Derby Teaching Hospitals NHS
NHS Foundation Trust

TRUST POLICY AND PROCEDURES FOR MAINTAINING THE PRIVACY AND DIGNITY OF PATIENTS INCLUDING CHILDREN AND YOUNG PEOPLE

Reference Number CL -OP/2010/028	**Version:** V5		**Status** Final	**Author: Libby Keep Head of Clinical Governance**
Version / Amendment History	Version	Date	Author	Reason
	V1	March 2010	Kerry Pape/ Lynne Fryatt/ Gill Ogden	New Policy - includes merger of 3 policies
	V2	May 2010	Kerry Pape/ Lynne Fryatt/ Gill Ogden	Final amendments
	V3	July 2016	Libby Keep	Review and update
	V4	April 2017	Libby Keep	Update
	V5	October 2017	Meg Haselden	Update

Intended Recipients: All Trust staff

Training and Dissemination: Dissemination will be via the Intranet

To be read in conjunction with:

Mental Capacity Act Policy

Trust Policy for Maintaining a Safe Environment

Trust Policy and Procedures for Consent

Trust Chaperoning Policy

In consultation with and Date:

Patient Experience Group

Medical Advisory Committee (MAC)

Joint Professionals Advisory Committee (JPAC)

Divisional Directors of Nursing

Clinical Governance Facilitators

Matrons

EIRA stage One Completed	Yes
Stage Two Completed	No

Procedural Documentation Review Group Assurance and Date	Yes Date
Approving Body and Date Approved	Trust Management Team (TMT)
Date of Issue	July 2016
Review Date and Frequency	July 2019 then every 3 years
Contact for Review	Head of Governance
Executive Lead Signature	Director of Patient Experience & Chief Nurse
Approving Executive Signature	Director of Patient Experience & Chief Nurse

TRUST POLICY AND PROCEDURES FOR MAINTAINING THE PRIVACY AND DIGNITY OF PATIENTS INCLUDING CHILDREN AND YOUNG PEOPLE

1 Introduction

All Trust staff has a crucial role to play in creating an environment in which human rights are respected. They are the basic rights that everyone has, regardless of who a person is, where they live or what they do. A fundamental aspect of human rights is an individual's right to humane and dignified treatment.

Human rights represent all the things that are important to people as human beings, such as being able to choose how they live their life and being treated with dignity and respect.

They are based on a number of core values, including:

Fairness
Respect
Equality
Dignity
Autonomy

(Department of Health, 2008)

Privacy and dignity are embedded in the care of patients as well as in the environment in which that care is delivered. This includes Inpatient areas, Outpatient Departments and all Specialist areas including Imaging, Day Case, Theatres and all areas that care for Children and young people. Responsibility for protecting and promoting privacy and dignity does not lie with one individual or group, but with all staff at every level. Staff should deal sensitively with the varied circumstances in which a patient's privacy and dignity may be infringed and must always be aware of actual and potential clinical risks as they implement the responsibilities for privacy and dignity described in this policy.

Part One of this policy focuses on patients' privacy and dignity, the care environment, Essence of Care Benchmarks and describes the Trust's standards for good practice including equality and diversity and the protection of human rights in healthcare.

Part Two focuses on ensuring that all patients admitted to the Trust are placed in an acceptable and appropriate ward environment, which respects their right to privacy and dignity in line with national standards relating to Same Sex Accommodation.

Part Three focuses on the Intimate examination of Patients and the principles of good practice to ensure that staff and patients are protected from situations in which allegations of impropriety, particularly of a sexual nature, may occur.

2 Purpose and Outcomes

The aim of this policy is to ensure that:

Patients experience care in an environment that actively encompasses

respect for individual values, beliefs, cultural needs and personal relationships.

Patients feel that they matter and do not experience negative or offensive attitudes or behaviour.

Patients' individual needs are communicated to all relevant staff involved in their care, treatment and transfer.

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas including childrens' and young peoples' areas.

Appropriate staff attitudes and behaviour are promoted, including consideration of non-verbal behaviour and body language.

Separation of patients of a different gender is an essential aspect of privacy and dignity. Ensuring that bays are same gender and that there are separate washing and toilet facilities is expected. However, for many children and young people, clinical need and age and stage of development may take precedence over gender considerations and mixing of the sexes is reasonable, or may even be preferred.

Privacy and dignity is an important aspect of care for children and young people of all ages. Decisions should be based on their clinical, psychological and social needs and not the constraints of the environment or the convenience of staff.

The child or young person's preference should be sought, documented and respected where possible. Where appropriate the wishes of the parents should be considered, but with young people their preference should prevail.

Particular care to protect privacy is required for children, young people and vulnerable people of any age who may have been previously subject to abuse, including sexual violence.

Intimate examinations are carried out with appropriate care and protects the patient‘s needs regarding privacy and dignity at all times.

3 Definitions Used

Advocate:	Someone speaking for /acting on behalf of another.
Mixed Sex accommodation:	Where men and women have to share sleeping accommodation, toilets or washing facilities.
Same Sex Accommodation:	Same sex wards where the whole ward is occupied by men or women only. Single rooms/Mixed wards, where men and women are in separate bays or rooms.

Elective Admission:	A planned admission agreed between practitioners and the patient/ advocate.
Emergency Admission:	An unplanned admission.
Facilities:	Screens, curtains, toilets and personal washing accommodation.
Intimate Examinations:	Breast and vaginal examination including drug administration, scanning and catheterisation. Male catheterisation, penis/testicle
Chaperone:	A suitably trained member of staff present at an intimate examination.

4 Key Responsibilities

4.1 Director of Patient Experience & Chief Nurse

The Director of Nursing is the Executive Lead for this policy and is responsible for its delegation and development, dissemination and implementation within the Trust

4.2 Divisional Directors of Nursing

The Divisional Directors of Nursing are responsible for receiving monitoring reports and for escalating relevant issues relating to the implementation of this policy.

4.3 Operations Managers/Service Managers/Patient Flow - Bed Managers/Divisional Directors of Nursing/Senior Matrons/Ward Matrons

These staff will monitor their areas in relation to privacy and dignity issues which include environmental aspects and those arising out of the delivery of care. They will ensure compliance with this policy.

