

Nil

5.13 Exceptions

This Policy applies to adult learning disability inpatient facilities

6.0 MONITORING AND REVIEW

Cash held at ward level will be checked at each handover by two qualified nurses both of whom should be authorised signatories.

The ward manager/deputy ward manager will check once a week that the Cash Sheet (Ledger) (Appendix 7) for three randomly selected patients has been updated and that balances tally. Ward Manager / Deputy Ward Manager will sample a random receipt attached to the Cash Sheet ("Ledger") (Appendix 7) to check it corresponds with what is documented on the Cash Sheet ("Ledger") (Appendix 7); receipt will be initialled to evidence this check has taken place. Any discrepancies noted should be reported to the Assistant Service Manager for review.

The Assistant Service Manager will randomly select two patients, per ward, per month and complete the Monthly Patient Finance Monitor Report (Appendix 15). The Assistant Service Manager will also sign and date the Cash Sheet (Ledger) (Appendix 7). The Monthly Patient Finance Monitor Report should be filed in the patient's paper MDT notes and a copy sent to the Service Manager and Patient Finance Liaison Officer. Any discrepancies or issues noted should be reported to the Service Manager.

The Assistant Service Manager will review the monthly fluctuation reports for each of the wards for identification and investigation if required, of significant increase or decrease in Patient Private Property Account balances.

Each Ward Manager will review the monthly transaction reports, which detail income, expenditure and balance for each patient. The Ward Manager will sign as evidence of review and retain a copy at ward level and return a copy to the Cash Office.

External monitoring and auditing is provided through Internal Audits carried out by BSO and RQIA Finance Inspections.

RQIA

Internal Audit

7.0 EVIDENCE BASE / REFERENCES

This Policy has been developed following consultation with:

- Finance Staff
- Learning Disability Ward Managers
- Learning Disabiilty Assistant Service Managers
- Learning Disability Service Manager
- Learning Disability Co-Director
- Directorate of Legal Services (Guide on Law)

12.0 APPENDICES

Appendix 1:	LD Financial Capacity Assessment
Appendix 2:	Financial Support Agreement
Appendix 3:	Financial Support Plan
Appendix 4:	Patients'/Clients' Private Property Receipt Book
Appendix 5:	Property Record (Ledger)
Appendix 6:	Patients Private Property Label
Appendix 7:	Cash Sheet ("Ledger")
Appendix 8:	Patients' / Clients Private Property
Appendix 9:	Article 15
Appendix 10:	Withdrawal Form 1
Appendix 11:	Patients' Private Property Withdrawal Form 2
Appendix 12:	Authorised Signatory List
Appendix 13:	Commencement of Placement
Appendix 14:	Financial Planning Meeting
Appendix 15:	Monthly Patient Finance Monitor Report

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Patients' Finances and Private Property – Policy for Adult Inpatients within Learning Disability Hospitals** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to

ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

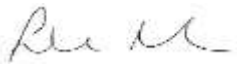
Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).



03/10/2021

_____ **Date:** _____

Authors

03/10/2021

_____ **Date:** _____

Director

Appendices 1

Ld Financial Capacity Ass

	Born	HCN
Preferred Name	Gender	Paris ID
Address		Contact

Key

Section A: To assess mathematical capability.

Level 1: Has no numeracy skill and cannot count.
Level 2: Has some numeracy skill but no understanding of the concept of money, e.g. does not recognise the different values
Level 3: Can count money in coins and notes up to the value of around £10.00.
Level 4: Performs basic additions and subtractions using coins and notes.
Level 5: Can perform all calculations necessary for dealing with own finances and can perform them in practical situations,

Section B: To assess understanding of value of money.

Level 1: Has no awareness of the value of money, e.g. does not understand that it is used to buy things.
Level 2: Understands that money may be used to buy things but has no understanding of how much money is worth in terms of purchasing individual goods/service, etc.
Level 3: Can relate the cost of goods/services to the amount that needs to be paid in money.
Level 4: Can tell the difference between expensive and inexpensive goods when out shopping. Level 5: Fully understands the importance and value of money.

Section C: To assess financial vulnerability in terms of theft and /or deception.

Level 1: Would not understand or would not be able to communicate if financial abuse is taking place.
Level 2: Would be easily manipulated or 'conned' into parting with money.
Level 3: Understands that other people may want to take their money away from them and so shows some evidence of Level 4: Takes steps towards protecting their money and would know and be able to communicate if they had been the Level 5: Protects their finances from abuse.

Section D: To assess understanding of 'abstract' money issues, e.g. bank accounts/benefit books/cheque books etc.

Level 1: Has no concept that items such as benefit book/cheques, etc. may have financial value. Has no concept of debt. Level 2: Has basic knowledge for 'abstract' monies, e.g. knows that their money may be kept in a bank account or post office of the basic systems used to withdraw/put in cash and has no awareness of personal funds/benefit amounts due to Level 3: Understands the systems used for accounts/post office withdrawals, etc. and can relate bank statements/benefit but would not recognise discrepancies in forms/system/procedures and understand the consequences of debt. some discrepancies within the abstract money systems relevant to them.
Level 4: Has good knowledge of abstract money systems/procedures and understands the consequence of debt. Would some discrepancies within the abstract money systems relevant to them.
Level 5: Has full understanding of the banking systems, benefits, consequences of debt, loans, overdrafts, etc. Would and would be able to communicate this information to the relevant parties.

Financial Capability Assessment

For each section give the person a score of 1-5 depending on which level you think best describes their ability, e.g. for Level 1 award 1 point.

Section A score

Section B score

Section C score

Section D score

Total score

A score of less than 12 -14 (out of a maximum of 20) would indicate an individual needs significant help with their finances

Summary Of Assessment:

Section A

Section B

Section C

Section D

Conclusion

Ld Financial Capacity Ass

	Born	HCN
Preferred Name	Gender	Paris ID
Address		Contact

Select Capability

Select Financial

Capable Patient

Nurse name Dat

Nurse name (2) Date

Medical Officer

Name Date

I agree to a maximum withdrawal limit of £ per week.

I will give one week's notice in writing to the cash office if I wish to withdraw more than this limit.

Patient name ☐ Date

Ld Financial Capacity Ass

	Born	HCN
Preferred Name	Gender Male	Paris ID
Address		Contact

Select Capability

Select Financial Capability

Incapable Patient

The above patient lacks capacity in relation to managing their finances due to an impairment of, or a disturbance in the functioning of, the mind or brain. They are unable to make financial decisions free from undue influence. This opinion is based on the best evidence and information available at the time of signing.

This is a permanent feature of their condition.

Staff may withdraw up to £250.00 per week. Amounts above this need to be processed through the normal authorisation

Medical Officer

Name Date

Ld Financial Capacity Ass

	Born	HCN
Preferred Name	Gender Female	Paris ID
Address		Contact

Select Capability

Select Financial Capability

Temporarily Incapable Patient

The above patient lacks capacity in relation to managing their finances due to an impairment of, or a disturbance in the functioning of, the mind or brain. They are unable to make financial decisions free from undue influence. This opinion is based on the best evidence and information available at the time of signing.
This situation may change with treatment and should be reviewed in

Staff may withdraw up to £250.00 per week. Amounts above this need to be processed through the normal authorisation process.

Nurse name (1) Date

Nurse name (2) Date

Medical Officer

Name Date

Appendice 2

Belfast Health and Social Care Trust
caring supporting improving together

Financial Support Agreement

This financial support plan should be read in conjunction with _____ care and support plans.

1. Service Users Details	
Service User Name	
Service Name	
Address	
DOB	
Key Worker Name	
Manager Name	
Senior Manager Name	

2. Current Arrangements to assist the service user in the management of services users finances • ***This should detail the support required*** • ***How this support will be delivered***

3. Human Rights Considerations / Financial Capacity
Human Rights Consideration   "BHSCT(BHSCT) aspires to be known as one of the safest, most effective and compassionate health and social care organisations and staff deliver services in accordance with this goal. In line with our Trust values to treat everyone with respect and dignity Belfast Trust is committed to the safeguarding and promotion of Equality, Good Relations and Human Rights in all aspects of its work.   This Financial Support Agreement (FSA) has been Equality Screened in terms of Equality and Good Relations in accordance with our Section 75 duties and in terms of our obligations under the Human Rights Act 1998.   Support staff will make every effort to ensure that respect for equality of opportunity, good relations and human rights, is part of their day to day work and is incorporated and reflected as an integral part of actions and decision making processes.   Support staff, when assisting ---------- (service user name) with the management of his/her finances must always consider the need to promote Equality of Opportunity, Good Relations and Human Rights whilst offering an appropriate level of support with financial management.   Details of this support is outlined in section 6 of this document and this FSA should be reviewed at least annually."

