Bedfordshire Hospitals NHS Foundation Trust

CORPORATE AND CLINCAL POLICIES

Policy [X] **Clinical Policy** [ ]

Policy Document Title: Patient Experience Policy

This document is relevant for staff at:	Luton Hospital site	Bedford Hospital site	Both Hospital sites X

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Policy Developed in Consultation with:
Chief Nurse
Director of Nursing
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Is this policy document new or revised / or has minor amendments? This is an amalgamated policy that is derived from past policies for:

- Privacy and Dignity
- Delivering Single Sex Accommodation,
- Hospital Accommodation for transgender and gender variant children

Reason for amendments: Please highlight all amendments in your document.
To develop a new cross site policy for the Trust.

Document Number:	Version Number:
P22T	1

Target Audience/Scope:
All staff within the Trust including temporary staff and trainees.

Associated Trust Documents
Consent Policy
Care of the Dying Patient Care Plan
Interpreting and Translation Services Policy and Guideline
:Mobile phone policy
Visual & Audio Recording on Hospital Premises.
Clinical Record Keeping
Lone Workers Policy
Safeguarding Adults – Raising Concerns
Appropriate Professional Codes of Conduct/Guidelines.
CQC Fundamental Standard 2, Regulation 10 (Treating people with dignity and respect).
Mental Capacity Act Policy
Deprivation of Liberty 2009 Policy

Patient Property Policy Learning Disability Strategy Equality & Diversity Policy Complaints Policy Patient Experience Strategy	
Date of Approval: 15th August 2022	**Review Date:** August 2025
Chair /Chief Executive Signature:	D Carter

Contents

INTRODUCTION

The aim of the policy is to provide all Bedfordshire Hospitals Trust (the Trust) staff with guidance and outline the expected standards of practice in the promotion of privacy, dignity and respect, which affects all healthcare users. The Trust is committed to providing high quality care to all healthcare users at all times.

The Trust is eager to ensure that all healthcare users will feel that they are treated appropriately, and that their right to privacy, dignity and respect is upheld and actively promoted at all times.

The policy includes transgender patients, gender variant children, the provision of single sex accommodation and the provision of chaperones.

1.0 Roles and Responsibilities

1.1 The Trust Board
Oversee patient experience, and ensure that privacy and dignity is valued and maintained at a high level throughout the Trust. Ensure there are adequate resources for staff to fulfil their duties.

1.2 Chief Executive
The chief executive has overall responsibility to ensure that all patients are treated with privacy, dignity and have a positive experience throughout their stay and at every contact with the Trust.

1.3 Medical Director
Will ensure that all medical staff including trainees, treat every patient with dignity, respect and to provide a positive experience.

1.4 Chief Nurse
Will ensure that all staff including trainees, treat every patient with dignity and respect so they have a positive experience.

1.5 Heads of Nursing and Midwifery and Matrons
Will:

- support staff to comply with this policy
- encourage patients and carers to provide feedback on their experience
- encourage incident reporting and investigation
- implement findings from investigations and lead improvements
- escalate when resources risk a poor experience or a breach in privacy and dignity

1.6 Ward Managers
Will:

- ensure staff are familiar with and comply with this policy
- encourage incident reporting and investigation
- implement findings from investigations and lead improvement
- ensure staff have appropriate knowledge and skills to deliver care, in line with the policy

- escalate when resources risk a poor experience or a breach in privacy and dignity
- be responsible for feedback to ward staff should a breach of this policy be reported.

1.7 Bed Managers and Site Team

- ensure that the policy is complied with when allocating patients to beds
- follow the escalation and reporting processes when breaches occur

1.8 All staff

- should be aware of the principles of the policy
- should be aware of their responsibility to ensure compliance with the policy
- should report breaches of the policy
- maintain privacy and dignity of all patients at all times
- should be aware of the principles of single sex accommodation within their department
- should be aware of when it is appropriate to offer or request a chaperone when providing care or treatments to patients
- prioritise an excellent patient experience

2.0 Patient experience, privacy and dignity overview

2.1 Treating patients as individuals

Staff must always treat patients as individuals, enquiring about a person's needs and wants; taking into account different requirements of privacy, dignity and respect for people from different faiths, cultures, generations and genders. Every effort must be made to ensure that preferences are included in care plans and treatment choices as well as wider considerations such as meal preferences and personal hygiene choices.