Issues regarding Same Sex Accommodation will be discussed at the daily Bed Meetings and will be escalated to the relevant General Manager and Divisional Director of Nursing

4.4 All Trust Clinical Staff

All Trust staff in contact with patients have a duty to respect an individual patient's privacy and dignity at all times.

PART ONE

5.1 Maintaining the Privacy and Dignity of Patients

5.1.1 Attitudes and Behaviour

Staff will treat patients, their relatives, partners and carers in a manner that makes them feel that they are valued and respected and do not experience negative or offensive attitudes or behaviour.

Staff must ensure that sensitive attitudes and behaviour are promoted, including consideration of their non-verbal behaviour and body language.

Staff will ensure that each patient experiences care in a sensitive way that actively encompasses respect for their individual values, beliefs and personal relationships. Each patient's needs will be ascertained, documented and appropriately reviewed.

Staff will ensure that patients and their partners in same-sex relationships are treated with the same level of courtesy, dignity and respect as patients and their partners of the opposite sex.

5.1.2 Communication with Patients

Communication with patients will be in a manner that respects their individual knowledge, abilities and preferences.

Staff will listen to patients and ensure their views and needs are taken into account.

Staff will communicate "with" not "at" patients relatives and carers, at an individualised pace and must check understanding appropriately. Repeating and explaining information where relevant is essential to ensure understanding.

Interpreting services may be necessary and it is only in exceptional circumstances that family members should be asked to interpret.

Information about their diagnosis and care should be shared only with the patient themselves (adults) or for children those with parental responsibility. A professional judgement will have to be made in relation to young people.

In providing care staff must at all times be sensitive to the need for confidentiality of patient information. Every effort must be made not to discuss any patient or visitor within the hearing of another patient or visitor, particularly when sensitive information is being discussed. This includes telephone conversations, written records or computer information.

A patient must formally agree to information about their diagnosis and care being shared with any other person.

All important communications should be recorded in the patient health record and should include a summary of who was present and any outstanding actions.

5.1.3 Personal Boundaries and Space

The name by which each patient wishes to be called must be sensitively determined, recorded and communicated to others in the care team. The default form of address should be Mr. Ms. or Mrs. With children and young

people the first name is normally used.

Staff will establish with each patient the acceptability of personal contact and their preferred personal space and boundaries and communicate this to the care team.

Staff will respect and protect each patient's personal space by knocking or making their presence known before entering the clinical area or by respecting dignity signs when bedside curtains are drawn.

Whenever possible staff will promote the dignity of all patients when others are required or requested to be present (e.g. medical, nursing or other students), by seeking the patient's permission in advance.

Staff will ensure that they include the patient in all conversations held in front of them, especially during personal care, intimate examinations and ward rounds.

5.1.4 Protecting Patient Modesty

Staff will protect patients from unwanted public view (including that of clinicians) by effective use of curtains, screens and blankets etc.

Patients should have access to their own clothes whenever possible and should be assisted to dress if necessary. This includes the use of patients own nightwear, dressing gowns and slippers.

Staff will ensure that patients unable to help themselves are never left without a covering to maintain their dignity, especially during bed bathing and changing of bed linen/nightwear. Staff must also make every effort to ensure that where patients expose themselves that they are covered appropriately and shielded from the view of others.

Dependant patients will be given assistance to dress and to insert hearing aids and dentures where required.

Staff will ensure that patients are always adequately dressed or covered within a clinical area and prior to leaving a clinical area for any reason, so that their privacy and dignity is maintained and they are warm and comfortable.

Privacy and dignity should be maintained whenever children and young peoples' modesty may be compromised, e.g. when wearing hospital gowns or nightwear, or where their bodies (other than the extremities) are exposed, or when they are unable to preserve their own modesty, e.g. following a general anaesthetic, or when sedated.

5.1.5 The Care Environment

Patients will be cared for in an environment that actively promotes their privacy and protects their dignity, especially when they are unable to do this for themselves.

5.1.6 Transfers between Departments/Wards

It is essential that patients' privacy and dignity is maintained during all transfers between wards and departments. Patients must be offered the

choice of wearing their own clothing prior to transfer and must be adequately dressed /covered prior to leaving any clinical area.

Adequate clothing includes the patient's dressing gown, worn over a hospital gown or their own nightwear, together with slippers or shoes (where available). A sheet or blanket must be provided when the patient is transferred in a wheelchair or trolley. More blankets must be provided where necessary to keep the patient warm during transfer, particularly during cold weather.

5.1.7 Outpatient Departments

Outpatient Departments will provide a 'Fast-Track' service to patients where possible to ensure the patient is seen promptly and then transferred back to the originating area. To facilitate this service the inpatient area must ring the relevant department prior to transfer, to enable the receiving area to make provision to ensure the patients individual care needs are met without unnecessary delays.

Senior Matrons will monitor all Outpatient areas to ensure that patients' privacy and dignity are maintained. Where there are concerns or incidents the relevant Ward or Department Matron will be informed immediately.

PART TWO

5.2 Maintaining Patient Privacy and Dignity with Regard to same Sex Accommodation

5.2.1 Emergency Admissions to a Ward

All patients admitted as an emergency will be cared for on wards with single gender bays or single rooms. Bays and single rooms have en-suite facilities which are close to patients' beds and are signposted appropriately. Patients should not need to pass through areas occupied by the opposite sex to use toilets and washing facilities. High standards in care involve these presumptions and are intended to protect patients from unwanted exposure, including overlooking or overhearing. All toilet and washing facilities will be lockable by the patient but also accessible to staff in an emergency.

In facilities where limited medical equipment is held for use by either gender, e.g. use of a fixed bathroom hoist, all personal washing areas and toilets must have appropriate signage. However all wards must ensure that reasonable steps are taken to implement segregation where possible.

In emergency situations temporary mixing of the sexes may be justified and decisions must be made based on the clinical needs of individual patients and not the constraints of the environment or the convenience of staff.

For emergency admissions, arrangements must be in place to move the patient into appropriate accommodation as soon as possible. Staff must make it clear to the patient/relatives/advocate that this is an exception and not the norm for this Trust.

In the first instance this may involve moving the patient into a single room within the ward. Where this is not feasible or acceptable the nurse in charge must liaise with their line manager/Operational Manager.

Greater segregation should be provided when the privacy and dignity of the patient may be compromised particularly if sedated or unconscious, when wearing hospital

gowns or where the body is exposed. This could involve curtains or more appropriate clothing and covering.