4.	Please name the staff who will be assisting the service user to manage their finances (minimum of two and maximum of four names)

5.		**Income Sources** ***a) The benefits which I am entitled to are paid directly to me for my personal use.*** ***b) The BHSCT provide my care and support. This is paid from the Supported Housing budget. I do not pay for any care or support provided.***	
		Weekly/monthly *Please state*	£
	Supporting People –*This money is paid from the NIHE directly to the BHSCT to pay for my housing support*		£
	Salary		£
	State Pension		£
	Pension Credit		£
	PIP – Care Component		£
	PIP – Mobility Component		£
	Income Support		£
	Incapacity Benefit		£
	Employment & Support Allowance/Job Seekers Allowance		£
	Housing Benefit – *paid directly by NIHE to landlord*		£
	SDA		£
	Other		£
	TOTAL		£

6.	**Anticipated Weekly/Monthly Expenditure** ***a) If utility bills are paid in equal amounts by each tenant when the bill is received this should be noted.*** ***b) Please note if any of these bills are paid by direct debit.***	
	Amount Per Week	**Amount Per Month**
Supporting People - *This money is paid from the NIHE directly to the BHSCT to pay for my housing support*	£	£
Electricity	£	£
Gas/Oil	£	£
Rent/Rates –*paid directly by NIHE to landlord*	£	£
TV Licence Fee	£	£
Sky TV	£	£
House Insurance	£	£
Groceries	£	£
Telephone	£	£
Care Line	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending	£	£
Gardener	£	£
Window Cleaner	£	£
House Cleaner	£	£
Launderette	£	£
Taxi's	£	£
Social outings-(Meals, transport etc.)	£	£
Other-(Clothes)	£	£
TOTAL	£	£

7.	**Savings (if relevant)**
	Name of Bank/Post Office Account Address of Bank/Post Office Account Account Number Lodgement Arrangements (e.g. post/in branch/lodgement slips) Withdrawal Arrangements (e.g. cash card/pass book etc.) Current savings on (Date) Amount

8.	Banking Management (Currents Accounts) (if relevant)

Name of Bank/Post Office Account _____

Address of Bank/Post Office Account _____

Account Number _____

ATM Debit Card ☐Yes ☐No

Pass Book ☐Yes ☐No

Cash Card/Pass Book
Where is this held? _____

Who has access to it? _____

Pin Number *The pin number must be stored separately from debit card*
Details to be kept in safe on Trust premises and locked cash box in users home

Who has access to it? _____

9.	Cash Box Arrangements (if relevant)

Where is the cash box held? _____

Who holds the key? _____

Where is the key kept? _____

Who has access to the key? _____

10.	Monitoring

The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.

Signatures:	
Family Member/NOK:	**Date:**
Manager:	**Date:**
Social Worker:	**Date:**

This Financial Support Agreement has been discussed and shared with me and I am in agreement with it. ☐

Service Users signature: _____

Social Worker / Ward Manager signature _____

Date: _____

Appendices 3 Financial Support Plan

Belfast Health and Social Care Trust
caring supporting improving together

Financial Support Plan

This plan is to be used with service users who lack financial capacity and require an appointee
This financial support plan should be read in conjunction with ---------- care and support plans.

1. Service Users Details	
Service User Name	
Service Name	
Address	
DOB	
Key Worker Name	
Manager Name	
Senior Manager Name	

3. Human Rights Considerations / Financial Capacity

Human Rights Consideration

BHSCT(BHSCT) aspires to be known as one of the safest, most effective and compassionate health and social care organisations and staff deliver services in accordance with this goal. In line with our Trust values to treat everyone with respect and dignity Belfast Trust is committed to the safeguarding and promotion of Equality, Good Relations and Human Rights in all aspects of its work.

This Financial Support Agreement (FSA) has been Equality Screened in terms of Equality and Good Relations in accordance with our Section 75 duties and in terms of our obligations under the Human Rights Act 1998.

Support staff will make every effort to ensure that respect for equality of opportunity, good relations and human rights, is part of their day to day work and is incorporated and reflected as an integral part of actions and decision making processes.

Support staff, when assisting ---------- (service user name) with the management of his/her finances must always consider the need to promote Equality of Opportunity, Good Relations and Human Rights whilst offering an appropriate level of support with financial management.

Details of this support is outlined in section 6 of this document and this FSA should be reviewed at least annually."

4. What Financial Support is required

Opening of a bank/post office account (Please detail suggested bank/branch and if cheque book/ cash card required etc.) ☐

Management of a current bank/post office account (withdrawals/lodgements) ☐

Opening a savings account (Please detail suggested bank/branch/type of account, access/cash card required etc.) ☐

Management of a savings account (including making withdrawals/lodgements) ☐

Spending service users' money on their behalf ☐

5. Authority

- ***This should detail any authority and powers granted***

6. Appointeeship Details if Relevant
Rationale for appointeeship: Name of Appointee: Address of Appointee: Date Appointeeship Granted:

7. Please name the staff who will be managing the person's finances (minimum of two and a maximum of four names)

8.		**Income Sources** ***c) The benefits which I am entitled to are paid directly to me for my personal use.*** ***d) The BHSCT provide my care and support. This is paid from the Supported Housing budget. I do not pay for any care or support provided.***		
			Weekly/monthly *Please state*	£

	Supporting People –*This money is paid from the NIHE directly to the BHSCT to pay for my housing support*		£
	Salary		£
	State Pension		£
	Pension Credit		£
	Personal Independence Payment (PIP) – Care Component		£
	Personal Independence Payment (PIP) – Mobility Component		£
	Income Support		£
	Incapacity Benefit		£
	Job Seekers Allowance		£
	Housing Benefit – *paid directly by NIHE to landlord*		£
	SDA		£
	Employment & Support Allowance		£
	Other		£
	TOTAL		£

9. Anticipated Weekly/Monthly Expenditure

c) If utility bills are paid in equal amounts by each tenant when the bill is received this should be noted.

d) Please note if any of these bills are paid by direct debit.

	Amount Per Week	**Amount Per Month**
Supporting People - *This money is paid from the NIHE directly to the BHSCT to pay for my housing support*	£	£
Electricity	£	£
Gas/Oil	£	£
Rent/Rates –*paid directly by NIHE to landlord*	£	£
TV Licence Fee	£	£

Sky TV	£	£
House Insurance	£	£
Groceries	£	£
Telephone	£	£
Care Line	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending	£	£
Gardener	£	£
Window Cleaner	£	£
House Cleaner	£	£
Launderette	£	£
Taxi's	£	£
Clothes	£	£
Other- Leisure etc. Social Outings- (meals)	£	£
TOTAL	£	£

10. Savings (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

Lodgement Arrangements (e.g. post/in branch/lodgement slips)

Withdrawal Arrangements (e.g. cash card/pass book etc.)

Current savings on (Date) Amount _____

11. Banking Management (Currents Accounts) (if relevant)

Name of Bank/Post Office Account _____

Address of Bank/Post Office Account _____

Account Number _____

ATM Debit Card ☐Yes ☐No

Pass Book ☐Yes ☐No

Cash Card/Pass Book
Where is this held? _____

Who has access to it? _____

Pin Number *The pin number must be stored separately from debit card*
Details to be kept in safe on Trust premises and locked cash box in users home

Who has access to it? _____

12.	Cash Box/Safe Arrangements (if relevant)	
	Where is the cash box/ money wallet held?	
	Who holds the key/safe code?	
	Where is the key kept?	
	Who has access to the key/safe code?	

13. Monitoring

The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.

Signatures:	
Family Member/NOK:	**Date:**
Manager:	**Date:**
Social Worker:	**Date:**
Ward Manager:	**Date:**

This Financial Support Plan has been discussed and shared with me and I am in agreement with it. ☐

Service Users signature: _____

Date: _____

Appendices 4 Receipt book

PATIENTS' CLIENTS' PRIVATE PROPERTY

RECEIPT BOOK

PATIENT NAME _____ WARD/FACILITY _____

PATIENT NUMBER _____ DATE ADMITTED _____

PATIENT ADDRESS _____

_____

_____

	DETAILS
CASH	
OTHER VALUABLES *Including:* BANK BOOKS/CARDS CHEQUE BOOKS BENEFIT BOOKS JEWELLERY N.B Account numbers should not be recorded on this form.	

The details of my property as recorded above are correct. I understand that any cash handed over for safe custody will be returned in the form of a cheque. I understand that any articles retained in my possession are my own responsibility and that the Belfast Health & Social Care Trust will not accept liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt is not obtained.

PATIENT / CLIENT / NEXT of KIN SIGNATURE _____ DATE / / 20___

Witnessed, checked and received by:

STAFF SIGNATURE 1 _____ DATE / / 20___

STAFF SIGNATURE 2 _____ DATE / / 20___

Registered Nurse

CASH AND VALUABLES RETURNED TO PATIENT CLIENT

PATIENT / CLIENT / NEXT of KIN SIGNATURE _____ DATE / / 20___

Witnessed by:

STAFF SIGNATURE 1 _____ DATE / / 20___

TO BE COMPLETED BY CASH OFFICE

I ACKNOWLEDGE RECEIPT OF THE PROPERTY AS DETAILED

CASH HAS BEEN LODGED TO PPP ACCOUNT _____

Appendices 5 Property Ledger

Name of Patient / Client

Name of Ward / Facility

DATE	TIME	PROPERTY DETAILS	IN (✓)	OUT (✓)	STAFF SIGNATURE 1	STAFF SIGNATURE 2	COMMENTS

Belfast Health and Social Care Trust
caring supporting improving together

Appendices 6 Envelope Label

PATIENTS' PRIVATE PROPERTY LABEL

Receipt Reference Number:

Date: _____ Patient Name: _____

Ward/
Facility: _____

Counted By: _____ Checked By: _____

Contents:

MONEY	JEWELLERY	OTHER VALUABLES

Cash Office Use:
Sign and date to reflect agreement that above detailed items are placed in envelope.