Best Practice

Staff ensure that they:

- ✓ Listen to patients and respect their views
- ✓ Treat patients politely and considerately
- ✓ Treat information about patients as confidential
- ✓ Due attention must be paid to confidentiality when discussing sensitive matters and an appropriate area should be found that maintains confidentiality when practically possible.
- ✓ Respect the right of patients to be fully involved in decisions about their care.
- ✓ Recognise that patients may have lifestyle, culture, beliefs, race or social status which may affect their choice of treatment.
- ✓ Be aware of the protected characteristics relating to discrimination under the Equality Act 2010. They are;
    - Age
    - Disability
    - Gender re-assignment

- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual Orientation

- ✓ Respect a patient's right to make a decision that may not be considered in the best interest of that patient by hospital staff, when the patient has been given all the options available.
- ✓ Care planning will take account of issues regarding individual patient's dignity; recognising the issues that may occur when caring for confused patients and the wider ward patients, on an open ward and at end of life care.
- ✓ Ensure privacy, dignity and patient choice continues during 'end of life' and after death.

2.2 Communication

Patients have a right to be treated as individuals and with courtesy at all times, to know who is responsible for their care, have private conversations about their care when required, be listened to and have their views taken into account.

A patient must be able to understand information given to them and options offered in terms of care and treatment to be able to consent, please refer to the interpreting and translation policy. http://intranet/Policies/Documents/Interpreting%20Translation%20Services.pdf. Necessary provision should be made to facilitate access to interpreting services if requested.

Best Practice

- ✓ Staff introduce themselves on initial contact with patients they state their name and role:- 'Hello my name is…… and I am a ……..'
- ✓ When answering the telephone state "hello …… ward/department, then their name and role', how can I help you?
- ✓ Staff must wear photo identification badges at all times
- ✓ Staff should ask each patient how they wish to be addressed
- ✓ A balance should be struck between being friendly and being respectful, avoid lapses into over familiarity and use of endearments
- ✓ Staff must knock on a door and wait to be invited to enter, where knocking is not possible, for example curtains surrounding a bed, permission to enter, should be sought before entrance
- ✓ Patients should be spoken to in an open friendly manner. Staff should be aware of their tone of voice and body language to avoid offence
- ✓ Staff must not have personal conversations with colleagues that exclude the patient when providing care.

- ✓ Staff required to carry bleeps or work mobile phones should answer them in a sensitive manner and, wherever possible, switch them off during meetings with patients and families.
- ✓ Trust mobile telephones or personal mobile phones being used for work related business must be used away from areas where direct clinical care is taking place.
- ✓ The increased availability of smart phones increases the risk of breach of confidentiality. The Trust's policy is therefore that patients should not use mobile phones for recording in clinical areas in the hospital, without specific consent. Staff should refer to the policy http://intranet/Policies/Documents/Recording.pdf
- ✓ Staff should deal with requests for assistance promptly. Where there is an unavoidable delay ensure an apology is given.

Patients with complex communication needs

- ✓ Staff must ensure patients with other communication impairments such as deafness, sight loss or a learning disability are provided with the appropriate communication support or equipment
- ✓ For patients who are deaf or hard of hearing, with or without a hearing aid, staff can use personal amplifiers, if the ward does not have one they can be borrowed from PALS.
- ✓ Ensure patients who are deaf or hard of hearing, have heard and understood conversations, if appropriate involve family or carers. Where appropriate sign language interpreters should be used
- ✓ Ensure that enhanced communication needs are identified, assessed and recorded
- ✓ For patients who are blind or partially sighted, every effort should be made for patients to maintain independence in hospital and therefore maintain their privacy and dignity.
- ✓ For those patients whose knowledge and understanding may be limited, their diagnosis, care and treatment must be explained to them in a manner that they are able to understand and that does not demean them.
- ✓ Staff must ensure that they use language and demonstrate behaviour which is inclusive. All patients must be treated in the same manner regardless of gender, sexual orientation, ethnicity, culture, disability, religion or age.
- ✓ Patients (carers and relatives) are provided the opportunity to decline the presence of healthcare professionals not directly involved with their care at ward rounds, outpatient consultations etc. (prior to these events occurring).

3.0 Maintaining patients modesty and dignity whilst providing personal care

Patients have a right to have their modesty protected at all times and not be caused embarrassment by the actions of others. They also have the right to be treated with dignity at all times, whilst remaining as independent as possible.

Verbal consent should be sought for the provision of all care. Should a patient decline help with personal care, if this could lead to a potential risk, it is essential to communicate that

risk to the patient, for example pressure area care and the risk of developing pressure ulcers.

