

PRIVACY AND DIGNITY POLICY

Department / Service:	Nursing Directorate
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Accountable Director:	Chief Nursing Officer
Approved by:	Privacy & Dignity Comparison Group Clinical Governance Group
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Clinical and medical
Target staff categories	Nurses, Midwives, HCA's, Doctors

Purpose of this document:

Worcestershire Acute Hospitals NHS Trust is committed to providing high quality care to patients at all times. This includes respecting an individual's rights to privacy and dignity and is an essential part of everyone's practice as outlined in this policy.

Key amendments to this Document:

Date	Amendment	By:
Sept 2010	Additional reference provision of Same Sex Accommodation for patients (April 2010)	Rani Virk
Nov 2010	Additional references to Department of Health guidance on eliminating mixed sex accommodation	Rani Virk
Nov 2010	Additional reference to the updated Trust Chaperone policy (Dec 2010)	Rani Virk
Nov 2012	No review or amendments made	Rani Virk
May 2015	No amendments following review form Privacy & Dignity group – 21 st May 2015	Rani Virk
August 2017	Document extended for 6 months in line with TMC approval	TMC
Dec 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
October 2018	Document extended for 6 months whilst review is undertaken	Jackie Edwards
July 2019	Extensive Review & Amendments made.	Rachel Sproston

Privacy & Dignity Policy

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1. Introduction

Worcestershire Acute Hospital NHS Trust is committed in respecting an individual's rights to privacy and dignity, which is fundamental in providing high quality care to patients at all times.

The Trust is committed in recognising the importance of ensuring that a culture valuing patient privacy and dignity exists within the organisation and that patients are treated with courtesy and kindness.

The intimate nature of many health care interventions, if not practised in a sensitive and respectful manner can lead to misinterpretation and occasionally, allegations of abuse.

The NHS constitution (DH2013) defines respect and dignity as:
We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

2. Scope of the Policy

Philosophy

The trust is committed to provide care and treatment in a way that ensures people's dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local community, advocating 'Patient Centered Care'. <https://www.hee.nhs.uk/our-work/person-centred-care>

Patients will feel that they matter, that their values, beliefs and personal relationships will be respected. Communication with patients will take place in a manner that respects individuality. Information will be shared to enable treatment and care to be given efficiently and effectively.

All patient care will actively promote privacy and dignity so protecting modesty at all times

This policy will apply to all patients irrespective of age, ethnicity, social, cultural backgrounds, psychological and physical requirements. It is recognised that whilst patients have the right to confidentiality, it is the health professional's duty in law to disclose certain information.

This Policy should be read in conjunction with the following:

NMC Guidance The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. (2018)
Race Equality Scheme
Gender Equality Scheme Worcestershire
Disability Equality Scheme Worcestershire
Trust Safeguarding Vulnerable Adults Guidelines
Worcestershire Vulnerable Adult Protection Policy and Procedure
Confidentiality Policy – WAHT-IG-001
Chaperone Policy – WAHT-CG-606
Provision for Same Sex Accommodation for patients – WAHT-CG-521
End of Life Care Pathway
Guidelines for nurses, midwives, medical and non-medical practitioners performing intimate interventions or procedures
Human Rights Act 1998
Mental Capacity Act
Access and Delivery of Interpreting Services- WAHT-CG-682
Carer's Policy - WAHT-CG-663

3. Definitions

For the successful implementation of this policy it is crucial we have a common understanding of the terms 'privacy and dignity'.

- **Privacy** refers to freedom from intrusion and relates to all information and practice that is personal or sensitive in nature to an individual.
- **Dignity** consists of many overlapping aspects, involving respect, autonomy and self-worth. It comes from putting the individual receiving care at the centre of that care; delivering 'person centred care'. It is about asking them what their needs and wants are whilst respecting their rights to independence and privacy, taking their religious and cultural needs into account.

Essence of Care (DH, 2010)

4. Responsibility and Duties

This policy applies to all Trust employees including locum, contracting, bank and agency staff that are working on behalf of the Trust and are involved in the direct care of our patients.