See Appendix 1: Delivering Same-Sex Accommodation When Patients are Admitted in an Emergency

5.2.2 Elective Admissions

For elective admissions, patients must be given written information regarding the environment in which they will be cared for. This information must include the physical layout / accommodation of the ward, and staff must ensure that the patients are happy with this arrangement. If a patient refuses admission due to shared accommodation, it must be noted, and a further date, within one month of the original date, must be confirmed whereby segregated accommodation is available.

See Appendix 2: Delivering Same-Sex Accommodation in Day Treatment Areas

5.2.3 Admission of Children and Young People

Decisions regarding same sex accommodation in Childrens Units should be based on the clinical, psychological and social needs of the child or young person. The approach should be discussed with the child or young person if they are old enough to understand and with their parents or carers. Their choice should be sought, documented and respected where possible. If they prefer to be cared for with members of their own sex then this preference should be accommodated.

Children and young people find great comfort from sharing with others of their own age and often, this outweighs their concerns about mixed sex rooms. Young people should be given the choice. Washing and toilet facilities need not be designated as same sex as long as they accommodate only one patient at a time, and can be locked by the patient but also accessible to staff in an emergency.

It may be appropriate to segregate children and young people because of age rather than gender, but these decisions must be in the best interests of the patient. Flexibility may be required as children and young people may prefer to spend most of their time in mixed areas, but to have access to single gender spaces for treatment or personal care. Such flexibility is encouraged as it is not acceptable to assume that mixing is always excusable.

In children's areas parents are encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care must be taken to ensure that this does not cause embarrassment or discomfort to patients.

5.2.4 Critical Care and High Dependency Units

A minority of patients will have a clinical condition which requires access to potentially life-saving treatments which can only be delivered within critical care/high dependency environments. At these points in a patient's journey, access to and treatment within appropriate locations is paramount and mixing of the sexes can be justified on these grounds.

Under such circumstances a breach is said to have occurred when mixing of the sexes occurs for any reason other than the need for critical/high dependency care. For example a patient of the opposite sex being placed in a critical care/high dependency area simply because there is an empty bed not because of clinical need **or** a patient remains in the critical care/high dependency area for more than 4 hours post being declared medically fit for normal ward based care.

See Appendix 3: Delivering Same-Sex Accommodation in Critical Care Environments

5.2.5 Patient Requests for Alternative Accommodation

Patient preference should be sought and where possible respected. Patients must be given an opportunity to request alternative accommodation if they are in a mixed sex sleeping area. Arrangements must be in place to address patient / advocate concerns.

5.2.6 Reporting a Mixed Sex Accommodation Breach

A breach is defined as occurring when males and females are required to:

- Share sleeping accommodation
- Remain in a critical care/high dependency area for more than 4 hours post being declared medically fit for normal ward based care.
- Be admitted to a critical care/high dependency area simply because there is an empty bed not because of clinical need
- Share toilets and bathrooms
- Pass through an area of opposite sex accommodation to access toilets and bathrooms or their own sleeping accommodation

The ward areas must report all breaches by completing the Mixed Sex Accommodation Breach Form found behind the Mixed Sex Breach icon on Flo.

See Appendix 5: Mixed Sex Accommodation Breach Flow Chart for Ward Staff.

The number of breaches that need to be declared will be dependent on the number of each of the sexes in the area at the time of the breach.

See Appendix 6: Mixed Sex Breaches: What to Declare for guidance with regard to what constitutes a breach and how many to declare.

Every effort must be made by the Nurse in Charge of the ward/area, the Matron and the Flow Team to transfer the medically fit patient out of the critical care/high dependency environment within the 4 hour transfer window.

See Appendix 7: Mixed Sex Accommodation Breach Flow Chart for Patient Flow Team.

The number of Mixed Sex Breaches is reportable monthly to NHS Improvement via a Unify submission and to the Clinical Commissioning Group (CCG). Each breach attracts a fine of £250 to the Trust payable to the responsible CCG.

See Appendix 8: Reporting Process for Mixed sex Accommodation Breaches.

PART THREE

5.3 Maintaining Patient Privacy and Dignity During Intimate Examinations

All clinical consultations, examinations and investigations are potentially distressing. Patients can find examinations, investigations or photography involving the breasts, genitalia or rectum particularly intrusive. These examinations are collectively referred to as Intimate Examinations. Consultations involving dimmed lights, the need for patients to undress or longer periods of examination may also make the patient feel particularly vulnerable.

5.3.1 Use of a Chaperone: Principles for Practice

The offer of a chaperone should be made with a full explanation of the procedure. If a chaperone is not available the examination should be postponed until one is available. The patient may agree to proceed without a chaperone.

Clinicians may insist on a chaperone being present if the patient declines but the clinician feels it would be appropriate.

All patients regardless of age, gender, ethnicity, sexual orientation, or mental status, have the right to request a chaperone. Issues relating to chaperoning patients must be recorded in the patient's Health Record and communicated to all relevant staff.

A chaperone must always be present if the patient has a reduced level of consciousness, is intoxicated, is under the influence of drugs of a hallucinogenic nature, or lacks mental capacity.

The patient may request a relative, carer, or friend to be present. All efforts

should be made to facilitate this; however they will not fulfil the role of chaperone.

Consent must be obtained for intimate examinations by medical students and the patient has the right to refuse this. See Guidelines for the Intimate Examination of Patients by Medical Students (Appendix 5).

When intimate procedures or examinations are required staff should ensure that they are aware of any relevant cultural or religious beliefs, which prohibit this type of examination being done by a member of the opposite sex.

For some nursing and midwifery procedures it is unrealistic to offer a chaperone on every occasion, e.g. assistance with washing. In these circumstances staff should obtain consent from the patient and undertake the care in a sensitive manner.

5.3.2 The Examination

Prior to any intimate examination:

- The examining clinician will explain to the patient why an examination is necessary and what it will involve, including any potential pain or discomfort.
- Where necessary the patient must be assisted to undress.
- The independent patient will be left in private to undress.
- Gowns / drapes will be provided to ensure limited patient exposure.
- Any clinician who undertakes an examination without a chaperone who begins to feel vulnerable must withdraw immediately and document details of the patients' behaviour in the health records.
- On documenting the examination in the health records a note will be made of the chaperone present, or if a chaperone was declined.