Best practice

- ✓ It is important that patients are enabled to keep themselves clean and tidy and appropriate staff should support them to do this.
- ✓ Read supporting documentation, care plans, "All about me" or "This is me" for patient care needs and preferences
- ✓ Clinical staff contributing to the personal care of patients should first establish the patient's capabilities. Patients must be allowed to wash themselves and undertake other aspects of self-care wherever possible and should be encouraged to do so.
- ✓ When helping those who require assistance with personal hygiene care, staff should ensure that the patient is offered the choice, to wash intimate areas themselves, should they need assistance this should be carried out with a chaperone unless the patient expressed a wish not to have one. Do not assist the patient in removing clothing unless you have gained consent.
- ✓ No part of the patient's body should be exposed unless absolutely necessary. All fastenings must be closed unless specified otherwise by the patient and clothing adjusted in accordance to individual patient wishes. Every effort should be made to choose clothing that matches both in colour scheme and pattern when the patient is unable to specify themselves.
- ✓ Patients should wear appropriate clothing or covering which does not cause embarrassment or offence to themselves or others. Staff have a responsibility to respectfully draw attention to clothing which is liable to offend and issue covering where appropriate.
- ✓ In the event that staff have established that a patient requires help with their personal care it should be offered or, if requested, given in a timely manner to maintain dignity. Where there is an unavoidable delay an apology should be offered.
- ✓ In order to maintain personal dignity, "personal hygiene" must include the opportunity for patients to have adequate oral hygiene, shaving, hair and nail care.

- ✓ Every effort must be made to ensure items of personal clothing do not get lost or damaged in line with the Trusts Patient Property Policy
- ✓ Patients being discharged should be fully dressed (wherever possible) and in appropriate clothing in order to maintain dignity. If this is not possible ensure the patient, next of kin and place of discharge understand why and the patient is warm and dry.

Washing and toilet facilities are individually designated by gender and staff should ensure that access to these facilities is restricted to the designated sex.

Providing a full explanation before an examination and displaying sensitivity are essential. Patients should be offered a chaperone, or be given the opportunity to invite a friend or relative to be present (in advance if possible) when intimate examinations are performed. If the patient does not want a chaperone, it should be recorded that the offer was made and declined. If a chaperone is present, this must be recorded and a note made of the chaperone's identity. If for justifiable practical reasons a chaperone cannot be offered, an explanation to the patient should be given with an offer to defer the intervention until a time when a chaperone can be found.

4.0 Delivering same sex accommodation (DSSA)

The physical environment and the provision of single sex facilities are considered to be key factors in maximising patient privacy and dignity.

The Trust provides accommodation that complies with the NHS Operating Framework 2012-13 and NHS E/I Delivering same-sex accommodation, 2019. There is Board level commitment for compliance with these standards, which are closely linked to the Trust's strategic themes and values, by providing a clear definition of same sex accommodation, and support staff to respectfully deliver same sex accommodation.

4.1 Same sex accommodation standards

The NHS standard is that, same sex accommodation can be provided in:

- ✓ Single sex wards
- ✓ Single rooms with adjacent single sex toilet and washing facilities
- ✓ Single sex accommodation within mixed wards (i.e. bays or rooms which accommodate either men or women; with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room).
- ✓ In addition, patients should not need to pass through opposite sex accommodation to access toilet and washing facilities.
- ✓ Ward accommodation must be arranged to ensure that there is physical segregation of bed bays/rooms for men and women at all times.
- ✓ In circumstances where open ended bays are adjacent to one another, these should be of the same gender. If this is not possible curtains or screens should be in place to prevent bays being overlooked by patients of the opposite sex.
- ✓ If partitions are used to segregate patients of the opposite gender they must be fixed and of floor to ceiling in height.
- ✓ Where there are no ensuite facilities in bays or rooms, toilets and bathrooms must be adjacent to the appropriate single sex bed bays/rooms.
- ✓ The facilities must be designated by gender, using Trust approved signage. These signs are reversible and it is the responsibility of the nurse in charge to check that facilities are correctly signed following ward bay moves, and as a minimum once per shift.
- ✓ In addition, patients should not pass through, or close to opposite sex areas to reach toilets and bathrooms. Where this is unavoidable adequate screening (for example blinds or curtains at windows and doors) should be used to provide an acceptable level of dignity.

4.2 Definition of justified mix and unjustified mixing of accommodation

The Chief Nursing Officer (CNO) provided further guidance in 2019 which can be seen below, defining what is a justified mix (not a breach), and an unjustified mix (breach):

In the best overall interests of the patient

There are situations where it is clearly in the patient's best interest to receive rapid or specialist treatment, and same-sex accommodation is not the immediate priority. In these cases, privacy and dignity must be protected – e.g. by the enhanced staffing provided in critical care facilities. The patient should be provided with same-sex accommodation immediately the acceptable justification ceases to apply.