Trust staff will be made aware of this policy through local induction training supported by their line manager. Locum and agency staff will be made aware of this policy via departmental managers.

All staff are responsible for ensuring they are aware of the ethical, cultural, age and any sensory impairment or religious beliefs which may have an effect on care procedures, including those where intimate contact is required.

The practitioner must demonstrate the ability to create a relationship with the patient that involves mutual trust and respect.

5. Policy detail

Attitudes and behaviour

A professional attitude and behaviour should be demonstrated at all times and staff should be aware of the effects of non-verbal behaviour and how this may be interpreted or may have an impact on a person's perception. Staff should be aware of their tone of voice and use clear non-jargon language.

Staff will treat patients, their relatives or carers, in a manner that makes them feel that they are valued and respected. Patients will receive care in an environment that actively encompasses their individual values, beliefs and personal relationships whilst ensuring that principles of common courtesy are upheld by staff, especially when faced with challenging questions or working within challenging circumstances.

To ensure patients and carers are greeted appropriately staff should introduce themselves, using full name and job title/role on their first contact and patients should be asked how they wish to be addressed.

Supporting; *'#Hello my name is....'* campaign.

<https://www.hellomynameis.org.uk/>

All Trust staff must wear a Trust Identification Badge. All non-trust staff must wear an identification badge, which indicates their name, the name of their employer and their job title. Patients have the right to know who is directly or indirectly involved in their care.

Courtesy and Respect for Dignity.

All staff should be aware of the patients' physical, emotional, social, spiritual and cultural needs. On admission patients will undergo a full holistic assessment of their individual needs. This information will be documented clearly in the patients' healthcare records and will ensure that patients are not stereotyped or labelled but treated as individuals within a person centred care approach.

Being person-centred is about focusing care on the needs of the individual. Ensuring that people's preferences, needs and values guide our clinical decisions; providing care that is respectful of and responsive to them.

Health Education England (2018)

Personal boundaries and space

Staff should take care not to invade the patient's personal space, ensuring the patient environment is welcoming and supports appropriate standards of privacy, confidentiality and dignity.

Staff must not discuss their personal lives over a patient to the exclusion of that patient from the conversation.

Mixed sex Accommodation

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient

As well as monitoring and reporting all unjustified mixing of sleeping accommodation, the NHS is also required to monitor all justified mixing in sleeping accommodation, all mixed-sex sharing of bathroom / toilet facilities (including passing through accommodation or toilet/bathroom facilities used by the opposite gender), and all mixed provision of day space in mental health units at a local level. For practical reasons, central reporting has been mandated for MSA breaches in respect of sleeping accommodation only.

"Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicle. (refer to WAHT Policy for provision of same sex accommodation for patients (WAHT-CG-521).

Acceptable justification – i.e. 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 ICU
- 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). This would be unacceptable if staff shortages or skill mix were the rationale
- 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 – i.e. 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

In the case of patients who have undergone Transgender reassignment each case must be treated with the utmost understanding and discretion when agreeing with the patient which clinical area they may prefer.

Patients should have access to toilet and washing facilities designated as single sex.

All toilet and bathrooms must be able to be locked by the patient. A nurse call system should be in place and hospital staff must be able to gain access in case of emergency.

Toilets should be reasonably adjacent to the appropriate sex bay.

Bed curtains should allow for the full bed area to be screened from view without any gap.

End of Life Care

Staff should ensure that patients at the end of their life are cared for in an appropriate environment, by offering the patient and their family the choice of moving to a single room where possible and appropriate. Staff should do everything possible to honour requests that patients and their families' make about where the patient wishes to die. Where possible any requests for

spiritual support should be responded to including requests by patients who wish to see a religious minister before death. Staff should consider the different cultural and religious beliefs that are associated with last offices.

The Trust plans and delivers end of life care in accordance with national guidance to ensure patients receive high quality care. A person who is dying will have their care individualised and will be treated with the upmost dignity, respect and compassion. When a patient has died, the body will be treated with the same dignity and respect as when they were alive whilst encompassing cultural and religious beliefs. Relatives/Carers will be treated with particular sensitivity and compassion at this time.