Date: _____ ***Signature:*** _____

Date: _____ ***Signature:*** _____

Belfast Health and Social Care Trust
caring supporting improving together

Cash Sheet

Month: **Account No:** **Patient Name:**

Appendices 7 - Balance Forward:

Date	Incomings	Outgoings	Expenditure Details	Balance	PPA No(s) & Receipt No(s)	Signature 1	Signature 2	Weekly / Monthly Audit

Belfast Health and Social Care Trust

Appendices 8

PATIENTS/CLIENTS PRIVATE PROPERTY

HOSPITAL: _____ WARD/FACILITY: _____

PATIENT NAME: _____ HOSPITAL NUMBER: _____

DATE: _____ TIME: _____

Reason for Completion (please circle) Admission /Transfer / Discharge / New Purchase / Other (_____)

Please List Property below:

I understand that any property retained in my possession are my own responsibility and that The Belfast Health & Social Care Trust will not accept

PLEASE PRINT USING BLOCK CAPITALS

liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt is not obtained.

Patient / Client Signature: _____

Staff Signature 1: _____

Staff Signature 2: _____

Appendices 9

ADHOC (ONE-OFF) PAYMENTS FOR CLIENTS NOT RECEIVING REGULAR PAYMENTS

ADHOC (ONE-OFF) PAYMENTS FOR CLIENTS NOT RECEIVING REGULAR PAYMENTS

To **PATIENTS BANK**

From ***(FACILITY DETAILS)* – WARD DETAILS:**

Please Pay: £	**BACS** ☐	**Uncrossed cheque** ☐	**Crossed cheque** ☐	**Petty Cash** ☐
Payee:			**Food voucher No.**	
Payee Address:				
Subject to recovery Y N ☐ ☐ **ALREADY PAID TO PATIENT IN CASH –** **RE-IMBURSEMENT TO PATIENTS BANK** ☐		**Cost Centre Code**		

Client Name:	**In Respect Of (Name):**	**DOB**
Client's Address:		
Other Surnames:		
PARIS No		

Section Of Order	**Purpose Of Assistance**	**Precipitating Factors**	
Article 15 700B2200 ☐ Reason for Assistance:	Patient has no access to their own money whilst in the Hospital and the Hospital cannot get access to their money via a third party (i.e. relative). ☐	Benefit Delayed / Lost Income support/Disability Working Allowance/Recoverable (delete as applicable) ☐	
	If Patient does not get access to finances their behaviour could cause an adverse incident to occur. ☐		
Asylum Seekers ☐ **700B2290** Reason for Assistance:	Other: Patient has no money and has no right to benefits (i.e. overseas patient).	Lost Pension Book ☐	

Article 15 Purpose For Assistance		
Personal Expenditure **700B2210** ☐	Clothing **700B2260** ☐	

Authorisation and Patient Signature	
Social Worker:	Signature:
Charge Nurse/Ward Sister:	Signature:
Patients Name	Authorised by ASM/Operations Manager:
Signature:	Signature:

COPIES TO BE RETAINED BY PATIENTS BANK AND ON PATIENTS FILE

Appendice 10

Belfast Health and Social Care Trust

PATIENTS' PRIVATE PROPERTY
WITHDRAWAL FORM 1

NAME OF PATIENT	
WARD/FACILITY	
PATIENT NUMBER	

ACCOUNT NUMBER		AMOUNT	£ :

PLEASE WRITE THE AMOUNT IN WORDS HERE

DETAILS OF EXPENDITURE:

PATIENT SIGNATURE _____ STAFF SIGNATURE _____

DATE _____ DATE _____

TO BE COMPLETED BY

SIGNATURE _____

DATE _____ TRANSACTION # [ ]

Appendice 11

Belfast Health and Social Care Trust

PATIENTS' PRIVATE PROPERTY
WITHDRAWAL FORM 2

WARD/FACILITY	
DATE	

PATIENT NAME	A/C NUMBER	AMOUNT REQUESTED	SPECIFIC PURPOSE	TRANSACTION # (USE)
TOTAL			AMOUNT TO BE WRITTEN IN WORDS	

REQUESTED BY _____

APPROVED BY _____

TO BE COLLECTED BY _____

AUTHORISED SIGNATURE REQUIRED

CHEQUE SHOULD BE MADE PAYABLE TO: _____

Appendice 12

AUTHORISED SIGNATORY LIST TEMPLATE

WARD:			
NAME OF STAFF	GRADE	SIGNATURE	DATE

Appendice 13

Belfast Health and Social Care Trust

COMMENCEMENT OF PLACEMENT FORM

Client Name:			
Address :			
Post Code:		Telephone No:	
Nat. Insurance No:		Date of Birth:	

Care Manager:		Cost Centre/ICT:	A5U160

1.Date of Admission:		NB. If client is currently in hospital state date of admission:
1a. Date of Discharge		Or if client has been in hospital in preceding 28 days give dates:

2. Type of Admission:	Respite	3. Programme of Care:	Learning Disability

4. Care Home Details:	Name:
	Address: Tel No:

5. Gross Cost of Placement:	£

6. Third Party Top-Up Amount: If Gross Cost of placement is in excess of Regional Rate			£	
	Name & Address of Third Party:			
Post Code:			Telephone:	
Has Third Party Undertaking to Pay form been signed and is attached?:				
How does the Third Party wish to pay the Third party Top-up?			Direct Debit ☐	Invoice ☐

Representative					
Address:					
Post Code:		Telephone:		Email	

Please ensure that this person has knowledge of client's finances and the contact details are correct.

Has the Client/Representative been given the Information Pack?	
Has request been made for the assessment of HPSS nursing contribution and do you wish £100 to be paid to home?	

Please provide any additional information that Finance staff should be aware of when visiting representative / client: _____

Once the form has been completed please forward by Email to : CareHomeAdmissions

Appendice 14

Belfast HSC Trust – Muckamore Abbey Hospital

Financial Planning Meeting

Date of Meeting:

Patient Name:_____ Patient DOB:_____

Patient Paris ID: _____ Financial Capacity: YES / NO

Appointee: TRUST / FAMILY / OCP appointee Current financial balance:_____

Attendees and Apologies:	
Summary of Discussion **To include:** *Benefit check *Current Identified needs *Resettlement plans and associated spend *Quality of life considerations	

Consent / Need for benefit review Will Funeral Plan	
Actions by whom and by when	
Date of next financial planning meeting	

Appendice 15

Monthly Patient Finance Monitor Report

Completed by: **Title:**

Date: **Ward:**

Patient Name:

1. **Does the balance on cash sheet match balance in cash drawer?**
   Yes / No

2. **Are there two signatures recorded on cash sheet for every transaction?**
   Yes / No

3. **Do the receipts match the spend recorded on the cash sheet?**
   Yes / No

4. **Is it evident from the cash sheet that ward managers are completing weekly audit checks?**
   Yes/ No

5. **Has the ward manager initialled a receipt as part of their audit?**
   Yes / No

6. **Is it evident that cash drawers are being checked at each handover including 2 nurse in charge signatures?**
   Yes/ No

Please ensure ASM sign cash sheet evidencing ASM Monthly audit took place.