There is no justification for placing a patient in mixed-sex accommodation where this is not in the best overall interests of the patient and better management, better facilities, or the removal of organisational constraints could have averted the situation.

Acceptable justification – e.g. NOT a breach

- In the event of a life-threatening emergency, either on admission or due to a sudden deterioration in a patient's condition.
- Where a critically ill patient requires constant one-to-one nursing care, e.g. in critical care
- Where a nurse must be physically present in the room/bay at all times (the nurse may have responsibility for more than one patient, e.g. level 2 care).
- Where a short period of close patient observation is needed e.g. immediate post-anaesthetic recovery, or where there is a high risk of adverse drug reactions.
- On the joint admission of couples or family groups.

Unacceptable justification – e.g. a breach

- Placing a patient in mixed-sex accommodation for the convenience of medical, nursing or other staff, or from a desire to group patients within a clinical specialty.
- Placing a patient in mixed-sex accommodation because of a shortage of staff or poor skill mix.
- Placing a patient in mixed-sex accommodation because of restrictions imposed by old or difficult estate.
- Placing a patient in mixed-sex accommodation because of a shortage of beds.
- Placing a patient in mixed-sex accommodation because of predictable fluctuations in activity or seasonal pressures.
- Placing a patient in mixed-sex accommodation because of a predictable non-clinical incident e.g. ward closure.
- Placing or leaving a patient in mixed-sex accommodation whilst waiting for assessment, treatment or a clinical decision.
- Placing a patient in mixed-sex accommodation for regular but not constant observation
  It is not acceptable to mix sexes purely on the basis of clinical specialism.

Patients admitted in an emergency

- It is recognised that in some emergencies, a decision to mix sexes may be necessary due to the clinical needs of individual patients. This must always be in the patients best interest otherwise it is unjustified.
- The reason for mixing the sexes and the steps being taken to address the issue should be explained fully to the patient and family.
- Staff should make it clear to the patient that the Trust considers mixing to be an exception and never normal procedure. Where possible a consent form will be signed by the patient and any other patients in that bay or area. (Appendix 1 – Consent form)
- Where mixing the sexes is unavoidable, transfer to same sex accommodation should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.
- Data is monitored and reported monthly to the Trust Board for breaches on Adult wards
- The form for reporting a decision to mix is available on the intranet under 'what's new', 'clinical information page' and under 'useful forms' (appendix 2).

Patients with cognitive impairment may need support from a family member or carer overnight this may mean a person of the opposite gender, this would be considered in the best interest of the patient, this situation should be handled sensitively with all patients within the immediate areas privacy and dignity considered

4.3 Escalation process

Day surgery/treatment/clinical decision unit/diagnostics and ambulatory care areas

This policy applies to all Trust day care areas including surgery, treatment, diagnostics, observation and ambulatory care areas, and these areas should have designated segregated facilities, as follows;

- Treatment areas should be same sex.
- Changing areas/cubicles should be single sex
- Bathroom facilities must be designated as single sex, and must be lockable and clearly signed.
- Curtains must be well fitting and no gaps.

Exceptions to the above may be acceptable in the case of very minor procedures where patients are not required to undress or otherwise be exposed. This must be approved by the Matron for the area, and staff must confirm the patient is happy with this. If not alternative arrangements may be necessary on an individual basis and the decision clearly documented.

In areas such as Radiology where patients are required to change, changing cubicles should be segregated and signed. If this is not possible changing room doors should be solid and lockable.

Recording Breaches

Breaches of the same sex accommodation standard must be recorded on the Trust Risk Management Reporting System as an incident. Staff should select the subject 'bed management' and sub subject 'same sex breaches', which will allow the incident to be reported. Data will be collated and reported on a monthly basis. Staff should also complete the form in appendix

4.4 Children and young people

Children must be placed on a ward that is appropriate for their age and stage of development. If the young person is over 16 and not known to paediatrics they will be admitted to an adult ward. Young people between 16-18 years and known to paediatrics will be discussed with Riverbank.

In general, adolescents prefer to be located alongside other people of their age; where possible they should be given this choice on admission. The care of children and young people must ensure that their separate needs, including any safeguarding concerns, are recognised and met.

Parents

In children's units parents are encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care should be taken to ensure this does not cause embarrassment or discomfort to individual parents/carers whilst the main focus remains centred on the child as a priority.