End of Life pathways should be in place where appropriate.

ReSPECT

The ReSPECT process will be implemented within the Trust from **1st July 2019**. The ReSPECT process creates a summary of personalised recommendations for clinical care in a future emergency when the patient is unable to make or express their wishes, to help inform immediate clinical decision making. The process is intended to respect both patient preferences and clinical judgement.

The agreed realistic clinical recommendations that are recorded include ceilings of care and a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

A ReSPECT form does not automatically indicate the patient is not for CPR and if there is any doubt it is expected that CPR is commenced until clarity is achieved.

Communication with staff and patients

- To ensure patient's communication needs are assessed and that patients and carers are provided with appropriate support when a need has been identified i.e. putting on spectacles, insert hearing aids and dentures as required.
- To ensure patients are informed when a service is unavailable and are provided with an explanation.
- Resources are available to translate and interpret for patients who are unable to hear fully or who cannot communicate in English. An interpretation service is available and should be accessed for the patient. Only in extreme circumstances should family members be used to translate. In addition written information should be available in large print, different languages and Braille.

<https://www.aaglobal.co.uk/>

<https://www.deafdirect.org.uk/>

- Patients should be actively involved in their own care and any decisions made. Patients may read their own care plans but visitors may only read them at the discretion of the patient. Care planning processes must focus on the individual.
- To ensure information is provided at the required level of understanding and that sufficient time is available to enable the patient and their carers to communicate their needs and preferences.
- Consent should be obtained from patients prior to disclosing information to family and friends. If appropriate, ask patient's to nominate 2 key people who will be responsible for liaising directly with nursing and medical staff. Patients should be kept well informed at all times and always be offered a choice.
- Staff must seek the views of patients on their experience. A Family and Friends Test should be offered to a patient to complete during their stay in hospital.

Privacy of patient-confidentiality of client information

General Data Protection Regulation (GDPR 2018), Data Protection Act (1998), NHS Code of Confidentiality and Professional Codes of Conduct relating to confidentiality must be adhered to.

Information about diagnosis and care will be shared with patients in the first instance and their relatives where the patient agrees or is unable, by virtue of their physical or mental illness, to make a reasoned and informed decision. Staff should consider whether a patient has the mental capacity to make informed decision for themselves. If you have any safeguarding concerns please contact the safeguarding team.

wah-tr.SafeguardingWorcsacute@nhs.net
<http://www.cqc.org.uk/content/safeguarding-people>

Personal and sensitive conversations should take place away from the bedside, in a designated quiet room or office. Where this is not possible, staff should take care to ensure the conversation is not overheard.

Bedside handovers promote patient participation in the planning of their care; however, it is imperative that issues, which are private and may affect the patients' privacy and dignity, are not discussed in a patient area where other patients are able to hear. Such discussion should take place away from the patient areas.

Ward rounds must be conducted sensitively with all delicate discussions taking place away from other patients. It must be ensured that we communicate clearly with patients and check their understanding afterwards.

Staff involved in handover/conversation at nurse bases should ensure voices are moderate to ensure conversations are not overheard and the use of privacy zone should be encouraged.

Moderated voice should be used when patient's details are being discussed, for example during telephone calls.

Staff using Dictaphones should ensure they are not recording within earshot of other patients.

Queuing arrangements at reception desks should be designed to ensure patient details are not overheard

Staff should avoid displaying patient's personal information at the bed head, such as patient's address or unnecessary information regarding the patient's condition. However, it is recognised that on occasions some information is required for maintaining and promoting patient safety.

Staff need to ensure the computer screens do not have patients' confidential details on display. All members of staff need to adhere to the Information Governance procedures to ensure they log off their computers when they are leaving the work station, even for a short period of time, or have finished.

White boards should be used sensitively giving basic information such as patient's name, bed number and consultant to comply with the Data Protection Act (1998) and GDPR (2018). Where possible these boards should not be in full view of members of the public.

Where white boards are in view of members of the public, staff need to be sensitive to the fact that some patients may not wish to have their names displayed and if they specifically state this, then their wishes must be respected.