6 Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trust monitoring template.

Monitoring Requirement:	To demonstrate that the Trust is monitoring compliance with the documented processes for: **Part One** Maintaining the Privacy and Dignity of Patients **Part Two** Maintaining Patient Privacy and Dignity with regard to Same Sex Accommodation **Part Three** Maintaining Patient Privacy and Dignity during Intimate Examinations

Monitoring Method:	**Part One** Compliance will be monitored via Patient Surveys, clinical incidents and complaints. This will be reported to the Patient Experience Group and relevant issues will be reported in the quarterly reports to the Quality Review Committee. **Part Two** Internally performance with regard to Mixed Sex Breaches is reported via the 'Right First Time' PRIDE Objective section of the Integrated Performance Report. This report goes to Trust Delivery Group, Finance and Investment Committee and Trust Board. A monthly Divisional report is generated by the Information Team and sent to the respective Divisional Nurse Directors and Matrons. Externally Mixed Sex Accommodation Breaches are reported monthly to NHSI via Unify and via the Quality Report to the Southern Derbyshire Clinical Commissioning Group for the Quality Account. **Part Three** Compliance will be monitored via Patient Surveys, clinical incidents and complaints. This will be reported to the Patient Experience Group and relevant issues will be reported in the quarterly reports to the Quality Review Committee.
Monitoring Report presented to:	**Part One and Part Three** Quality Review Committee **Part Two** Trust Delivery Group, Finance and Investment Committee and Trust Board.
Frequency of Report:	Monthly to Trust Delivery Group, Finance and Investment Committee and Trust Board, Divisional Nurse Directors and Matrons. Quarterly to Quality Review Committee.

7 References

Patient Privacy and Dignity-Intimate Examinations: CMO letter	DOH (2003)
Committee of Enquiry-Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling	DOH (2004)
Eliminating Mixed Sex Accommodation	DOH (May 2009)
Beasley, C. and Flory,D	

The Kerr/Haslam Inquiry Report	DOH (2005)
Human Rights in Healthcare	DOH (2008)
Patient Charter	DOH (1995)
Health Service Circular 1998/43	January, (1997)
Ethics Briefings English, V,, Mussell, R, Sheather, J and Sommerville, A	(2004)
Intimate Examinations General Medical Council	(2001)
Healthcare for All: Report of the Independent Enquiry into Access to Healthcare for People with Learning Disabilities. Sir Jonathan Michael	(2008)
Nursing and Midwifery Council Guidelines for Chaperoning Patients	(2008)
Nursing and Midwifery Council Guidelines for Record Keeping	(2003)
Royal College of Nursing Chaperoning: The Role of the Nurse	(2003)
Royal College of Obstetricians and Gynecologists: Gynaecological Examinations; Guidelines for Specialist Practice	(2002)

Appendix 1

DELIVERING SAME-SEX ACCOMMODATION WHEN PATIENTS ARE ADMITTED IN AN EMERGENCY

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including when admission is unplanned.

High standards usually involve a presumption that men and women do not have to sleep in the same room, nor use mix bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through areas occupied by members of the opposite sex to reach their own facilities.

However, it is recognised that in some emergencies, mixing of the sexes can be justified.

Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. This means that mixing must be justifiable for all patients in the room.

Further detail and background

These notes explain the Trust expectations in relation to patient perceptions in emergency and unplanned admissions, whether direct to a ward, or via an admissions unit .

Separate guidance is available for children's services, intensive care units, and day treatment areas

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff.
- Admissions Units should be capable of delivering segregation for most of patients for most of the time.
- Patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives, carers or loved ones.
- The reasons for mixing, and the steps being taken to put things right should be explained fully to the patient and her/his family and friends.
- Staff should make clear to the patient that the Trust considers mixing to be the exception, never the norm.
- Greater segregation should be provided where patients' modesty may be compromised (e.g. when wearing hospital gowns/nightwear, or where the body (other than the extremities) is exposed.
- Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated).

- Where mixing 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.

Implications and Examples

When a patient's survival and recovery depend on rapid admission, the requirement for full segregation may take a lower priority. But this does not imply a blanket exemption for all emergency admissions, nor does it imply a blanket exemption for Admissions Units.

Individual clinical needs must be judged for each individual patient. If a patient is admitted into a multi-bed room, then either all patients must be of the same gender, or mixing must be clinically justified for all patients in the room, not just the newly-admitted one.

Where patients cannot be immediately admitted to the "appropriate bed" (i.e. one in the appropriate specialty, with same-sex accommodation) then the final placement decision should weigh the benefits and disadvantages of each available option. Wherever possible, the patient or their family should be consulted.

Clearly, patient safety is paramount, but the requirement for segregation must not be ignored. It should be demonstrably possible for the majority of emergency patients to have their clinical needs met within segregated accommodation.

Appendix 2

DELIVERING SAME-SEX ACCOMMODATION IN DAY TREATMENT AREAS

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity and this applies to all areas, including Day Treatment areas.

High standards involve a presumption that men and women do not have to be cared for in the same room, nor use mixed bathing and WC facilities. This is intended to protect patients from unwanted exposure, including overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

However, the Trust recognises that in some Day treatment areas, mixing of the sexes may be appropriate, or even desirable. Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff.

Further detail and background

These notes explain Trust expectations in relation to patient perceptions in day treatment areas.

Separate guidance is available for children's services and for intensive/high-dependency care and emergencies.

What is a "day treatment area" in this context?

Examples of "day treatment areas" include, amongst others:

- Renal Dialysis Units
- Day Surgery Units
- Endoscopy Units
- Elderly Care Day Hospitals
- Chemotherapy Units

Principles

- Decisions should be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff.

- Greater segregation must be provided where patients' modesty could be compromised (e.g. when wearing hospital gowns/nightwear, or where the body other than the extremities, is exposed).

- Staff must make clear to the patient that the Trust considers mixing to be the exception, never the norm.

- Greater protection must be provided where patients are unable to preserve their own modesty (e.g. following recovery from a general anaesthetic or when sedated).

- Patient preference must be sought, recorded and where possible respected. Ideally, this should be in conjunction with the patient's relatives, carers or loved ones.

Implications and examples

Using these principles allows staff to make sensible decisions that may vary from day to day. For instance, in a Renal Dialysis Unit, if all patients are well-established on treatment, wear their own clothes and have formed personal friendships, mixing may be a good thing.
By contrast, a new dialysis patient, with a femoral catheter, and wearing a hospital gown, should be able to expect a much higher degree of privacy.
Similar considerations apply wherever treatment is repeated, especially where patients may derive comfort from the presence of other patients with similar conditions. Thus, for instance, it may be appropriate to nurse a mixed group of patients together as they receive regular blood transfusions. Likewise, it is clearly reasonable for both men and women to attend an elderly care day hospital together – as long as toilet and bathroom facilities are separate, and very high degrees of privacy and segregation are maintained during all clinical or personal care procedures.

Day Surgery and Endoscopy Units

The presumption of same-sex accommodation applies in day surgery units, especially those where patients may remain overnight. The exception might be where very minor procedures are being undertaken – eg “lumps and bumps” on the hand or foot. As a starting point, if the patient is in a hospital gown, and may have difficulty preserving their own modesty due to sedation or anaesthesia, then segregation should be the norm.

Appendix 3

DELIVERING SAME-SEX ACCOMMODATION IN CRITICAL CARE ENVIRONMENTS

Introduction

There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including critical care environments.

High standards usually involve a presumption that men and women do not have to sleep in the same room, nor use mixed bathing and WC facilities. These presumptions are intended to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities.

On occasion, however, a minority of patients may have a clinical condition which requires immediate access to potentially life-saving treatments which can only be delivered within critical care environments. At these points in a patient's journey, access to and treatment within appropriate locations is paramount. In these situations, mixing of the sexes can be justified.

Further detail and background

This note explains our expectations in relation to patient perceptions in critical care environments. Separate guidance is available for children's services, emergencies, and day treatment areas.

Principles

- Decisions should be based on the needs of the individual patient whilst in critical care environments, and their clinical needs will take priority.

- Decisions should be reviewed as the patient's clinical condition improves and should not be based on constraints of the environment, or convenience of staff.

- The risks of clinical deterioration associated with moving patients within critical care environments to facilitate segregation must be assessed

- Where mixing does occur, there should be high enough levels of staffing that each patient can have their modesty constantly maintained by nursing staff. This will usually mean one-to-one nursing, or at the least, a constant nurse presence within the room or bay

- Where possible (for instance for planned post-operative care) patient preference should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives or loved ones.

Implications and examples

When a patient's survival and recovery depend on the presence of high-tech equipment and very specialist care, the requirement for full segregation clearly takes a lower priority. But this does not mean that no attempt at segregation is necessary. At the very least, staff should consider whether it is possible to improve segregation. In new units, the design should support segregation as far as possible.

The same principles apply to theatre recovery units where patients are cared for immediately following surgery, before transfer to the ward. Whilst separate male and female recovery units are not required, some degree of segregation remains the ideal. High levels of observation and nursing attendance should mean that all patients can have their modesty preserved whilst unconscious.

Breach Standards for Same Sex Accommodation

A breach is defined as occurring when males and females are required to:

- Share sleeping accommodation
- Share toilets and bathrooms
- Pass through an area of opposite sex accommodation to access toilets and bathrooms or their own sleeping accommodation (DH 2010c)

It is acceptable to have toilets and washing facilities that can be allocated to men or women according to need; as long as there is good signage to make it clear which sex is designated at any particular time.

The breach occurs as soon as the above circumstances happen and lasts until they are resolved.

In Specialist areas in order to facilitate the relocation to same sex accommodation, it has been agreed with the Commissioners that a timeframe of 4 hours is appropriate. The breach time will be taken after the 4 hours has lapsed from when the patient did not require level 2 or 3 cares. The breaches all need reporting, however, For ICU and HDU areas , the breaches will be taken on a case by case basis and discussed with the Commissioners to determine the actual number of breaches. This will be done by the Head of Governance or nominated Deputy.

The number of breaches caused by a particular event will be equal to the total number of affected patients (1 female in a bay with 5 males = 6 breaches) where bays open into other bays both bays are required to be of the same sex. Within ICU a floor plan has been shared with the Commissioners the following as it is recognised due to the layout some spaces will not be affected – further information is available in ICU

Same Sex Accommodation Exception (Appendix 6) In the event of a breach of these standards the form should be completed by the Senior Nurse/Nurse in charge within the clinical area. In normal working hours this should be supported by the relevant Matron who should ensure that all aspects of the process are logged

Out of hours the Senior Nurse should support this process ensuring that the information provided is completed and an email is sent to the on call Manager informing them of the breach if they have not been involved in the initial discussion. A log needs to be made in the Operations Centre and captured on the Bed Profroma that is circulated throughout the day

In the event of a mixed sex breach the Commissioners will be informed within one working day by the Head of Governance or nominated Deputy.

Appendix 4

DELIVERING SAME-SEX ACCOMMODATION FOR TRANS PEOPLE AND GENDER VARIANT CHILDREN

Transsexual people, that is, individuals who have proposed, commenced, or completed reassignment of gender, enjoy legal protection against discrimination. In addition, good practice requires that clinical responses be patient-centred, respectful, and flexible towards all transgender people who do not meet these criteria, but who live *continuously or temporarily* in the gender role that is opposite to their natal sex. General key points are that:

- Trans 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 of the chest or genitalia;
- It does *not* depend upon their having a gender recognition certificate (GRC) or legal name change;
- It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities);
- Views of family members may not accord with the trans person's wishes, in which case, the trans person's view takes priority.

Those who have undergone full-time transition should **always** be accommodated according to their gender presentation. Different genital or breast sex appearance is **not** a bar to this, since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a gender appropriate ward. This approach may only be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a trans person being placed in an otherwise opposite gender ward. Such departures should be proportionate to achieving a 'legitimate aim', for instance, a safe nursing environment.

This may arise, for instance, when a trans man is having a hysterectomy in a hospital, or hospital ward that is designated specifically for women, and no side room is available. The situation should be discussed with the individual concerned and a joint decision made as to how to resolve it. At all times this should be done according to the wishes of the patient, rather than the convenience of the staff (see http://www.gires.org.uk/assets/trans-rights.pdf section 1.4, pp9,10).

In addition to these safeguards, where admission/triage staff are unsure of a person's gender, they should, where possible, ask **discreetly** where the person would be most comfortably accommodated. They should then comply with the patient's preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their *continuous* gender presentation (unless the patient requests otherwise).