Best Practice

- ✓ Privacy and dignity is an important aspect of care for children and young people.
- ✓ Decisions should be based on the clinical, psychological and social needs of the child or young person, not the constraints of the environment, or the convenience of staff.
- ✓ Privacy and dignity should be maintained whenever children and young people's modesty may be compromised (e.g. when wearing hospital gowns/nightwear), or where the body (other than the extremities) is exposed, or they are unable to preserve their own modesty (for example following recovery from a general anaesthetic or when sedated).
- ✓ The child or young person's preference should be sought, recorded and where possible respected.
- ✓ Where appropriate the wishes of the parents should be considered, but in the case of young people their preference should prevail.

4.5 Toilets and bathrooms

Where there are no ensuite facilities in bays or rooms, toilets and bathrooms must be adjacent to the appropriate single sex bed bays/rooms. The facilities must be designated by gender, using trust approved signage. These signs are reversible and it is the responsibility of the person in charge of the area to check that facilities are correctly signed following ward bay moves, and as a minimum once per shift.

In addition, patients must not pass through, or close to opposite sex areas to reach toilets and bathrooms.

Toilets and bathrooms must be lockable, and patients should be able to identify from the outside whether or not the facilities are occupied.

5.0 Hospital accommodation for trans people and gender variant children

Background

The Equality Act 2010 protects people who propose undergoing, are undergoing, or have undergone 'gender reassignment', from direct and indirect discrimination, harassment and victimisation. The Human Rights Act 1998 ensures non-discriminatory treatment and provides protection of an individual's dignity and privacy.

Transgender (the term trans is the preferred term by transgender people) is an umbrella term used to cover numerous types of gender identity such as transsexual, transvestite, intersex, bi-gendered or non-gendered. Their gender identity may not fit neatly into society's idea of gender, for example they may feel they are not totally one gender or the other, they may not identify with their assigned birth gender or they may not identify with any gender at all. Gender is not just the physical body; we all have gender traits or behaviours e.g. a gay man may have feminine features and mannerisms but that does not mean he wishes to become a woman.

5.1 Accommodating transgender patients in an acute hospital setting

The key principles are:

- ✓ Transgender people should be accommodated according to their presentation: the way they dress, and the name and pronouns that they currently use.
- ✓ This may not always accord with the physical sex appearance
- ✓ It does not depend upon their having a Gender Recognition Certificate (GRC) or legal name change;
- ✓ If staff are unsure of a patient's gender they should, where possible, discreetly ask the person where they would most comfortably be accommodated.
- ✓ The views of the transgender person should take precedence over those of family members where these are not the same
  In all matters, members of staff must be aware that it breaches legislation to disclose a person's transgender status to a third party without first gaining their express permission to do so.
- ✓ Staff must take particular care to protect the preferred gender identity of the trans-gender patient when physiological appearance is not congruent with their preferred gender presentation.
- ✓ Staff should monitor feedback from patients who may feel uncomfortable with these arrangements to ensure all feelings are taken into consideration.

5.2 In emergency admissions, day units and intensive care/high dependency units

If upon admission it is impossible to discuss this matter with the patient because they are unconscious or incapacitated, then the clinical staff should use the patient's presentation

and mode of dress to determine where they would like to be accommodated. No investigation as to the genital sex of the person should take place unless this is specifically necessary in order to carry out treatment.

5.3 In hospital wards

Sufficient privacy must be maintained with curtains at the bedside or by the use of individual toilet, washroom and shower facilities for those whose outward gender presentation does not accord with their genital sex. It may be appropriate to accommodate a patient in a single side room adjacent to a gender appropriate ward, to maintain privacy and dignity.

5.4 Transgender men attending x-ray department or pre-surgical procedures

Due to the risks involved to the foetus it is necessary to ask any female of childbearing age, including transgender men who have not completed their gender reassignment, if there is a possibility of them being pregnant. Any discussions should be carried out sensitively, discreetly and respectfully and confidentially maintained.

5.5 Gender variant children and young people

Gender variant children and young people should be treated with the same respect for their self- defined gender as transgender adults.

Where there is no segregation there may be no requirement to treat a young gender variant person any differently from other children and young people. Where segregation is deemed necessary, then it should be in accordance with the dress, preferred name and/or stated gender identity of the child and young person.

Parents may have a view that is not consistent with the child or young person. If possible the child/ young person's preference should prevail.

More in depth and sensitive discussions may need to be had with those adolescents whose secondary sex characteristics have developed and may, in their opinion, contradict their gender identity. It should be borne in mind that they are extremely likely to continue, as adults, to experience a gender identity which is inconsistent with their sex appearance at birth so their current gender identity should be fully supported in terms of accommodation and use of toilet and bathing facilities.

It should also be noted here that, although rare, children may have conditions where genital appearance is not clearly male or female and therefore maintaining personal privacy is a priority.