Any Issues / Comments:

1	
2	
3	
4	
5	
6	

Appendice 16

Monthly Patient Property Monitor Report

Completed by: **Title:**

Date: **Ward:**

Patient Name:

Does the property in the drawer match what's documented on the property sheet?
Yes / No

Are there two signatures recorded on property sheet for every transaction?
Yes / No

Is it evident from the property sheet that ward managers are completing weekly audit checks?
Yes/ No

Any Issues / Comments:

Belfast Health and Social Care Trust
caring supporting improving together

Policy Code: BHSCT/ASPC/MH (10) 2022

Title:	**Patients' Finances and Private Property – Policy for Inpatients within Mental Health Hospitals**			
Policy Author(s)	Kerry McVeigh, Principle Social Worker (Mental Health) Tel: [redacted] Orla Tierney, Divisional Nurse (Mental Health & Elderly Care) Tel: [redacted] Jonathon Killough, Assistant Services Manager (AMHIC) Tel: [redacted] Carrie Cruikshank, Team Leader (AMHIC) Tel: [redacted] Ann McDonald, Senior Professional Nurse lead (Mental Health) Tel: [redacted] Noel Burke, Charge Nurse (AMHIC) Tel: [redacted] Eugene McNulty, Senior Social Work Practitioner (Shannon Clinic) Tel: [redacted]			
Responsible Director:	Moira Kearney, Director of Mental Health and Intellectual Disability			
Policy Type: (tick as appropriate)	*Directorate Specific ☒	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐	
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**				
MH Governance Committee	21/03/2022			
Approval process:	Standards and Guidelines Committee Executive Team Meeting		**Approval date:**	07/06/2022 09/06/2022
Operational Date:	June 2022		**Review Date:**	June 2027
Version No.	1	**Supercedes**	New policy	
Key Words:	Mental Health Finance, Private Property, Inpatients, Hospital			
Links to other policies	BHSCT/PtCtCare (01) 2021 Management of Patient's handed in property BHSCT/PPI (02) 2021 Records Retention and Disposal Policy BHSCT Records Management Policy (2018) TP 13/08 BHSCT/ASPC/MH (01) 2021 Search of Patients, their Belongings and Environment of Care with Adult MH and LD Inpatient facilities (excluding CAMHS and Iveagh) BHSCT Financial Procedures for Care Home Admission (Draft)			

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

All staff have a responsibility to ensure that patients' finances and private property are safeguarded and that their money is used in a way which reflects their wishes as appropriate and is in keeping with their treatment or person-centred plan.

1.2 Purpose

This policy provides staff with guidelines regarding the handling of patients' finances and private property across the Belfast Health and Social Care Trust in Mental Health Wards.

This policy should be read in conjunction with:

- BHSCT/PtCtCare (01) 2021 Management of Patient's handed in property
- BHSCT/PPI (02) 2021 Records Retention and Disposal Policy
- BHSCT Records Management Policy (2018) TP 13/08
- BHSCT/ASPC/MH (01) 2021 Search of Patients, their Belongings and Environment of Care with Adult MH and LD Inpatient facilities (excluding CAMHS and Iveagh)

1.3 Objectives

This document aims to:

- Establish clear guidance for staff in relation to the handling of patients' finances and private property;
- Safeguard the interests of patients;
- Guide and protect staff when dealing with patients' finances and private property.

2.0 SCOPE OF THE POLICY

This policy applies to all patients in a Mental Health Inpatient Ward and to all staff working within inpatient Mental Health Services within the Belfast Health and Social Care Trust.

3.0 ROLES AND RESPONSIBILITIES

3.1 Service Managers

Service Managers are responsible for Inpatient Wards within Mental Health. They must ensure that this Policy and its Procedures are disseminated to all staff and implemented.

As required, Service Managers / Co-Directors, in conjunction with Corporate Appointee, can commission independent benefits advice to be made available to patients and/or their families to ensure patients are in receipt of optimum benefit entitlement.

3.2 Assistant Service Manager

ASM's are responsible for Inpatient Wards within Mental Health and must ensure that:

- Staff are aware of the Management of Patients' Finances and Private Property Policy and Procedures;
- They provide staff with training and guidance regarding the implementation of this policy;
- Monitor the implementation of the Policy and Procedures within their service area.

3.3 Charge Nurses/Ward Sisters

Charge Nurses/Ward Sisters responsible for a Mental Health Inpatient Ward must ensure that:

- The Policy and its procedures are made available to all staff;
- Staff have an understanding of the policy and its procedures and have completed the policy template confirming this;
- This policy is fully implemented within their area of responsibility;
- This policy forms part of the ward's local induction;
- Any updates or issues arising in relation to this policy are discussed at ward meetings or supervision sessions;
- Any issues not resolved should be escalated to their line management;
- Patient monies held by the Trust are actively managed in the best interests of the individual patient.

3.4 Community Social Worker

- It is the responsibility of the patient's community Social Worker/Care Manager, on admission and discharge, to ensure that the patient is receiving all benefits that they are entitled to – this can be done in conjunction with the Benefits Advice Officer at the Social Security Agency.

  If the person is not yet known to community services, this will be undertaken by the hospital Social Worker.

3.5 Hospital Social Worker

- It is the responsibility of the patient's hospital Social Worker/Key Worker to ensure, on a continuing basis while in hospital, that the patient is receiving the benefits they are entitled to. This can be done in conjunction with the Trust's Patient Finance Liaison Officer and the Appointee. The hospital Social Worker should liaise with the Community Key Worker and keep them updated of any developments.

3.6 Appointee

- Ensure appropriate documentation is in place and retained to confirm appointeeship for relevant patients.
- Communicate with Social Security Agency regarding patient savings and change of circumstances which may impact on Benefits entitlement.
- Reconciliation of Benefits between entitlements and amounts received via Patients Private Property Accounts.

3.7 Patient Finance Manager/ Corporate Appointee

- In conjunction with the Hospital Social Worker and / or Benefits Agency, ensure that patients without capacity are receiving all benefits they are entitled to.
- Ensure that long term patients for whom we manage their monies, have funeral plans and Wills in place as appropriate.
- Ensure that patient finances are pro-actively managed to meet or enhance patients' needs via a Financial Support Plan. Ensure that where there are any disagreements with the appointee in regard to payments, that this is escalated immediately to the MDT and an urgent MDT/Care Management review is held.
- The Care Manager should ensure that, where a declaration of means is to be signed by the appointee, that they understand this role and all information requested in relation to the patient's finances are provided as required. Where information is requested and not provided, this should be escalated to the Care Manager/Key Worker and Finance Manager immediately.

3.8 Finance

- Safeguard the security and optimum return of monies deposited to Patients' Private Property Accounts including the use of interest bearing bank accounts where appropriate.
- Ensure that an individual computerised financial ledger is accurately maintained for each patient for whom the Trust holds monies.
- Issue Transaction and Fluctuation Reports to relevant managers for monitoring purposes.
- Report balances held in respect of all patient's to RQIA on a quarterly basis.
- Seek permission from RQIA when a patient's balance is approaching £20k for the Trust to continue to hold and manage these funds.

3.9 Staff Member

- All staff have a responsibility to ensure that finances and private property held by the Trust are safeguarded for all patients, while they are on the ward.
- If a staff member has any concerns regarding the way in which a patient's money is being used, they should immediately inform the Ward sister/Charge nurse or Assistant Service Manager.
- Where the patient lacks capacity to understand their affairs, staff must ensure that all purchases on their behalf are appropriate for their needs and individual to them in keeping with their treatment or person-centred plan.

4.0 CONSULTATION

Consultation took place with;

- Mental health key stakeholders
- Professional leads
- Senior management team
- Service user consultant and advocacy representatives
- Finance Dept.

5.0 POLICY STATEMENT/IMPLEMENTATION

Key Policy Statements

The Trust will support patient's as far as possible to be involved in the management of their finances and private property through the use of accessible and inclusive communication, where necessary reasonable adjustements will be made to support this.

Where possible, patients will be able to go out of hospital to make their purchases.

Staff will not ask for or have access to a patient's PIN number for their bank cards.

No patient should be purchasing items from their own finances which should be provided by Public Funds (e.g. essential food items, standard furniture etc.).

The Trust has legislative authority to manage individual patient finances up to £20k and in consideration of the Mental Capacity Act (NI) (2016). Above this limit, permission must be sought from RQIA to retain the balances.

The Trust will actively manage patient monies, where appropriate, in the best interests of the individual and make referrals to the Office of Care and Protection (OCP) as appropriate.

All patients' finance records must be retained for a seven year period.

5.1 Patient Property and Cash on Admission to Hospital

Patient admission

- Patients and next-of-kin should be given information at point of admission not to keep items of value or money in hospital.
- All belongings must be kept in patient's own room as minimal storage is available on wards.
- Patients should be informed of the patient property policy on admission and encouraged to send non-essential items and valuables home for safekeeping. Only a small amount of money should be kept for personal use.
- Patients should be advised that all property retained by themselves or next-of-kin on admission are at their own risk.
- For patients who lack financial capacity, family members will be asked to bring their belongings home until such a time as they have capacity to care for their own belongings.
- If a patient is admitted with their own personal mobility equipment aids such as walking frames, crutches, wheelchairs etc, these should be labelled with the patient's name and details. This equipment should be available for the patient's use and transferred or discharged with the patient.

- The ward Manager to ensure patient or next of kin will be contacted within one month of discharge if property is not collected. This conversation will be recorded on Paris. Any property left on the ward will be disposed of in an appropriate manner if not collected within one month of this conversation unless there are extenuating circumstances.
- All patient property should be stored in strong brown paper bags/sacks and clearly marked with patient's name and ward. Disposable household wastebags are not to be used for storing patients' belongings.

5.1.1 Patients' Property and Money

When a patient is admitted to hospital, they may have with them:

- Items of value/property;
- Money
- Bank cards (Note: under no circumstances should staff ask or allow a patient to make known the PIN Number of such bank cards);
- Loyalty cards.
- Smartphones/ tablets that enable access to making payments.

In the instance of this occurring, capacitous patients should be advised to keep these belongings at home.

If they choose to keep them in person, they do so at their own risk, but will be encouraged to keep them in a safe place.