If upon admission, it is impossible to ask the view of the person because he or she is unconscious or incapacitated then, in the first instance, inferences should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary in order to carry out treatment.

In addition to the usual safeguards outlined in relation to all other patients, it is important to take into account that immediately post-operatively, or while unconscious for any reason, those trans women who usually wear wigs, are unlikely to wear them in these circumstances, and may be 'read' incorrectly as men. Extra care is therefore required so that their privacy and dignity as women is appropriately ensured.
Trans men whose facial appearance is clearly male, may still have female genital appearance, so extra care is needed to ensure their dignity and privacy as men.

Particular considerations for children and young people
Gender variant children and young people should be accorded the same respect for their self-defined gender as are trans adults, regardless of their genital sex.

Where there is no segregation, as is often the case with children, 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 or young person.

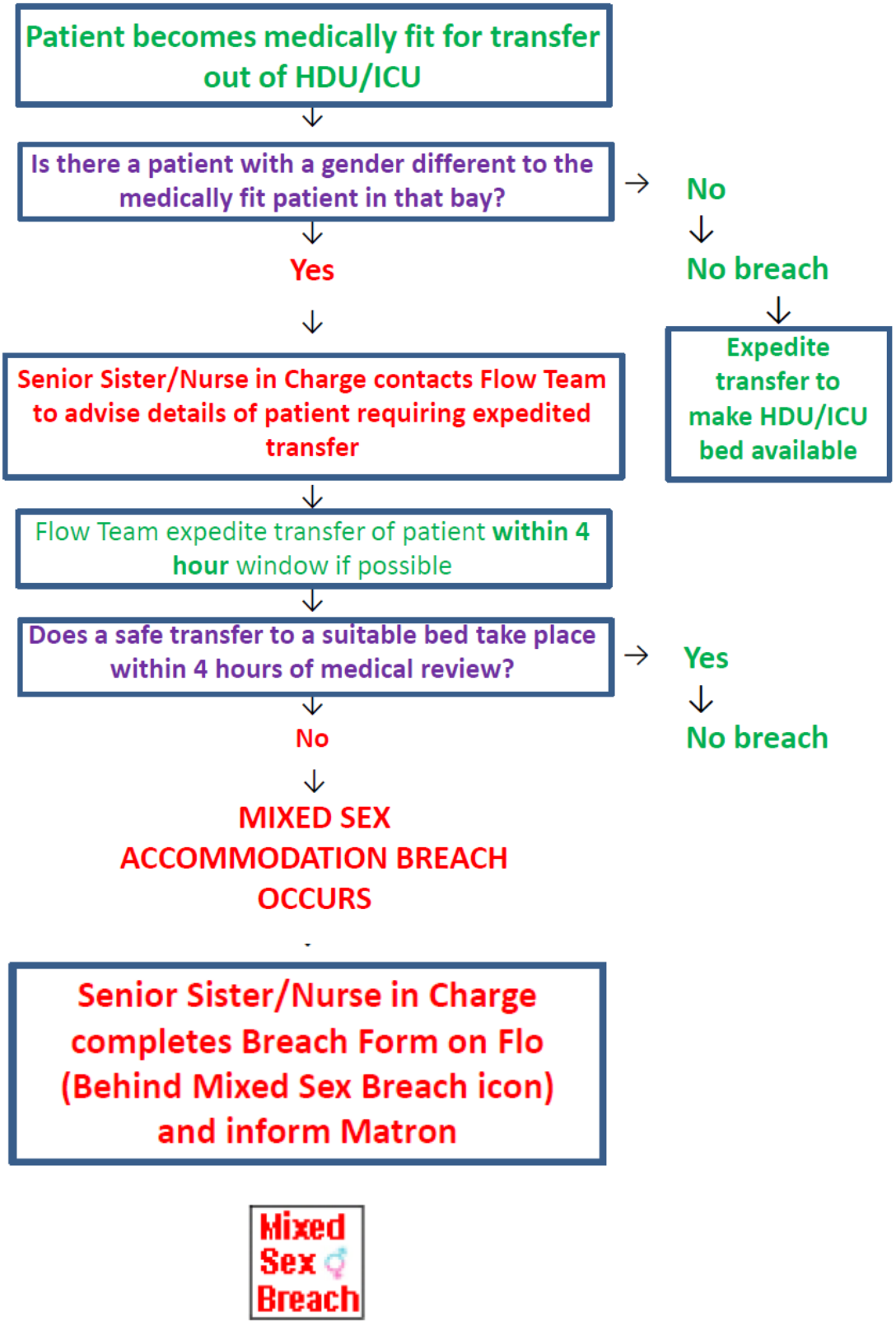
In some instances, parents or those with parental responsibility may have a view that is not consistent with the child's view. If possible, the child's preference should prevail even if the child is not Gillick competent.

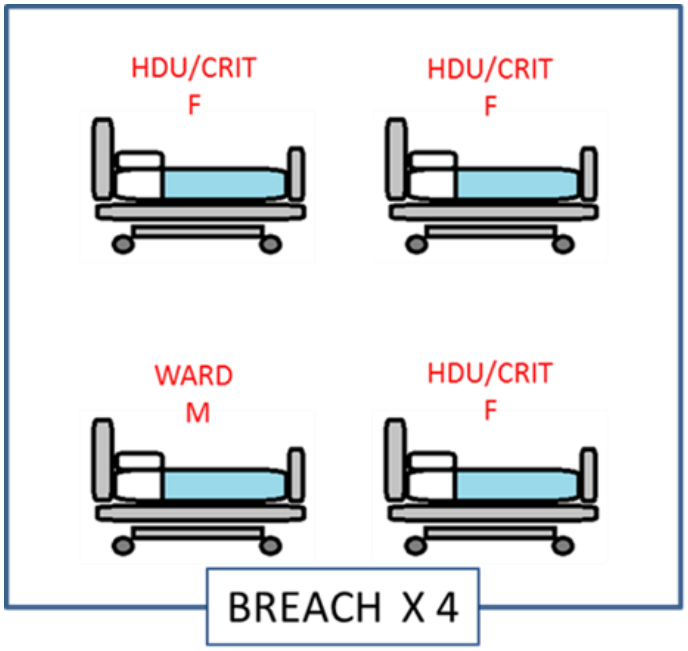
More in-depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that they are extremely likely to continue, as adults, to experience a gender identity that is inconsistent with their natal sex appearance so their current gender identity should be fully supported in terms of their accommodation and use of toilet and bathing facilities.