Ensure that written patient information e.g. handover sheets ward round changes and medical data, which contains confidential details, must be shredded or disposed of correctly in confidential waste at the end of each shift before a member of staff leaves the ward, not left in public areas or when necessary stored safely and in a secure environment.

Privacy, dignity and modesty (clothing)

Patients will be cared for in an environment that actively promotes their privacy.

Meal delivery must be responsive, protected and implemented to meet the individual needs of patients to include assistance, choice, culturally sensitive, adapted cutlery and enjoyable.

‘Vacant’ and ‘Engaged’ signs should be hung outside every toilet and bathroom to indicate occupancy and so avoid the need for patients to lock doors, which may cause Health and Safety problems.

A modesty curtain should be between the patient and the door to prevent exposure by staffs that enter the bathroom/toilet and side rooms.

Matrons and senior nurses will assess dignity routinely in Matron’s Quality Nursing audits, Patient Led Assessments of the Environment care (PLACE), Care Quality Commission (CQC) and Ward Accreditation assessments.

Staff should ensure they knock prior to entering a patient’s side room/bathroom etc. Staff should check prior to entering a curtain space that it will not invade their privacy.

All curtains will be of the correct size for the space they are used in.

Staff should ensure that bed curtains are fully closed prior to commencing any procedure.

Privacy Signs are recommended to remind staff and other visitors to request permission before entering. Pegs or clips may be used to secure curtains.

Patients should have appropriate, well-fitting clothing and adequate cover at all times to protect their modesty.

Bariatric clothing can be obtained from linen rooms, and bariatric chairs and beds from the equipment stores.

Patients should be encouraged to wear their own outdoor and night clothing where possible, incorporating pjparalysis campaign.
<https://www.england.nhs.uk/2018/03/70-days-to-end-pyjama-paralysis/>

Patients should have their clothes changed promptly after any spillage occurring during mealtimes etc.

Theatre /examination gowns and hospital nightwear should prevent the patient and others from embarrassment, whilst allowing appropriate access to their body for examination/treatment.

All staff should maintain a patient’s dignity when a patient’s presentation compromises their modesty, privacy or dignity. Staff must take appropriate steps to rectify the situation.

Ensure patients have enough access to blankets and bed linen to ensure their modesty and comfort is maintained.

Patients should be encouraged to remove minimal clothing required (in privacy) to carry out procedures and then an attempt to maintain their modesty should be made whilst any procedures are undertaken.

Chaperones

See Worcestershire Acute Hospitals NHS Trust Chaperone Policy (WAHT – CG-606). Guidelines for nurses, midwives, medical and non-medical practitioners performing intimate interventions or procedures.

Checking with a patient that they give their permission to be washed/examined by a person of the opposite sex, and respect their wishes.

Obtain written consent from patients requiring clinical photography, including the use of digital cameras; refer to the consent policy for further details.

The patient's permission should always be sought if the presence of medical/nursing students is purely for teaching purposes on wards/ clinics and theatres.

Every effort will be made to ensure that confused or mentally ill patients who continually expose themselves are shielded from the view of other patients and visitors on the ward. Similarly patients who are lucid, but expose themselves need to be made aware of other patient's privacy and dignity and the general feelings of all who may be in the clinical area including; staff patients and visitors and asked to cover themselves.

The patient's right to privacy should be balanced with the need for safety, e.g. patients with a mental health problem who may be a danger to themselves, these circumstances should be reviewed using the Trust's Risk Assessment Process.

Availability of an area for complete privacy

When breaking bad news or other difficult discussions, this should be done in a private area

'Do not disturb' signs will be available and used on all doors where a private conversation is being held.

Any problems that affect the ability to maintain the privacy and dignity of patients should be reported to the *appropriate person so that* they can be resolved as quickly as possible.

Summary

Staff have a professional duty to care for patients. They have responsibility via their professional bodies to act in the patient's best interest and are accountable for their actions. Staff should be sensitive to differing expectations associated with race, ethnicity, age, gender, disability and culture.