6.0 Chaperone

The section of the policy sets out guidance on the use of chaperones and procedures that should be in place for consultations, examinations and investigations and is based upon the Model Chaperone Framework for the Role and Effective Use of Chaperones in Primary and Community Settings (DOH 2005).

Staff must be aware that intimate examinations may cause anxiety for both male and female patients regardless of whether the examiner is of the same gender or not.

For most patients, respect, explanation, consent and privacy take precedence over the need for a chaperone. The presence of a third party does not negate the need for adequate explanation and cannot provide full assurance that the procedure or examination is conducted appropriately.

6.1 Role of the Chaperone

The chaperone should be regarded as a third party to a clinical examination. The chaperone is present as a safeguard for all parties and is a witness to continuing consent of the procedure; the role of the chaperone includes:

- ✓ Providing emotional support and reassurance
- ✓ Ensure patients understand why the chaperone is present
- ✓ Be familiar with the procedures involved to be able to identify unusual or unacceptable behaviour on the part of the clinician
- ✓ To assist with undressing patients
- ✓ Stay for the whole examination and be able if practical to see what the practitioner is doing
- ✓ To listen observe and verify what was said and done
- ✓ On completion of the episode the chaperone, should date and countersign the record to confirm that what was said and done is a true record
- ✓ To recognise that in the case of children and young people, patients with cognitive impairment or patients with mental health needs whilst relatives or supporters may not be accepted as suitable chaperones, they must not be excluded from attending.

6.2 Offering a chaperone

All patients should be routinely offered a chaperone during an intimate examination or procedure irrespective of the gender of either patient or the health professional. The offer of a chaperone should be made clear to the patient prior to any procedure, ideally at the time of booking the appointment (in the case of outpatients), clear information should be visible in the department to ensure patients know they can ask for a chaperone.

If the patient is offered and does not want a chaperone, it is important to record that the offer was made and declined. Clinicians have the right to have a chaperone present to protect them against any possible allegations of abuse. Should a patient request a ‘same sex’ chaperone; patients should notify the clinician immediately and the nurse in charge who will try to accommodate this.

6.3 Further points to consider

Staff are advised to consider the following circumstances when making the decision whether a chaperone should be present;

- If the patient is semi-conscious or unconscious. If a patient is undergoing a local anaesthetic procedure in theatre then the ODP/RN can act as a chaperone.
- If the patient is intoxicated with alcohol or has been given parenteral drugs known to have a hallucinogenic or sedating effect.
- Where the room must be darkened for the examination e.g. retinoscopy.
- Do not make assumptions about what the patient wants or their level of embarrassment.
- Consider the cultural and religious needs of the patient.

6.4 Issues specific to children and young people

Parents will not automatically be expected to chaperone their children, as a registered nurse will be present. In the event a child does not wish for the nurse to be present, a parent can be present as a chaperone for their child. In this event, the role should be clearly explained to the parent and the consent of the child sought and documented in the patients' medical notes. The following situations must always have a chaperone:

- Examination for child protection procedures
- Perineal examination in the assessment of sexual, genitourinary and elimination disorders.
- When the patient is pubertal or post-pubertal.
- Those who are not accompanied by an individual with parental responsibility, or where an individual is thought to be unable to provide appropriate support.

Healthcare professionals should refer to their local Child Protection policies for any specific concerns and contact the Trust's Safeguarding Children Team.

6.5 Issues specific to learning disabilities

For patients with a learning disability, a familiar individual such as a family member or carer may be the most appropriate chaperone. It should not be assumed that the patient's family or carer will act as a chaperone. The role of the family and paid carer is to act as the patients advocate. Therefore, the option of having a chaperone present must be made to the patient and/or family and carer for their decision. A careful, simple and sensitive explanation of the technique is vital. Particular care should be made to ensure that the patient's views and wishes are respected.

If the patient lacks capacity to agree to the examination please review the Mental Capacity Act Policy for specific advice. M08T-Mental-Capacity-Act-Policy-MCA.pdf (bedsft.nhs.uk)

The Learning Disability Liaison Nurses should be contacted for further assistance and guidance.

6.6 Lone Working

Where a healthcare professional is working in a situation away from other colleagues e.g. community based midwifery/home birth, home visit, the same principles for offering and use of chaperones should apply. If the visit or series of visits are pre-planned and are likely to involve an intimate examination, it is advisable to ask the patient in advance if a chaperone would be needed and if so, to arrange for one to be present.

In cases where this is not an option, for example due to the urgency of the situation or because the practitioner is community based, then procedures should be in place to ensure that communication and record keeping are treated as paramount. Clinicians should note that they are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present.