For patients who do not have capacity, cash will be lodged in the drop-safe.

Bank cards are not to be stored in the Ward office. If the patient is deemed capable, they are responsible for the security of their own Bank card, or they may choose to send their card home with family members. Incapable patients' Bank cards must be kept secure in the cash office and not on the Ward.

Note: This section does not relate to clothes or items of low value which may remain with the patient during their admission.

The pre-numbered Patients' / Clients' Private Property Receipt Book form (Appendix 3) should be completed where cash and / or property is to be lodged to the Cash Office. The patient should sign and date the form when completed, as appropriate. Where the patient is not capable of signing the form, a relative may sign on their behalf. The form should then be signed, dated and witnessed by two members of staff, one of whom should be a Registered nurse. The top copy of the form should be given to the patient (or relative where appropriate). Staff must also reflect these transactions on the Property Record (Ledger) (Appendix 4).

Staff must place the money and / or property in a pre-addressed Patient Property envelope.

- The Patients' / Clients' Private Property Receipt Book form (Appendix 3) form should be brought to the Cash Office still attached to the Patients' / Clients' Private Property Receipt Book and brought along with the property in the designated envelope.
- Ward Staff and Cash Office Staff will check and agree the contents of each envelope when it arrives in the Cash Office and will both sign the envelope to validate each other's agreement to the contents.
- The Cash Office will sign and date the bottom of the form, acknowledging receipt of the property. The Cash Office will then take the second copy of the form for their records. The third copy of the form should be retained in the Patients' / Clients' Private Property Receipt Book (Appendix 3) permanently as this is the ward's permanent record. The process should be repeated when patient's property is being removed from the Cash Office for return to the patient.

Staff should take cognisance of the following when completing the Patients'/ Clients' Private Property Receipt Book form (Appendix 3):

- Tippex must not be used when making alterations to the form – all alterations must be made with black ink and signed by the person making the change.
- Jewellery and any other valuables should be described in non-value adding terms, for example, white/yellow coloured metal with white stone rather than silver/gold with diamond.
- Forms must not be removed from the book if an error is made. In such cases forms should be cancelled with two diagonal lines across the form with "cancelled" in between and a new form should then be started.

5.1.2 Patient's Property and Cash not being lodged to Cash Office on Admission

For a patient's who may lack capacity or deemed to lack capacity, any cash in the patient's possession on admission that is not to be lodged to the Cash Office, should be entered onto a Cash Sheet ("Ledger") form (Appendix 1).

Any property in a patient's possession on admission that is not to be lodged to the Cash Office should be entered onto a Patients' / Clients Private Property List (Appendix 5); this details a full inventory of the patient's property on admission. Any property items that are handed in for safe keeping in the property drawer on the ward should be documented on a Property List (Appendix 5).

5.1.3 Patients who have no Cash on Admission

If a patient is admitted to hospital with no money and purchases are required, the Ward Manager should consider the following:

- Discussion with family regarding access to money for the patient
- Access to the patient's personal Bank Account – note that this will be dependent on whether the patient is deemed to have capacity or not.
- Article 15 Payment (Appendix 6).

5.2 Patient Property and Cash During a Stay in Hospital

5.2.1 Safe Keeping of Cash

An upper limit of cash to the value of £250.00 may be held on the ward for any individual patient. The exception to this is when an amount of money has been placed in the cash drawers to be spent within a 24-hour period or over a weekend for a specific purpose e.g. weekend leave, shopping trip.

Withdrawals of monies from the Cash Office should, as far as is practicably possible, have a specific purpose e.g. Clothing / Shoes / Personal Spend. Excess money above the agreed £250.00 limit for any individual should be lodged in their Private Property Account.

In regard to patients who are deemed to lack capacity, a Cash Record ("Ledger") (Appendix 1) must be used. Each ledger should record:

- The date of the transaction
- Incomings
- Outgoings
- Expenditure Details
- Balance.

5.2.2 Adding or withdrawing of funds

If a staff member is adding or withdrawing funds from the cash drawer, this must be recorded and countersigned by a second member of staff. The staff must assure themselves that balances are correct, any discrepancies are noted and reported to the ward manager and adjusted/reported to the Assistant Services Manager where this cannot be resolved. All signatures should be in full in black ink and should be legible. If the ledger is signed by one nurse and the patient or their family, a second nurse's signature is not required.

Cash held at ward level should be checked by two nurses at the start and end of each handover, preferably by one nurse coming on shift and one nurse going off shift. Any discrepancies should be referred to the Assistant Service Manager immediately for investigation.

5.2.3 Safe Keeping of Property

Currently all wards have minimum capacity on the ward for storing patients' belongings (one cupboard with no secure access). As such the following applies:

- Patients are requested to have minimal person belongings on the ward.
- All belongings must be kept in the patient's own room as long as it is compatible with the Health and Safety policies on the ward.
- For capacitous patients, Belfast Trust will not accept liability for any loss, damage or theft of personal belongings, except for those which have officially been placed in Trust care for safe keeping (i.e. cash office).

- For patients with no capacity, family members will be asked to bring their belongings home until such a time as they have capacity to care for their own belongings.
- Only cash or jewellery can be held by ward staff and these will be lodged in the drop-safe. Ward staff will have no access to this safe and access will need to be requested from the Operations Manager. Any other belongings will be sent home with family, or for larger sums of money, lodged in the patients bank, as per the limits set out in this policy
- When a member of staff accepts any item for a patient which is to be placed into the safe, this is accepting responsibility for safe keeping of the item. All items must be recorded on the Property List (Appendix 5). Any personal jewellery or other items must have a brief description recorded on the ledger, in non-value adding terms, where possible (e.g. yellow coloured metal, watch). Property Drawer contents and records must be checked on the handover of keys at the end of each shift, or sooner if required, by two members of staff; one of whom should be a registered nurse. Ward manager will check property drawers once per week and monthly by the Senior Nurse Manager.
- Any **new** belongings of significant value acquired during the patient's stay remain the responsibility of the patient, unless handed in for safekeeping. If handed in for safekeeping, this should be documented on the Patient's / Client Private Property List (Appendix 5) e.g. laptops, smart phones, game consoles. All items received need to be viewed to ensure the items are appropriate to hold on a ward. The items should be checked and recorded by two members of staff, one of whom must be a registered nurse.
- Article 16 (2) MHO indicates that a postal package addressed to a detained patient may be withheld and Article 16 (4) indicates that the Trust may open and inspect any postal packet if it is the opinion of the Trust that it is in the best interests of the patient to do so or for the protection of other persons. Where this is necessary, the Trust must give 7 days' notice to the patient or to the person from whom the package was sent (see also article 17 review of decision to withhold postal packet.).
- When a member of staff accepts any item for a patient which is to be placed into a property drawer this is accepting responsibility for safe keeping of the item. All items must be recorded on the Property List (Appendix 5). Any personal jewellery or other items must have a brief description recorded on the ledger, in non-value adding terms, where possible (e.g. yellow coloured metal, watch). Property Drawer contents and records must be checked on a weekly basis, or sooner if required, by two members of staff; one of whom should be a registered nurse.

5.3 Financial Capacity

5.3.1 Assessment of Financial Capacity

It must be assumed that all patients have the capacity to make a decision about financial management unless the contrary is proven with the burden of proof is on those seeking to prove absence of capacity.

Staff must follow procedures in assessing and recording capacity in line with the Mental Capacity Act (NI) (MCA, NI) (2016): Deprivation of Liberty Safeguards (DOLS) (2019) and the Belfast Trust's MCA Guidance (November 2019).

Capacity can:

- Vary over time
  - At what point in time is capacity being considered? Possibility of fluctuating capacity.
  - What is the available evidence in relation to capacity at that point in time? How can the picture at that time be reconstructed?

- Vary in respect of different issues
  - What is the nature, size and complexity of the transaction in question?
  - What is the individual's capacity in respect of that particular transaction?

There are three outcomes in relation to capacity of the patient to manage their own finances:

- Capable
- Incapable
- Temporarily Incapable

5.3.2 Capable

If a Patient has been assessed as having the capacity to manage their own finances they are deemed to be "Capable". Patients, whilst capable in the management of their own financial affairs, may still seek the help of staff to support them with management of their finances. A Financial Support Agreement (Appendix 2) should be drawn up if the patient wishes/agrees to this.

5.3.3 Temporarily Incapable

If there is reason to believe that a patient lacks capacity or their capacity to take decisions on financial matters is fluctuating due to their mental health, the reasons for the concerns should be clearly recorded in the medical file and a request for a capacity assessment to be undertaken by the RMO arranged as soon as possible. It may be necessary to put an interim plan in place to safeguard the patients finances or valuables until this assessment has taken place. Any action taken should be clearly recorded in the medical file with a timescale for review documented.

If required, a Financial Support Agreement Plan (Appendix 2) should be discussed and agreed as soon as possible and not longer than 4 weeks from the date of the patient's admission in conjunction with the MDT, Appointee/Corporate Appointee, the patient and family (if appropriate). Where an assessment of temporary incapability is made, this should be kept under regular review in light of potential changes in circumstances and / or in respect of the particular transaction being undertaken.