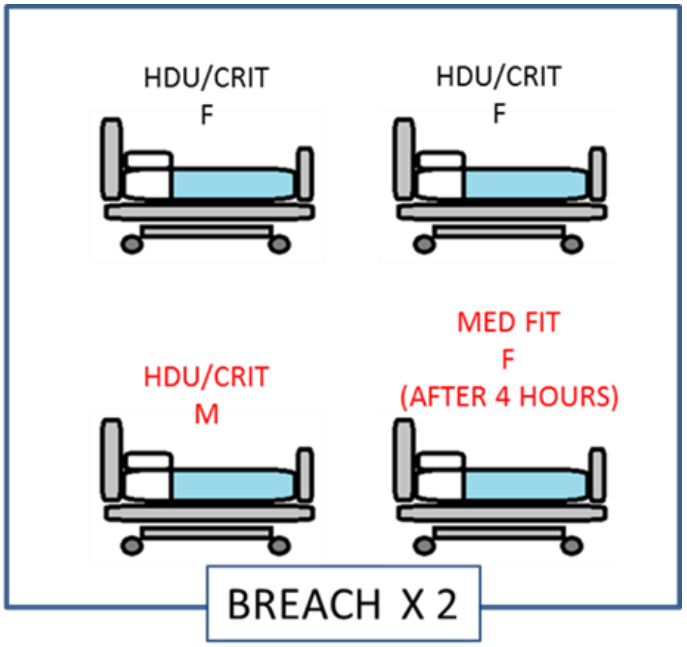
It should also be noted that, although rare, children may have conditions where genital appearance is not clearly male or female and therefore personal privacy may be a priority.

Appendix 5

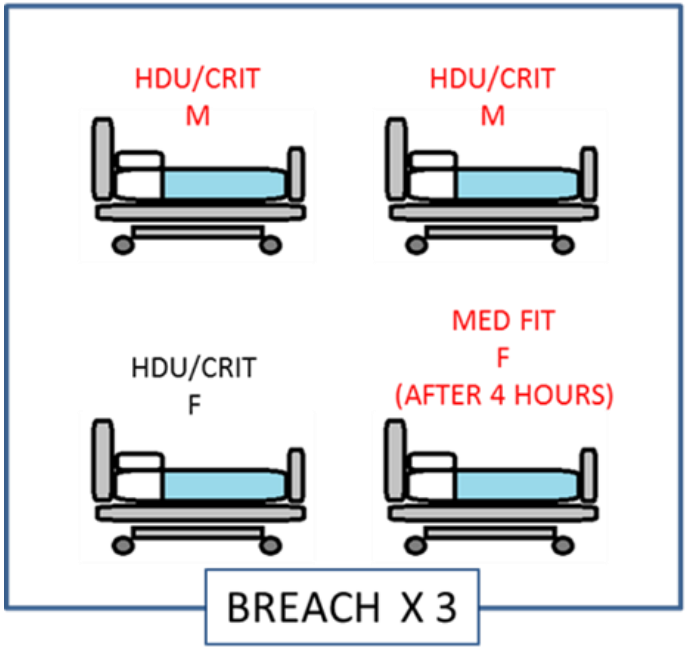
Mixed Sex Accommodation Breach Flow Chart For HDU/ICU Ward Staff







Mixed Sex Breaches: What to Declare



KEY

F = FEMALE PATIENT
M = MALE PATIENT
HDU/CRIT = A PATIENT WHO NEEDS CRITICAL OR HIGH DEPENDENCY CARE
WARD = PATIENT WAS ADMITTED TO A HDU/CRIT BED THAT DID NOT NEED CRITICAL OR HIGH DEPENDENCY CARE
MED FIT = A PATIENT WHO'S CARE HAS BEEN DEESCALATED FROM CRITICAL OR HIGH DEPENDENCY CARE AND HAS EXCEEDED THE 4 HOUR TRANSFER WINDOW

Mixed Sex Accommodation Breach Flow Chart For Patient Flow Team

Patient becomes medically fit for transfer out of HDU/ICU and ward staff inform Patient Flow of the need to safely transfer patient to an alternative bed due to mixed Sex Breach

↓

Patient Flow Manager to liaise with the Bed Manager to review beds and a formulate a plan to avoid a mixed sex breach within 4 hours

↓

Transfer completed within 4 hours? → Yes ↓ No breach

↓ No

↓

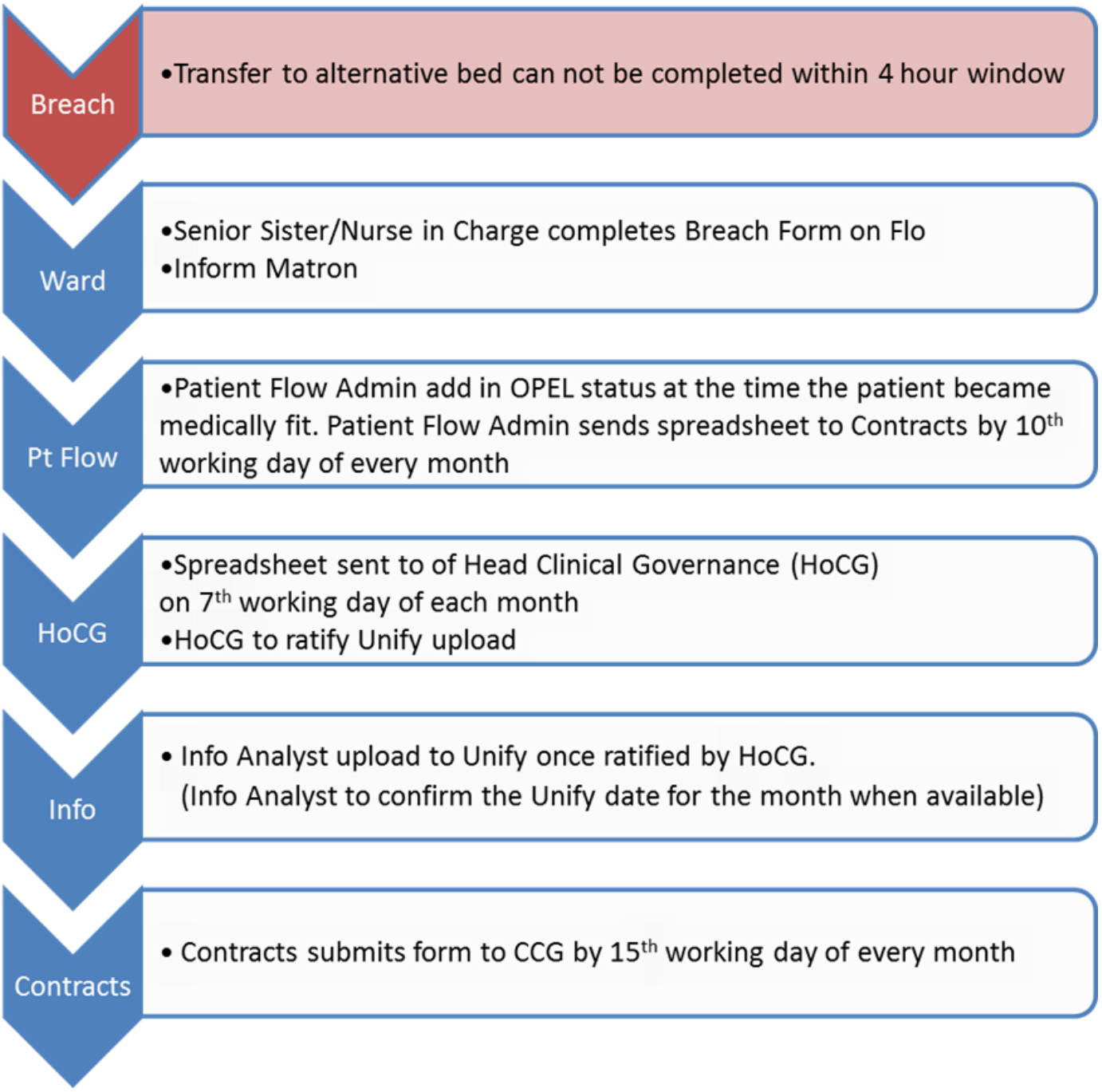
If it is not possible to move a patient out within 4 hours, the ward staff complete a Mixed Sex Breach reporting form on 'flo' and inform their Matron

Bed Meetings:

- Patient Flow Manager to record the details in the ops centre for discussion at bed meetings
- If no bed is available, the situation must be kept under constant review for opportunities to rectify Mixed Sex Breaches and continue to escalate at the bed meetings until resolved

Appendix 8

Reporting Process for Mixed Sex Accommodation Breaches



Appendix 9

GUIDELINES FOR THE INTIMATE EXAMINATION OF PATIENTS BY MEDICAL STUDENTS

Purpose:

According to the GMC's Recommendations on Undergraduate Medical Education, medical students are expected to acquire knowledge and develop certain skills, attitudes and behaviour consistent with the principles set out in Good Medical Practice (2006).

All medical students are expected to be competent in physical examination, including the examination of intimate parts.

This presents an ethical problem for students and educators. Whilst it is important for students to learn and be competent in these procedures "to benefit future patients and improve standards of care", patients must also be protected. These guidelines outline good practice in obtaining consent and in conducting an intimate examination.

Definitions:

For the purpose of this guideline an 'intimate part' will be defined as breast, external and internal female genitalia, penis, scrotum and rectum.

An intimate examination, therefore, includes:

- Vaginal examination (including speculum examination, cervical smear taking, taking triple swabs and bimanual pelvic examination)
- Rectal examination
- Female catheterization
- Breast examination
- Examination of the external genitalia of the male

Implementing the Guidelines:

The Royal College of Obstetricians and Gynaecologists (RCOG) recommends that the student is taught how to wear gloves and handle a vaginal speculum in a classroom setting in order to practice and gain experience before examining a patient in an outpatient clinic.

All pelvic and speculum examinations in an awake patient should be performed under direct medical / midwifery supervision.

Intimate examination in conscious patients:

The following are recommended:

- Explain to the patient what is going to happen and why the examination is necessary.
- Obtain verbal consent. The health care professional supervising the medical student should obtain this.
- It is the patient's right to refuse to be examined by a medical student. Consent must be voluntary.
- Students are at liberty to refuse to examine a patient for educational purposes, particularly if they feel that the consent obtained is inappropriate or invalid.
- An appropriately qualified health professional (either a doctor or a midwife in the Labour ward setting) must supervise the medical student during the conduct of the examination.

- A chaperone (someone not related to the patient) should be present throughout the examination and should be a member of staff. This is irrespective of the gender of the clinician or of the student.
- Communicate with the patient during the procedure and explain what is happening.
- Gloves should be worn at all times on both hands.
- Avoid any remarks of a personal nature.
- Remain alert to any verbal or non-verbal indications of distress from the patient. Abandon the procedure promptly if there is any request to do so.
- Any obstetric patient agreeing to be examined by a medical student should have the examination repeated by the supervising obstetrician / gynaecologist / midwife.
- Patients under 18 years old should be excluded from intimate examinations by medical students.
- Patients who lack the capacity to give valid consent should not be examined by medical students.

Remember:

Where the examination is inappropriate, or unconsented, it may constitute the criminal or civil offence of common assault or battery.

References:

1. Gynaecological Examinations: Guidelines for Specialist Practice, Royal College of Obstetricians and Gynaecologists, July 2002
2. RCOG Response to the Guilty Verdict in the trial of Paul Vinall, 08 March 2002
3. GMC Tomorrow's Doctors, Recommendations on undergraduate medical education
4. GMC Guidance for Doctors, Intimate Examinations, December 2001
5. Developing guidelines for medical students about the examination of patients under 18 years old, Tony Hope, Peggy Frith, Janet Craze, Francis Mussai, Ambika Chadha and Douglas Noble, BMJ2005;331;1384-1386
6. The ethics of intimate examinations-teaching tomorrow's doctors, Yvette Coldicott, Catherine Pope, Clive Roberts, BMJ2003;326:97-101
7. Please don't touch me there: the ethics of intimate examinations, BMJ2003;326:1327
8. Intimate examinations and other ethical challenges in medical education, BMJ2003;326:62-63