Staff who are lone workers should also use an agreed process whereby they can contact colleagues to inform them of their whereabouts and working patterns, particularly when in the community. This will enable staff who are working alone to check in on a regular basis to ensure their safety and wellbeing.

6.7 During the examination/procedure

Facilities should be available for patients to undress in a private, undisturbed area. There should be no undue delay prior to examination once the patient has removed any clothing.

Intimate examination should take place in a closed room or, if in ward settings, undertaken in screened bays that must not be entered without consent while the examination is in progress. Examination should not be interrupted by phone calls or messages.

Where appropriate a choice of position for the examination should be offered for example left lateral, dorsal, recumbent and semi-recumbent positions for speculum and bimanual examinations. This may reduce the sense of vulnerability and powerlessness described by some patients.

Where a chaperone feels that a patient's privacy is compromised during the consultation or that their dignity is not being upheld in any way then they must request the consultation stops immediately to the clinician. This must be documented in the patient's notes and escalated to the safeguarding team and ensure the Trust safeguarding policy is implemented. Any requests that the examination be discontinued must be respected.

During an intimate examination: - (appendix 3)

- Offer reassurance
- Be courteous
- Keep discussion relevant
- Do not make personal comments
- Encourage question and discussion
- Remain alert to verbal and non-verbal indications of distress from the patient

6.8 Where a chaperone is needed but not available

If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment. If the seriousness of the condition would dictate that a delay is inappropriate then this should be explained to the patient and recorded in their notes. A decision to continue or otherwise should be jointly reached. In cases where the patient is not competent to make an informed decision then the clinician must use their own clinical judgement and record and be able to justify this course of action.

Where there are other patients waiting, and a chaperone would be available later in the clinical session, it is acceptable to offer to see the patient then.

6.9 Verbal consent

Before proceeding with an examination, clinicians should always seek to obtain, by word or gesture, some explicit indication that the patient understands the need for examination and agrees to it being carried out. Written consent is not usually necessary but it is good practice to record that the patient has consented to the procedure/examination. Clinicians should be aware that touching a patient without their consent is tantamount to 'battery' (minor assault). Consent should always be appropriate to the treatment or investigation being carried out.

It is essential that the clinician explains the nature of the examination to the patient and offers them a choice whether to proceed with that examination at that time. The patient will then be able to give an informed consent to continue with the consultation.

Appropriate explanations and adequate information should be given to the patients prior to any procedure being undertaken. If necessary an interpreter should be provided. (See Trust Interpreting and Translation Services Policy)

Easily understood literature and diagrams should, where available, be provided to support verbal explanation so that informed consent is obtained. This should be, where possible, provided in advance of the examination to allow the patient to have time to go through the information with relatives/supporters and therefore be adequately prepared for the examination.

If the patient is under 16 or unable to understand an appropriate explanation this could be given to a parent, carer or guardian to obtain the patients co-operation and consent. Where necessary an interpreter should be present to assist with the explanation.

7.0 TRAINING

The training department will ensure staff can access the training they need on privacy and dignity. Staff training addresses patient's needs and wishes for privacy and dignity, including cultural and religious beliefs.

The Trust provides essential skills training, based on ‘Care Certificate’ principles for clinical support workers/health care assistants; this is included within the induction package which is mandatory for all new employees to the Trust.

Appendix 1

Checklist for consultations involving intimate examinations

1. Establish there is a genuine need for an intimate examination and discuss this with the patient.

2. Explain to the patient why an examination is necessary and give the patient an opportunity to ask questions.

3. Offer a chaperone or invite the patient to have a family member/friend present. If the patient does not want a chaperone, record that the offer was made and declined in the patients notes.

4. Children should be given the opportunity to have parents present if they wish. If a child does not wish a nurse to be present during an intimate examination then the parents can act as chaperones, ensuring that the role is fully explained and consent sought.

5. Obtain the patients consent before the examination and be prepared to discontinue the examination at any stage at the patient's request.

6. Record that permission has been obtained in the patients notes.

7. Once chaperone has entered the room, give the patient privacy to undress and dress. Use drapes where possible to maintain dignity.

8. Explain what you are doing at each stage of the examination, the outcome when it is complete and what you propose to do next. Keep discussion relevant and avoid personal comments.

9. If a chaperone has been present record that fact and the identity of the chaperone in the patient's notes.

10. Record any other relevant issues or concerns immediately following the consultation.

Appendix 2

Guidance on communicating and interacting with a person with learning disabilities/Autism

Think about the environment and how this might affect communication, move to an area less distracting or noisy if possible. People with autism may become overloaded.

Always introduce yourself and your role and speak directly to the patient, even if they are unable to answer verbally. This is essential as integral to patient centred care. If you require clarification from the patient's relative/supporter, ask if it is ok to speak to them but then engage the patient back into the conversation afterwards.

If people with autism are anxious use less eye contact, facial expression and gestures
Be attentive to the patient as they may respond with nonverbal methods such as nodding, shaking their head, smiling, and using gestures.

Listen to the patient's family and/or carer's advice and information to guide you in your interactions with the patient. Ask to read the patients "All about me". Speak clearly and at a normal pace. Patients sometimes find strong dialect/accents hard to understand and require a slightly slower pace.

Avoid jargon, use simple terminology in short sentences. If you need to use medical terms explain what this is using simplified everyday language. Use pictures, social stories, easy read information, drawings, and videos to support explanation. Use persons own words for body parts to aid understanding.

Use open ended questions (questions that require more than a yes/no answer). Examples of these are:

How can I help you?
Please tell me why you have come to the hospital today.
Would you tell me about…..?
Some people (especially patients with autism) may need direct questions, they may not tell you what is happening or how they feel unless you ask i.e. Does it hurt?

Broach one subject at a time. Allow the patient time to process the information. Some people may need extra time to process the information and provide a response.

Check the language you use as some people will be very literal and some words have several meanings, check the patient has understood.

There can be a tendency for people with learning disabilities to interpret negative phrases positively, e.g. 'You can't go home yet' may be responded to as 'You're going home'. So, try to use positive instead of negative phrases: perhaps, 'You need to stay here for another night' rather than 'You can't go home yet'.

Watch the person, they may communicate by their body language or facial expression

Check the person has understood i.e. can you tell me, what we have talked about today? This is helpful in establishing if the person has understood parts or most of the conversation. This is very important when assessing capacity.

Appendix 3: Same Sex Breach Form.

NHS Bedfordshire

Same Sex Accommodation Exception Report

Date		Time					
Name of staff member reporting							
Name of Trust							
Nil reporting for week commencing Monday		(✓)	Y		N		*If yes, no further details required, if no please complete section below*

Name of Manager agreeing Mixed Sex Occurrence												
Ward or Unit		Bay/wing of Mixed Sex Occurrence										
Mixed Sex Occurrence Classification	Category 1 – All base wards, Community & Mental Health Providers	(✓)	Y		N		Category 2 – DSU/Endoscopy, Day Treatment Units	(✓)	Y		N	
Start date of Mixed Sex Occurrence		Start time of Mixed Sex Occurrence										

Gender & hospital number of patient causing initial Mixed Sex Occurrence	M / F	

Gender & hospital number of other patients affected by Mixed Sex Occurrence										
(please continue on separate sheet if required)	M	F	M	F	M	F	M	F	M	F

Page 1 of 2

Clinically justified for initial patient? (✓)	Y		N	

Further Explanation	

Clinically justified for all other patients in bay/unit? (✓)	Y		N	

End date of Mixed Sex Occurrence		End time of Mixed Sex Occurrence		Total hrs of Mixed Sex Occurrence	

Cause of Mixed Sex Occurrence (✓)	Clinical need	A&E Targets	Other Target	Other reason

Analysis of SSA Mixed Sex Occurrence (✓)	Y		N		Attached (✓)	Y		N	

Any other information	

TO ENSURE PATIENT CONFIDENTIALITY PLEASE ONLY USE A SECURE NHS E-MAIL ACCOUNT TO SEND THIS FORM TO:
bccg.contracts@nhs.net

Monitoring / Audit Criteria

Aspect	Method	Frequency	Responsibility	Reporting Arrangements
DSSA Breaches	Reported	Monthly	HON PC	Trust Board
Complaints reviewed	Reported	Quarterly	ADON	CQuOB

References:

General Medical Council (2013) *Intimate Examinations and Chaperones*.

NICE patient experience in adult NHS services
https://www.nice.org.uk/Guidance/CG138

The Human Rights Act 1998 http://www.legislation.gov.uk/ukpga/1998/42/contents

Equality Act 2010 https://www. http://www.legislation.gov.uk/ukpga/2010/15/contents

Accessible Information Standards 2016
https://www.england.nhs.uk/ourwork/accessibleinfo/

NICE Transition from children's to adults' services for young people using health or social care services NG43 2016 https://www.nice.org.uk/guidance/ng43

NMC the code https://www.nmc.org.uk/standards/code/

NHSE/I Delivering same-sex accommodation 2019

NHS Operating Framework 2012/13