If the patients temporary incapacity could resolve with treatment and therapeutic intervention, the Temporarily Incapable part of the Cash Withdrawal Limits section should be signed by two members of nursing staff (Band 5 or above) or the Medical Officer at point of admission or in the event capacity changes.

5.3.4 Incapable

Patients lacking capacity

- If a patient has been assessed and deemed by staff to lack capacity, personal property and valuables should be taken into safekeeping in the patient's best interests and recorded and catalogued as per section 5.2.1. Actions taken by staff to protect a patient's property can be considered to be related to their 'care and treatment' and may thus be protected from liability, provided there is no negligence in the handling of the property.
- Before taking a patient's property into safe custody, staff should consider whether property can be handed over to next-of-kin or in the case of longer-term lack of capacity if there is anyone with authority to make decisions on behalf of the patient.
- If the patient has an 'Enduring Power of Attorney' or if a 'Controller' has been appointed by the 'Office of Care and Protection' they should be consulted regarding what to do with the patient's property. The 'Enduring Power of Attorney' or 'Controller' should be encouraged to remove from the premises any non-essential property, especially valuables, or otherwise to hand it over for safekeeping.
- Where an 'Enduring Power of Attorney' or 'Controller' are not immediately available, staff may decide to take part or all of the patient's property into safe custody, if this is in the best interests of the patient.
- The receiving, recording and depositing of the valuables to the Cash Office for safekeeping procedure should be undertaken **(as set out in Section 5.2**.)
- The property will be placed into safekeeping until the patient regains capacity to decide what should be done with it, or until the property can be given to the 'Enduring Power of Attorney' or 'Controller.'
- Where jewellery is left on the patient, this should be recorded in the 'Patients'/Clients' Valuables Record and Receipt' Property Book.'
- Where items are handed over for safekeeping by the attorney or deputy, their signature is required wherever the patient's signature is required in the 'Patients'/Clients' Valuables Record and Receipt' Property Book.'
- Explanation for the absence of the patient's signature must be documented in the Book and in the patient's nursing notes**.**
- If the patient lacks capacity to make a decision about their property, handed in property will **only be** returned to their next-of-kin, 'Enduring Power of Attorney' or 'Controller'.

5.3.5 Assessment Process

An assessment of financial capacity should be undertaken by a Consultant Psychiatrist/RMO, where the MDT has reason to doubt the assumption of the patient's financial capacity. The capacity assessment should be repeated as necessary during the admission and again by discharge.

If the Trust is the Corporate Appointee, a Financial Support Agreement (Appendix 2) must be drawn up in conjunction with Corporate Appointee, MDT and family (if appropriate). If the Trust are not Corporate Appointee a Financial Support agreement can be drawn up if the patient and / or their Appointee is agreeable to this.

When the Trust is the Corporate Appointee, ensure a copy of the Financial Support agreement is given to the Trust Finance Department and copies also be retained in the patient's MDT file.

When it is established that a patient will be remaining in hospital for a longer period of time and that community appointeeship (where applicable) has been relinquished and the Trust Corporate Appointee needs to undertake the role, this should be discussed with the DHSS and the current appointee should complete a BF56 form to relinquish responsibility (see section 5.4). It is then responsibility of the hospital Social Worker /community keyworker to contact the Corporate Appointee requesting them to make arrangements to have patient benefits transferred into a Patient Private Property Account. This should only occur after a full discussion with the MDT and a Financial Support agreement (Appendix 2) has been completed.

The Weekly expenditure section of the Financial Support Agreement should be completed with a maximum of up to £250.00 per week.

5.4 Cash Withdrawal and Expenditure

Cash withdrawals will be limited to what has been agreed for each patient on the Financial support agreement (Appendix 2), however the amounts can be changed should a patient's circumstances change.

Cash will be issued up to the agreed amount on the Financial support agreement (Appendix 2), but the Cash Office will contact the Ward Manager about exceptionally high withdrawal requests. A request for expenditure will be processed only after considering whether the patient has sufficient funds available. Accounts should never become overdrawn unless there are known arrangements in place to recoup the deficit.

Authorisation Levels

For patients who are incapable or temporarily incapable, the Ward Manager can approve withdrawal up to the maximum amount on the Financial Support agreement (Appendix 2).

For amounts above the withdrawal limit, the following authorisation is required:

Amount	Authorisation Level
Up to £250	Ward Manager
Up to £500	Assistant Services Manager
Up to £2,000	Service Manager
Up to £4,000	Co-Director
Above £4,000	Co – Director & Director

5.4.1 (a) Withdrawal Process

A patient who is not deemed to be capable has access to their money using Patients Private Property Withdrawal Form 2 (Appendix 7). This form will be signed by two members of staff who must both be on the authorised signatory list for that ward. When the money is returned to the ward, this must be documented on the Cash Sheet ("Ledger") (Appendix 1).

5.4.2 (b) Loyalty Cards

If staff are going to be involved in assisting patients with shopping, they must never use their own loyalty cards where patients' monies or Trust monies are being used. However, if the patient wishes to bring their own loyalty card/s on a shopping trip for their own usage, then they should be permitted to do so.

5.4.3 (c) Receipts for Expenditure

Where a patient is deemed to lack capacity, all receipts for expenditure should be attached to the Cash Sheet ("Ledger") (Appendix 1). If there are residual monies left after purchases, this should be documented on the Cash Sheet ("Ledger") (Appendix 1) and the monies placed back into the cash drawer.

Staff have a responsibility to ensure all expenditures are adequately receipted when making purchases on behalf of patients deemed to lack capacity. If receipts are not present at the time of the Assistant Service Manager Monthly Audit, an investigation should be commenced.

5.4.4(d) Online Purchases

Staff are not permitted to make online purchases for goods on behalf of patients. Where possible and if the patient has capacity, an account should be set up in the patient's own name or payment should be arranged by using a cheque following withdrawal request from the Cash Office.

Any items being ordered to the ward via the internet can only be kept on the ward via prior arrangement with the Ward Manager and at the patient's own risk. Any larger or valuable items (such as electrical goods) will not be stored on the ward and patients will be asked to bring these home. If the patient does not have accommodation they will be asked to pay for storage at their own expense.

5.4.5 (e) Borrowing / Bartering / Lending

The Trust operates a strict 'No Borrowing, No Bartering, No Lending' rule (Appendix 10) across all inpatient mental health units (AMHIC, Clare Ward / Shannon Clinic) regardless of patient capacity. Whilst it is recognised that capacitous patients have the right to make 'unwise decisions', the Trust has a positive obligation to ensure that all patients are protected from harm and exploitation. On admission, patients will be made aware of the 'No Borrowing, No Bartering, No Lending' policy and this will be reinforced by all staff members during an inpatient admission. Patients will be encouraged to alert staff if they are being asked to borrow, barter or lend their possessions or money.

On occasion, patients may be at risk of financial exploitation from other patients on the ward and this may reach the threshold for a response under the Adult Safeguarding Policy. Should a member of staff become concerned that a patient

is either in need of protection or at risk of harm they should follow the procedures as per Trust policy. Concerns should be recorded on an APP1 and forwarded to the Ward Manager for screening. Should the member of staff be unsure if the incident requires a safeguarding response they should contact the Ward Social Worker / DAPO for further advice and guidance.

5.5 Transaction and Fluctuation Reports

Cash Office Staff will issue a monthly transaction report to each Ward Manager which will detail all incoming monies and outgoing expenditure. This should be reviewed by the Ward Manager for any discrepancies and signed on the day that the report is reviewed, the Assistant Service Manager will audit this as part of their monthly checks.

Cash Office Staff will issue a monthly fluctuation report to the Assistant Service Manager for all patients within their respective wards who will view, sign and date the fluctuation report and report any discrepancies to the Service Manager for review.

5.5.1 Staff Signatures

Each ward will provide the Cash Office with a list of staff signatures on an annual basis. The Ward Managers must notify the Cash Office of any amendments to the list during the year. The Ward Manager must retain a list of these signatures. The Cash Office must only process transactions in line with the current Authorised Signatory List (Appendix 8).

5.6 Article 15 of the Health and Personal Social Services (NI) Order 1972

Article 15 gives provision for an extraordinary payment to be made to a patient in certain instances and should be issued if the following circumstances arise:

- A patient has no access to their own money whilst in the Hospital and the Hospital cannot get access to their money via a third party, i.e. relative;
- A patient has no money and has no right to benefits, i.e. overseas patient;
- If a patient does not get access to finances their behaviour could cause an adverse incident to occur.

If any of the above applies, then the hospital Social Worker completes an Article 15 ‘ADHOC Payments for Clients not Receiving Regular Payments’ form (Appendix 6) which must be signed by the relevant Senior Manager who is on duty (Assistant Service Manager). In the absence of an 8a or above, this will be delegated to a relevant nominated Band 7 Ward Manager. A staff member who is on the Authorised Signatory List (Appendix 8) can bring the Article 15 (Appendix 6) request to Cash Office and the money will be released. A copy of the Article 15 will be retained by the Cash Office and this will be signed by the staff member who is receiving the money. If possible, this money should be recouped from the patient when they get access to their own finances again.

Remand Prisoners who are admitted to a Mental Health In-Patient Unit are entitled to £20/week. The Ward Manager should put in place the necessary arrangements to have this paid into a Patient’s Private Property Account for the patient for the duration that they remain on remand status.

5.7 Appointeeship for Benefits

Where a patient is in receipt of benefits and lacks capacity, under Social Security Regulations, an Appointee can be appointed. A Corporate Appointee, such as the Trust, can be appointed. Where that authority is sought, documentation from the Social Security Agency should be requested as evidence. There is a responsibility to ensure that any change of circumstances is notified to the Social Security Office. The responsibility is only forward looking and is not retrospective in respect of any funds held by the patient prior to an appointeeship being made.

A reconciliation between notification of benefits received to benefit amounts actually received via the patients Private Property Accounts should be carried out by the Appointee and held in the Cash Office.

5.8 Article 116 Mental Health (Northern Ireland) Order 1986

The Trust can hold patient funds up to £20,000. Where the funds are greater than £20,000, the Trust can only hold those funds with the consent of the RQIA. It is necessary to proactively seek the consent of the RQIA.

5.9 Article 107 Mental Health (Northern Ireland) Order 1986 - referral to the Office of Care and Protection

Under this provision, the Trust has a duty to notify the Office of Care and Protection where certain criteria are met. There is a procedure for application which involves medical evidence regarding capacity (F5 to be completed), an application form which requires specific proposals in relation to the patient funds and a social circumstances report to be completed by the hospital/community Social Worker. The court will appoint a controller who will normally be a family member. It will not be the Trust who will be appointed as Controller, but the Trust has a statutory duty to refer where the conditions of the provision are met.

5.10 Deceased Patients' Property

Nursing staff must not give property / cash directly to relatives.

Any property / cash belonging to deceased patients and held at ward level should be lodged in the Cash Office, using the Patients'/Clients' Private Property Receipt Book Form (Appendix 3). This avoids the possibility of issuing property to the wrong person.

Property / Cash should be gathered, an inventory created and signed by two staff, one of whom should be a nurse.

Next of Kin should be informed that property / cash are being retained by the Cash Office until such times as the processes below have been completed;

- Letters of Administration are sent to the Next Of Kin by the Cash Office Staff where the patient's estate (including monies and property / valuables) is in excess of £10,000 and the administration is directed by the courts.
- Forms of Declaration are sent to the Next of Kin by the Cash Office staff where the patient's estate (includes property / cash) is less than £10,000. Upon receipt of these back to the Cash Office (signed by a family solicitor),

the Cash Office Staff will then proceed to forward all monies to the Next of Kin.

- Once the Cash Office Staff are in possession of either of the above Letter of Administration or Form of Declaration, a copy will be forwarded to the Ward Manager who will notify the Next of Kin in respect of property / cash so that a decision can be reached with them in respect of disposal of said items. A record should be retained in the patients MDT Notes of any items disposed of, including clothing and equipment.

Both of the situations described above refer to patients where there is no known will – where there is the existence of a Will, Grant of Probate must be applied for, and in such cases staff should follow the steps described above until the Grant of Probate is obtained.

5.11 Monitoring

Cash held at ward level will be checked at each handover by two qualified nurses both of whom should be authorised signatories.

The Ward Manager/Deputy Ward Manager will check once a week that the Cash Record (Ledger) (Appendix 1) is correct for each patient.

The Assistant Service Manager will check once a month that the Ward team are complying with the weekly checks and will sign the ledger accordingly. Any anomalies will be reported through the BHSCT Incident reporting system and investigated.

5.12 Dissemination

This policy will be disseminated to all staff working within Mental Health inpatient facilities.

5.13 Resources

Nil

5.14 Exceptions

This Policy applies to Mental Health inpatient facilities.

6.0 MONITORING AND REVIEW

Refer to procedures within this policy
RQIA
Internal Audit

7.0 EVIDENCE BASE / REFERENCES

This Policy has been developed following consultation with:

- Ward Managers
- Assistant Service Managers
- Professional leads

- Service Manager
- Co-Director
- Directorate of Legal Services (Guide on Law)
- Finance Staff

8.0 APPENDICES

Appendix 1: Cash Record Ledger
Appendix 2: Financial Support Agreement
Appendix 3: Patients'/Clients' Private Property Receipt Book
Appendix 4: Record of Staff Access to Patient Keypad Safe, Bisley Drawer, or Any Other Form of Storage for Patients' Monies or Private Property.
Appendix 5: Patients Client Private Property List
Appendix 6: Article 15
Appendix 7: Withdrawal Form 2
Appendix 8: Authorised Signatory List
Appendix 9: Staff Declaration
Appendix 10: Borrowing/Bartering Policy

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Patients' Finances and Private Property – Policy for Inpatients within Mental Health Hospitals**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to

undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

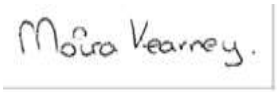
Wording within this section must not be removed.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

07/06/2022

_____ **Date:** _____

Authors



07/06/2022

_____ **Date:** _____

Director

Belfast Health and Social Care Trust

APPENDIX 1

PATIENTS'/CLIENTS' PRIVATE PROPERTY
CASH RECORD (LEDGER)

Name Of Patient	
Name Ward/Facility	

Date	Time	Transaction Details	Amount Received	Amount Withdrawn	Balance	Staff Signature 1	Staff Signature 2/ Patient Signature	Sister/Charge Nurse/SNM Weekly/Monthly Monitor
		Balance Brought Forward						
		Balance Carried Forward						

Belfast Health and Social Care Trust

APPENDIX 2

Financial Support Agreement

This plan is to be used with Service Users who lack financial capacity and require an appointee

This financial support plan should be read in conjunction with _____ care and support plans.

1. Service Users Details	
Service User Name	
Service Name	
Address	
DOB	
Key Worker Name	
Manager Name	
Senior Manager Name	

2. Current Arrangements to assist the service user in the management of services users finances

- ***This should detail the support required***
- ***How this support will be delivered***

Summary of Discussion to include:

Benefit check / Current identified needs / Resettlement plans and associated spend / Quality of Life considerations

Consent/Need to Benefit Review:

Actions by Whom and When:

3. Human Rights Considerations / Financial Capacity

Human Rights Consideration

"Belfast Health and Social Care Trust (BHSCT) aspires to be known as one of the safest, most effective and compassionate Health and Social Care Organisations and staff deliver services in accordance with this goal. In line with our Trust values to treat everyone with respect and dignity Belfast Trust is committed to the safeguarding and promotion of Equality, Good Relations and Human Rights in all aspects of its work.

This Financial Support Agreement (FSA) has been Equality Screened in terms of Equality and Good Relations in accordance with our Section 75 duties and in terms of our obligations under the Human Rights Act 1998.

Support staff will make every effort to ensure that respect for equality of opportunity, good relations and human rights, is part of their day to day work and is incorporated and reflected as an integral part of actions and decision making processes.

Support staff, when assisting ---------- (service user name) with the management of his/her finances must always consider the need to promote Equality of Opportunity, Good Relations and Human Rights whilst offering an appropriate level of support with financial management.

Details of this support is outlined in section 6 of this document and this FSA should be reviewed at least annually."

4. What Financial Support is required

Opening of a Bank/post office account (please detail suggested bank/branch and if cheque book/cash card required etc).

_____ _____

_____

Management of a current bank/post office account (withdrawals/lodgements)

_____

_____

Opening a savings account (please detail suggested bank/branch/type of account, access/cash card required etc).

_____

_____

Spending Service Users' Money on their behalf (MDT and family discussion)

_____

_____

5. Authority.
This should detail any authority and powers granted

6. Appointee Details if Relevant

Rationale for Appointeeship:

Name of Appointee:
Address of Appointee:
Date Appointeeship Granted:

7 Please name the staff who will be assisting the service user to manage their finances (minimum of two and maximum of four names)

8.		**Income Sources** ***a) The benefits which I am entitled to are;***		
			Weekly/monthly *Please state*	£
				£
	Salary			£
	State Pension			£
	Pension Credit			£
	PIP – Care Component			£
	PIP – Mobility Component			£
	Universal Credit			£
	Employment & Support Allowance/Job Seekers Allowance			£
	Housing Benefit – *paid directly by NIHE to landlord*			£
	Other			£
	TOTAL			£

9. Anticipated Weekly/Monthly Expenditure

a) If utility bills are paid in equal amounts by each tenant when the bill is received this should be noted.

b) Please note if any of these bills are paid by direct debit.

	Amount Per Week	**Amount Per Month**
Electricity	£	£
Gas/Oil	£	£
Rent/Rates –*paid directly by NIHE to landlord*	£	£
TV Licence Fee	£	£
Sky TV	£	£
House Insurance	£	£
Groceries	£	£
Telephone	£	£
Care Line	£	£
Contributions to Communal Funds (Please detail)	£	£
Personal Spending	£	£
Gardener	£	£
Window Cleaner	£	£
House Cleaner	£	£
Launderette	£	£
Taxi's	£	£
Social outings-(Meals, transport etc.)	£	£
Other-(Clothes)	£	£
TOTAL	£	£

10. Savings (if relevant)

Name of Bank/Post Office Account

Address of Bank/Post Office Account

Account Number

Lodgement Arrangements (e.g. post/in branch/lodgement slips)

Withdrawal Arrangements (e.g. cash card/pass book etc.)

Current savings on (Date) Amount

11. Banking Management (Currents Accounts) (if relevant)	
Name of Bank/Post Office Account	
Address of Bank/Post Office Account	
Account Number	
ATM Debit Card	☐Yes ☐No
Pass Book	☐Yes ☐No
<u>Cash Card/Pass Book</u> Where is this held?	
Who has access to it?	

13. Monitoring

The arrangements detailed in this plan will be monitored as per the Trust's Financial Support Policy.
Weekly review at MDT meeting.

Signatures:

Family Member/NOK:_____ **Date:**_____

Manager:_____ **Date:**_____

Social Worker:_____ **Date:**_____

This Financial Support Agreement has been discussed and shared with me and I am in agreement with it. ☐

Please note any disagreement

_____
_____
_____

Service Users Signature:_____

Social Worker/Ward Manager Signature:_____

Date:_____

APPENDIX 3

PATIENTS' CLIENTS' PRIVATE PROPERTY

RECEIPT BOOK

PATIENT NAME _____ WARD/FACILITY _____

PATIENT NUMBER _____ DATE ADMITTED _____

PATIENT ADDRESS _____

_____

_____

	DETAILS
CASH	
OTHER VALUABLES *Including:* BANK BOOKS/CARDS CHEQUE BOOKS BENEFIT BOOKS JEWELLERY N.B Account numbers should not be recorded on this form.	

The details of my property as recorded above are correct. I understand that any cash handed over for safe custody will be returned in the form of a cheque. I understand that any articles retained in my possession are my own responsibility and that the Belfast Health & Social Care Trust will not accept liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt is not obtained.

PATIENT / CLIENT / NEXT
of KIN SIGNATURE _____
DATE / / 20___
Witnessed, checked and received by:

STAFF SIGNATURE 1 _____
DATE / / 20___

STAFF SIGNATURE 2 _____
DATE / / 20___

Registered Nurse

CASH AND VALUABLES RETURNED TO PATIENT CLIENT
PATIENT / CLIENT / NEXT
of KIN SIGNATURE _____

DATE / / 20___
Witnessed by:

STAFF SIGNATURE 1 _____
DATE / / 20___

TO BE COMPLETED BY CASH OFFICE
I ACKNOWLEDGE RECEIPT OF THE PROPERTY AS DETAILED

CASH HAS BEEN LODGED TO PPP ACCOUNT _____

APPENDIX 4

Record of Staff Access to Patient Keypad Safe, Bisley Drawer, or Any Other Form of Storage for Patients' Monies or Private Property.

Please note that two staff should sign the form below when requesting access to a master key for any of the above forms of storage for patients' monies or private property at the patient's request or to perform reconciliations, add monies to a patient's existing balance or to withdraw monies from existing balances. (This should occur on every occasion as recommended by RQIA in their Quality Improvement Plan, Belfast Health and Social Care, Finance Inspection, December 2013

Date of Access	Signature 1	Signature 2	Reason for Access

APPENDIX 5

Belfast Health and Social Care Trust

PATIENTS / CLIENTS PRIVATE PROPERTY LIST

HOSPITAL: _____ WARD / FACILITY: _____

PATIENT NAME: _____ HOSPITAL NUMBER: _____

DATE: _____ TIME: _____

Reason for Completion (please circle) Admission /Transfer/ Other (_____)

Please List Property below

I Understand that any property retained in my possession are my own responsibility and that The Belfast Health & Social Care Trust will not accept liability in the event of any loss or theft of property which is not surrendered to staff for safekeeping and for which an official receipt is not obtained.

Patient / Service User Signature: _____

Staff Signature 1: _____

Staff Signature 2: _____

Belfast Health and Social Care Trust

APPENDIX 6

Article 15

ADHOC (ONE-OFF) PAYMENTS FOR CLIENTS NOT RECEIVING REGULAR PAYMENTS
Assistance under the Health & Personal Social Services (NI) Order, 1972

To	**PATIENTS BANK**	From	***(FACILITY DETAILS)* – WARD DETAILS:**

Please Pay: £	**BACS** ☐	**Uncrossed cheque** ☐	**Crossed cheque** ☐	**Petty Cash** ☐
Payee:			**Food voucher No.**	
Payee Address:				
Subject to recovery Y N ☐ ☐ **ALREADY PAID TO PATIENT IN CASH – RE-IMBURSEMENT TO PATIENTS BANK** ☐	**Cost Centre Code** **Date**			

Client Name:	**In Respect Of (Name):**	**DOB**
Client's Address:		
Other Surnames:		
PARIS No:		

Section Of Order	**Purpose Of Assistance**	**Precipitating Factors**	
Article 15 **700B2200** ☐ Reason for Assistance:	Patient has no access to their own money whilst in the Hospital and the Hospital cannot get access to their money via a third party (i.e. relative). ☐	Benefit Delayed / Lost Income support/Disability Working Allowance/Recoverable (delete as applicable)	
	If Patient does not get access to finances their behaviour could cause an adverse incident to occur. ☐		
Asylum Seekers ☐ **700B2290** Reason for Assistance:	Other: Patient has no money and has no right to benefits (i.e. overseas patient).	Lost Pension Book ☐	

Article 15 Purpose For Assistance		
Personal Expenditure **700B2210**	☐lothing **700B2260** ☐	

Authorisation and Patient Signature	
Social Worker:	Signature:
Charge Nurse/Ward Sister:	Signature:
Patients Name	Authorised by ASM/Operations Manager:
Signature:	Signature:

COPIES TO BE RETAINED BY PATIENTS BANK AND ON PATIENTS FILE

Belfast Health and Social Care Trust

APPENDIX 7

PATIENTS' PRIVATE PROPERTY

WITHDRAWAL FORM 2

For patients deemed not to have financial capability

WARD/FACILITY	
DATE	

PATIENT NAME	A/C NUMBER	AMOUNT REQUESTED	SPECIFIC PURPOSE	TRANSACTION # (CASH OFFICE USE)
TOTAL			AMOUNT TO BE WRITTEN IN WORDS	

REQUESTED BY_____

APPROVED BY_____

COLLECTED BY_____

AUTHORISED SIGNATURE REQUIRED

CHEQUE SHOULD BE MADE PAYABLE TO: _____

PLEASE PRINT USING BLOCK CAPITALS

AUTHORISED SIGNATORY LIST TEMPLATE

APPENDIX 8

WARD:			
NAME OF STAFF	GRADE	SIGNATURE	DATE

STAFF DECLARATION

APPENDIX 9

I acknowledge that I have read and understood the procedures on Patients' Finances and Private Property – Policy for Inpatients within Mental Health Hospitals

STAFF NAME	STAFF GRADE	DATE

APPENDIX 10

Borrowing / Bartering

Protocol

Borrowing / Bartering Protocol

On the ward we operate a strict protocol on bartering or borrowing. This is to safeguard everyone on the ward. We want to ensure that everyone's property is respected and protected.

We request patients adhere to the following:

- Strictly no borrowing money from other people under ANY circumstances.
- No 'borrowing' cigarettes.
- You should not ask other people to buy you take-aways or other items from the shop – if you are short on money ask staff for help.
- Strictly no swopping of personal items – everyone has the right to enjoy their own property.
- Strictly no buying or selling personal items.

If you feel that you are being pressured into borrowing / lending / bartering please speak to ward staff.

If you are pressuring others into lending / borrowing / bartering this may be a criminal offence and staff may contact the PSNI in order to ensure that all our patients are safe and protected.

Mate crime

Mate crime is when a person is harmed or taken advantage of by someone they thought was their friend.

This can include a friend asking for money and refusing to give it back or emotional or physical abuse by a person who was thought to be a friend.

This may include:

- Pressuring you to lend them money.
- Asking for your card details.
- Pressuring you to buy them take-away food / items from the shop.
- Asking you for cigarettes.
- Offering to sell you things / asking to buy your personal property.
- Making you feel uncomfortable if you say ‘no’ to them.

If you think that someone is taking advantage of you or someone you know:

- Tell someone you trust, such as a staff member.
- Do not tell the person who is pretending to be your friend.

Staff can help you to safeguard your money or property.

Remember:

We request that you do not borrow or lend money.
We request that you do not barter goods / personal items or cigarettes.

If you are concerned about being asked to lend money / barter goods, please speak to ward staff

Thank you for your co-operation