Any breach of privacy or dignity should be dealt with immediately and reporting using the Trust HR and governance structures.

6. Implementation of key document

6.1 Plan for dissemination

The Professional Development team will oversee the effective communication of the approved policy to all relevant staff. This includes emailing copies of the policy to the Matrons so that they may discuss in ward and department meetings, as well as to key heads of service who are involved. The policy is accessible via the policy link on the Trust Intranet.

6.2 Dissemination

Staff may print key documents at need but must be aware that these are only valid on the day of printing and must refer to the intranet for the latest version.

Individual members of staff have a responsibility to ensure they are familiar with all key documents that impinge on their work and will ensure that they are working within the current version of a key document via the trust internet.

Line managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new key documents and policy changes.

6.3 Training and awareness

It is the responsibility of the individual professional to ensure that they are aware of the contents of this policy. It is the responsibility of matrons to identify any training needs and to release relevant staff for training.

7. Monitoring and compliance

Lead clinicians, Matrons, Ward and Department managers are responsible for ensuring that their staff comply with this policy and for auditing practice against policy standards.

Individual staff members must be aware of the policy and ensure that their clinical practice is in line with its guidance.

8. Policy review

The policy will be reviewed after three years.

9. References

Department of Health (November 2010) Essence of Care Benchmark –Respect www.doh.gov.uk
General Medical Council (2001) Intimate examinations. www.gmc-uk.org/guidance/library/intimate
Nursing Midwifery Council (01/2005) NMC Guidelines for Records and Record Keeping http://www.nmcuk.org
Nursing Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.
Nursing Midwifery Council (07/2004) NMC Code of Professional Conduct Standards for Conduct, Performance and Ethics http://www.nmc-uk.org
Nursing Midwifery Council (2003) NMC Guidelines for Chaperoning Patients NMC Patient Dignity and Privacy- Intimate examination (DoH, Letter from Liam Donaldson, Jan 2003)
Royal College of Nursing Chaperoning (2003) the role of the nurse and the rights of the patients. Guidance for nursing staff. RCN Publication code 001446
Trust Chaperone Policy (WAHT-CG-606)
Trust policy for the provision of Same Sex Accommodation for patients (WAHT-CG-521)
Webster J Strategies to enhance privacy and dignity in care of older people <i>Nursing Times</i> 2004 vol. 100 no 8 p38-40

Death by Indifference – Mencap (2007)
Mid Staffordshire NHS trust Inquiry January 2005- March 2009 (vol 1&2)
Nursing Midwifery Council (2009) Care and Respect Every time
Department of health (November 2010) Eliminating Mixed Sex Accommodation
Essence of Care (DH, 2010)
The NHS constitution (DH2013)
#Hello my name is... https://www.hellomynameis.org.uk/
Person Centred Care (2018) https://www.hee.nhs.uk/our-work/person-centred-care
Data Protection Act 1998. - https://www.legislation.gov.uk/ukpga/1998/29/contents
General Data Protection Act 2018 - https://ico.org.uk/for-organisations/data-protection-act-2018/

10. Background

10.1 Consultation

This policy will be circulated to the following for comments:

- Director of Nursing
- Heads of Nursing
- Medical Director
- Clinical Directors
- Head of Clinical Governance
- Senior Nursing & Midwifery Group
- Trust Privacy & Dignity group
- Senior Nursing and Midwifery group

10.2 Approval Process

This policy will be approved by the Patient Quality and Safety Committee.

10.3 Equality requirements

There are no equality requirements

10.4 Financial Risk Assessment

There are no financial risks

Appendices

Supporting Documents

Supporting Document 1 Equality Impact Assessment
Supporting Document 2 Financial Risk Assessment

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Age	No	
	• Disability	No	
	• Gender reassignment	No	
	• Marriage and Civil Partnership	No	
	• Pregnancy and maternity	No	
	• Race	No	
	• Religion or belief	No	
	• Sex	No	
	• Sexual Orientation	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?		
6.	What alternatives are there to achieving the policy/guidance without the impact?		
7.	Can we reduce the impact by taking different action?		

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval