Privacy and Dignity Policy

During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Assurance Group.

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<tr>
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**DOCUMENT HISTORY**

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>5</td>
</tr>
<tr>
<td>3. Definitions</td>
<td>5</td>
</tr>
<tr>
<td>4. Scope</td>
<td>6</td>
</tr>
<tr>
<td>5. Purpose</td>
<td>6</td>
</tr>
<tr>
<td>6. Roles &amp; Responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>7. Policy Detail / Course of Action</td>
<td>7</td>
</tr>
<tr>
<td>8. Consultation</td>
<td>9</td>
</tr>
<tr>
<td>9. Training</td>
<td>10</td>
</tr>
<tr>
<td>10. Monitoring Compliance and Effectiveness</td>
<td>10</td>
</tr>
<tr>
<td>11. Links to other Organisational Documents</td>
<td>10</td>
</tr>
<tr>
<td>12. References</td>
<td>10</td>
</tr>
<tr>
<td>13. Appendices</td>
<td>11</td>
</tr>
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</table>
1 Executive Summary

The Isle of Wight NHS Trust recognises the fundamental importance of maintaining the dignity and privacy of all our patients and clients wherever care is provided for them.

This Policy sets out the expectations of the Trust in maintaining dignity and privacy, and provides a framework on which patients, staff and the public can determine our performance. This policy also outlines the Trust’s commitment to eliminating mixed sex accommodation as set out by the Department of Health Operating Framework 2010-11.

The report ‘Caring for Dignity’ published by the Healthcare Commission in 2007, highlighted a number of common examples of compromises in dignity taken from complaints received by the Healthcare Commission, these include

- Being addressed in an inappropriate manner
- Being spoken about as if they were not there
- Not being given proper information
- Not seeking their consent and / or not considering their wishes
- Being left in soiled clothes or bedding
- Being exposed in an embarrassing manner
- Not being given appropriate food or help with eating and drinking
- Being placed in mixed sex accommodation
- Being left in pain
- Being in a noisy environment at night causing lack of sleep
- Having to use premises that are unclean and smelly (toilets and wards)
- Lack of protection of personal property including personal aids (hearing or visual)
- Being subject to abuse and violent behaviour

The Trust is committed to ensuring that these types of compromises in dignity do not happen in any setting.

High quality care services that respect people’s dignity should:

- Have a zero tolerance of all forms of abuse.
- Support people with the same respect you would want for yourself or a member of your family.
- Treat each person as an individual by offering a personalised service.
- Enable people to maintain the maximum possible level of independence.
- Offer choice and control.
- Listen and support people to express their needs and wants.
- Respect people’s right to privacy.
- Ensure people feel able to complain without fear of retribution.
- Engage with family members and carers as care partners.
- Assist people to maintain confidence and a positive self-esteem.
- Act to alleviate people’s loneliness and isolation.
Ensure comfort

This policy sets out the expectations of staff in ensuring a culture that values patients, clients and service user’s privacy and dignity wherever their care is provided across the Isle of Wight NHS Trust. The Mental Health Act 1983-Code of Practice identifies specific privacy and dignity measures to be taken for service users with mental health service users see Appendix A.

2 Introduction

The Isle of Wight NHS Trust is committed to providing high quality care to patients and clients at all times (The term patient will be used throughout this document to reflect both patients and clients). The aim of this policy is to provide a framework for staff with guidance on the promotion of aspects of care which affect the privacy and dignity of our patients.

3 Definitions

Scope Definitions for the purpose of this policy:

Privacy – refers to, “freedom from intrusion and embarrassment and relates to all information and practice that is personal or sensitive in nature to an individual. Privacy is a key principle, which underpins human dignity, and remains a basic human right and the reasonable expectation of every person.” Human Rights Act 1998.

Dignity – “is concerned with how people feel, think and behave in relation to the worth and value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as individuals.” Royal College of Nursing 2008. This is irrespective of differences such as age, race, culture, gender, sexual orientation social background, health or marital status, disability, religion or political conviction.

Respect – is positive regard shown to a person as a human being as an individual, by others, and demonstrated as courtesy, good communication, taking time and equal access.

Modesty – refers to treatment being given in a manner which avoids unnecessary exposure and minimises anxiety and distress.

Single Sex Accommodation – refers to the provision of sleeping accommodation shared with other patients of the same sex. For more detailed definition of standards, breaches and justifications see Appendix B

The Healthcare Commission report on dignity in care for older people while in hospital ‘Caring for dignity’ (HCC, 2007), recommends that any compromise in dignity should be considered a serious issue and must be treated as a disciplinary matter. It is for this reason that this document is ratified as a policy within the Isle of
Wight NHS Trust, recognising that the Trust take privacy and dignity of all our patients very seriously.

4 Scope

This policy applies to all Trust staff irrespective of the type of contract of employment e.g. permanent, temporary, fixed term, part time, bank, agency and locum staff irrespective of job role or seniority within the Organisation. It also extends to those who are working with the Trust as trainees, and are involved in both the direct and indirect care of patients.

The Trust expects those people that perform work on its behalf such as volunteers, students, independent contractors and agencies to recognise and respect the principles of this policy and that such a requirement may be formalised though a service level agreement where appropriate.

This policy extends to all employees (as defined above) regardless of their protected characteristics as defined by the Equality Act 2010 namely, age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage or civil partnership, pregnancy and maternity.

This policy has been developed in accordance with views from patients and carers taken from NHS Patient Satisfaction Surveys and the Essence of Care – Patient Focused Benchmarks (DH, 2003)

5 Purpose

This policy is designed to guide all Healthcare Professionals in the maintenance of patient’s privacy and dignity.

6 Roles and Responsibilities

The Chief Executive has overall responsibility to ensure that the privacy and dignity of all service users are respected.

The Executive Director of Nursing is responsible for ensuring that this policy is accepted within the Trust and that the Board receives regular reports on issues relevant to dignity, respect and privacy of our patients.

Heads of Nursing and Quality for each Clinical Business Unit, Matrons and Service Leads are responsible for ensuring that the content of this Policy is disseminated across all clinical areas, and compliance to the policy and provision of single sex accommodation is maintained. This will be discussed at Development Day and the Patient Safety Working Group. They must ensure that staff training needs in relation to this policy are identified and met appropriately. Audits must be completed according to identified monitoring processes including Essence of Care Benchmarks for Privacy and Dignity if appropriate for the clinical area, and be discussed at CBU
level. Any breaches in the provision of single sex accommodation must be subjected to a full local review and root cause analysis assessment.

All staff members (as outlined in Section 3) have a duty to ensure that the privacy and dignity of all service users are respected. All staff must take responsibility for reporting breaches as identified in Appendix A via the Trust incident reporting Datix system.

Trainers - Staff with training remits have a responsibility to ensure privacy and dignity is highlighted appropriately and threaded through all care delivery.

7 Policy detail/Course of Action

7.1 When patients use the services of the Isle of Wight NHS Trust, all members of staff will ensure that the following rights are adhered to in all settings:

A. Personal Consideration and Respect

Patients have the right to:

- Be treated as individuals
- Be welcomed and offered assistance on arrival
- Be listened to and have their views taken into account
- Be treated courteously at all times
- To know who is looking after them
- Be cared for in a single sex environment, ensuring patients never share a bay with patients of the opposite sex unless in an emergency or times of significant crisis.
- Have access to appropriately segregated toilet and washing facilities

Examples of good practice to achieve personal consideration and respect can be found in Appendix D

B. Confidentiality

Patients have the right to expect that:

- All staff are bound by a legal duty of confidence to protect personal information that they may come into contact with
- All staff are obliged to keep any personal identifiable information safe and strictly confidential
- Patient information is only shared to enable care, with their consent

Examples of good practice to achieve confidentiality can be found in Appendix C

C. Privacy, Dignity and Modesty

Patients have the right to:
• Be treated with dignity at all times
• To have their modesty protected
• To be cared for in an area that has appropriate facilities to maintain their privacy e.g. a designated bed space or side room
• To remain autonomous and independent wherever possible
• To be cared for in an environment with high standards of cleanliness to reassure service users

Examples of good practice to achieve Privacy, Dignity and Modesty can be found in Appendix C

D. Equality and Diversity

Patients have the right to:
• Have their spiritual and cultural needs recognised and respected
• Have their gender, race, sexuality, disability, illness or age recognised and respected
• Help to access to our services or direction to the most appropriate services

Examples of good practice to recognise Equality and Diversity can be found in Appendix C

7.2 Single Sex Accommodation

The revised Operating Framework for 2010-2011 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice (Department of Health PL/CNO/2010/3).

There are some circumstances where mixing can be justified. These are few, and are mainly confined to patients who need highly specialised care, such as that delivered in critical care units. A small number of patients (especially children and young people) will actively choose to share with others of the same age or clinical condition, rather than gender. Further detail on the circumstances in which mixing is justified (and therefore does not constitute a breach) incorporating the Decision Making Matrix for Mixed Sex accommodation is provided in Appendix B.

Specific guidance for mental health service users can be found in Appendix A.

7.2.1 For many young people clinical need, age and stage of development may take precedence over gender consideration. Mixing of the sexes may be wholly reasonable and even preferred.

Washing and toilet facilities may not be designed as the same sex as long as they only accommodate one young person at a time, and can be locked by the young person (with an external override for emergency use only).

Staff must make sensible decisions for each young person. This may mean segregating on the basis of age rather than gender, but decisions must be demonstrably in the best interests of each young person.
7.2.2 Transsexual people, individuals who have proposed, commenced or completed reassignment of gender, are legally protected against discrimination. Transgender people should be accommodated according to their presentation (the way they dress, and the name and pronouns that they currently use). This presentation may not always accord with the physical sex appearance of the chest or genitalia. This does not depend on them having a gender recognition certificate (GRC) or legal name change, and the views of the transgender person should take precedence over those of family members where these are not the same, or the convenience of staff. Appropriate dignity and modesty considerations must also be given to other patients/clients through the appropriate use of screens and curtains.

7.2.3 In Healthcare, patients are accommodated and respected according to their choice of gender. In prison environment clients are treated as per their birth gender.

7.3 The Built Environment

The Trust has a responsibility to provide single gender facilities and appropriate equipment to maintain patients’ privacy and dignity, which may include the following:

- Curtains
- Screens
- Walls
- Rooms
- Blankets
- Appropriate Clothing

The Trust will ensure that when patients are admitted to our hospital they are provided with toilet, shower and washing facilities that are designated for one gender.

Patients may have to cross a ward corridor to reach their designated bathroom but they will not have to walk through sleeping accommodation designated to the opposite sex.

Patients may share some communal spaces such as day and dining rooms where these are available, and will encounter patients of the opposite sex in other departments such as Diagnostic Imaging and Outpatients.

8 Consultation

The following staff groups were consulted in regarding the development of the policy.

- Ward Sisters
- Modern Matrons
- Director of Nursing Team
9 Training

This Privacy and Dignity Policy does not have a mandatory training requirement but the following mandatory training is required, which particularly support privacy and dignity, and dependent on area of work:

- Safeguarding Adults and Children
- Dignity at Work
- Conflict Resolution Training
- Physical Intervention Training
- Equality and Diversity

10 Monitoring Compliance and Effectiveness

All clinical areas are required to complete the Essence of Care Benchmark audit for respect and dignity on an annual basis. This is coordinated and monitored through the Clinical Business Unit Quality Assurance structures.

Compliance to the provision of single sex accommodation is monitored via the Quality Report, and data from this is submitted to NHS England on a monthly basis via the Performance and Information Department.

The Risk Management and Patient Experience Officers will highlight any trends in reporting concerns through Datix incident reports and Directorate processes, and these should be discussed at Clinical Business Unit monthly Quality Risk and Patient Safety meetings.

11 Links to other Organisational Documents

This policy links to, but not limited to:
Bed Management policies and procedures
Chaperone Policy
Complaints and Compliments policy
Consent to Examination or Treatment – model policy
Dignity at Work policy
Equality and Diversity policy
Infection Control policies and procedures
Security policy

12 References

Department of Health (2007) Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals.
Department of Health (2001) Essence of Care

13 Appendices

Appendix A The Mental Health Act 1983- Code of Practice
Appendix B Provision of Single Sex Accommodation
Appendix C Decisions Matrix for Mixed Sex Accommodation
Appendix D Extract from the Social Care Institute for Excellence
Appendix E Expected Good Practice Guide
Appendix F Financial and Resourcing Impact Assessment on Policy Implementation
Appendix G Equality Impact Assessment (EIA) Screening Tool
Chapter 8 Privacy, safety and dignity

8.1 This chapter deals with privacy, safety and dignity in hospitals where patients are detained under the Act, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.

8.2 Privacy, safety and dignity are important constituents of a therapeutic environment and hospital staff should respect a patient’s privacy as far as possible, while maintaining safety. Patients should have every opportunity to maintain contact with family and friends by telephone, and hospitals should ensure they have policies for the use of mobile phones and computing devices.

8.3 Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders and transgender patients. The nature of engagement with patients and of therapeutic environments and the structure and quality of life on a ward are important in encouraging patients to remain in the ward and minimising a culture of containment. The chapter also includes guidance on conducting personal and other searches, enhanced security, physical security and blanket locked door policy.

Respect for privacy

8.4 Article 8 of the European Convention on Human Rights (ECHR) requires public authorities to respect a person’s right to a private life. Article 8 has particular importance for people detained under the Act. Privacy, safety and dignity are important constituents of a therapeutic environment. Hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction.

Respecting patients’ privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.

Blanket restrictions

8.5 In this chapter, the term ‘blanket restrictions’ refers to rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient’s records.
8.6 Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an individually identified risk; they should be applied for no longer than can be shown to be necessary.

8.7 Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient’s human rights.

8.8 Within secure service settings some restrictions may form part of a broader package of physical, procedural and relational security measures associated with an individual’s identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public. The individual’s need for such security measures should be justified to meet the admission criteria for any secure service. In any event, the application of security measures should be based on the needs of and identified risks for individual patients, and impose the least restriction possible. Where individual patients in secure services are assessed as not requiring certain security measures, consideration should be given to relaxing their application, where this will not compromise the overall security of the service. Where this is not possible, consideration should also be given as to whether the patient should more appropriately be managed in a service that operates under conditions of lesser security.

8.9 No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of the organisation’s policy and subject to local accountability and governance arrangements.

Blanket locked door policy

8.10 A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction or a deprivation of liberty.

8.11 It is unlikely that there will be a deprivation of liberty if an informal patient, who has capacity to consent to being admitted and has done so, is informed of the locked door policy and consents to being informally admitted and remaining on the ward under these conditions. The patient should be told who they can speak to if they wish to leave and must be able to leave at any time they wish to, unless they are being detained using the holding powers under section 5 of the Act (chapter 18) or an application for detention (chapters 14 and 15).

8.12 A patient’s article 8 rights should be protected by ensuring a locked door policy only imposes proportionate restrictions on their contact with family and friends which can be justified as being in the interests of the health
and safety of the patient or others. The impact of a locked door policy on each patient should be considered and documented in the patient’s records. The policy should conform to the ‘empowerment and involvement’ guiding principle (paragraphs 1.7 – 1.12).

8.13 Hospitals should not lock patients in clinical areas simply because of inadequate staffing levels. Local policies for locking clinical areas should be clearly displayed and explained to each patient on admission.

8.14 The safety of informal patients, who would be at risk of harm if they wandered out of a clinical environment at will, should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.

8.15 Services should consider how to reduce the negative psychological and behavioural effects of having locked doors, whether or not patients are formally detained.

Private telephone calls and e-mail and internet access

8.16 Communication with family and friends is integral to a patient’s care and hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media. Providers should, however, provide patients access to a coin or card operated phone.

8.17 Mobile phones and other electronic devices commonly have functions including cameras and video and voice recording capability. There is therefore the potential for patients and visitors to use such equipment in a way that interferes with the confidentiality, dignity and privacy of other patients, staff and visitors. Staff should be mindful of enabling patients and visitors to maintain communication and contact while protecting others against the misuse of such technology.

8.18 When patients are admitted, staff should assess the risk and appropriateness of patients having access to mobile phones and other electronic devices and this should be detailed in the patient’s care plan. Particular consideration should be given to people who are deaf who will have special communication needs. Patients should be able to use such devices if deemed appropriate and safe for them to do so and access should only be limited or restricted in certain risk-assessed situations.

8.19 Hospital managers should have a policy for the possession and use of mobile phones and other mobile devices (such as laptops and tablets). These should be proportionate to risk and not seek to impose blanket restrictions on patients.

8.20 When drawing up their policy on the use of mobile phones and mobile devices, hospital managers should bear in mind the following points.
• Mobile phones and mobile computing devices provide a readily available means of communication with family and friends and are in widespread use. Most detained patients are therefore likely to have one. It is unlikely to be appropriate to impose a blanket restriction banning their use except in units specifically designed to provide enhanced levels of security in order to protect the public. Blanket restrictions may breach article 8.

• Different considerations will apply to different locations within the hospital. There may be valid reasons for banning or limiting the use of mobile phones or mobile computing devices in some parts of the premises to which detained patients have access or certain types of mobile phone or mobile computing device, e.g. because of the potential risk of interference with medical and other electronic equipment which could adversely affect the health of patients or because of the risk of intrusion into the privacy of other patients or others.

• Each patient should expect a peaceful environment, and that constant interruptions from ringing telephones have a potentially anti-therapeutic effect.

• It may be reasonable to require mobile phones and mobile computing devices to be switched off except where their use is permitted and to restrict their use to designated areas to which detained patients have access.

• Many mobile phones and mobile computing devices have cameras and give access to the internet and can be used as sound recorders. This creates a potential for the violation of the privacy and dignity of other patients, staff and visitors to the ward and may constitute a security risk. It would therefore be appropriate to stipulate the circumstances in which photographs, videos and sound recordings can be taken, e.g. only with specific permission from hospital staff and the patients involved.

• The difficulty in identifying when camera functions are being used may be an additional reason for restricting the areas in which mobile phones and computing devices may be used.

• It is important to ensure that the hospital’s policy on the use of mobile phones and mobile computing devices can be enforced effectively, e.g. it may be appropriate in certain circumstances to confiscate mobile phones or mobile computing devices from patients who consistently refuse to comply with the rules.

• Any decision to prevent the use of cameras or to confiscate a mobile phone or mobile computing device should be fully documented and be subject to periodic review.

• There should be rules on when staff and visitors can bring mobile phones and mobile computing devices into a secure setting.
• The normal rules governing the use of the hospital’s power supply to
charge mobile phones or mobile computing devices may need to be
varied for detained patients (given the restrictions with which such
patients are faced).

• Staff should be fully informed of the hospital’s policy, and steps should
be taken to communicate it to all patients, carers, families and visitors, eg
by displaying it clearly in each unit and providing it in a format and
language that a patient can understand.

• The policy will need to be reviewed regularly, and updated where
necessary, in the light of experience. It is good practice to involve
patients, former patients and their carers in drawing up the policy.

8.21 Managers should develop policies on access by patients to e-mail and
internet facilities by means of the hospital’s IT infrastructure. This guidance
should cover the availability of such facilities and rules prohibiting access
to illegal or what would otherwise be considered inappropriate material, eg
pornography, gambling or websites promoting violence, abuse or hate.
Additionally, the guidance should cover the appropriate use of social
media such as Skype. A blanket restriction on access to the internet could
breach article 8 if it cannot be justified as necessary and proportionate. For
further details about not applying blanket restrictions see paragraphs 8.5 –
8.9.

8.22 Managers should also develop guidance on the use of social media. As in
paragraph 8.21 above, a blanket restriction on the use of social media
could breach article 8 if it cannot be justified as necessary and
proportionate. Staff should remind patients of confidentiality requirements
and the implications of breaching patient and staff confidentiality, and
encourage patients to consider what they post on social media. Where
wards contain coin-operated and card-operated telephones, hospital
managers should ensure that patients are able use them without being
overheard. Installing booths or hoods around them may help to provide the
necessary level of privacy. Some patients may need help to make a phone
call, but should still be given privacy during the call.

8.23 The principle that should underpin hospital or ward policies on all
telephone use is that detained patients are not free to leave the premises
but that their freedom to communicate with family and friends should be
maintained as far as possible and restricted to the minimum extent
necessary.

Private property

8.24 Hospitals should provide adequate storage in lockable facilities (with staff
override) for the clothing and other personal possessions which patients
may keep with them on the ward and for the secure central storage of
anything of value or items which may pose a risk to the patient or to
others, eg razors. Information about arrangements for storage should be
easily accessible to patients on the ward. Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

Separate facilities for men and women

8.25 All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.

8.26 A patient should not be admitted to mixed-sex accommodation. It may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, en-suite room in the opposite-gender area of a ward. In such cases, a full risk-assessment should be carried out and the patient’s safety, privacy and dignity maintained. Steps should be taken to rectify the situation as soon as possible. For more information see NHS guidance on eliminating the use of mixed-sex accommodation in relation to mental health patients. This includes information on temporary admissions in exceptional circumstances and the required reporting to the NHS Commissioning Board on mental health patients.

Separate facilities for other reasons

8.27 Arrangements for the patient’s accommodation should also consider the patient’s history and personal circumstances, including:
- history and personal circumstances where known, including history of sexual or physical abuse and risks of trauma
- the particular needs of transgender patients
- cultural or religious preferences
- mothers and babies during and after pregnancy, or
- other health conditions (physical disabilities, learning disabilities or sensory impairments.

8.28 If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient’s privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

Personal and other searches

8.29 Hospital managers should ensure that there is an operational policy for searching patients detained under the Act, their belongings and surroundings and their visitors. When preparing the policy, hospital managers should consider the position of informal patients. The policy
should be clearly displayed and communicated to patients in a format and language they understand.

8.30 The policy should be based on the following clear principles:
• the intention is to create and maintain a therapeutic environment in which treatment may take place and to ensure the security of the premises and the safety of patients, staff and the public
• the authority to conduct a search of a person or their property is controlled by law, and it is important that hospital staff are aware of whether they have legal authority to carry out any such search
• searching should be proportionate to the identified risk and should involve the minimum possible intrusion into the individual's privacy, and
• all searches will be undertaken with due regard to and respect for the person’s dignity and privacy.

8.31 The policy may extend to the routine and random searching without cause of detained patients, if necessary without their consent, but only in exceptional circumstances. For example, such searches may be necessary if the patients detained in a particular unit tend to have dangerous or violent propensities; which means they create a self-evident pressing need for additional security.

8.32 Patients, staff and visitors should be informed that there is a policy on searching. Information about searches should be provided in a variety of formats to meet patients’ and visitors’ needs and should be readily available.

Conducting personal and other searches

8.33 The consent of the person should always be sought before a personal search of them or a search of their possessions is attempted. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person. Undertaking a personal search in a public area will only be justified in exceptional circumstances.

8.34 Consent obtained by means of a threat, intimidation or inducement is likely to render the search illegal. Any person who is to be searched personally or whose possessions are to be searched should be informed that they do not have to consent.

8.35 A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in English, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a learning disability and those of children and young people should be considered.

8.36 A personal search should be carried out by a member of the same sex, unless necessity dictates otherwise. The search should be carried out in a way that maintains the person’s privacy and dignity and respects issues of gender, culture and faith. It is always advisable to have another member of
the hospital staff present during a search, especially if it is not possible to conduct a same-sex search.

8.37 A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made.

8.38 Staff involved in undertaking searches should receive appropriate instruction and refresher training.

8.39 In certain circumstances, it may be necessary to search a detained patient or their possessions without their consent.

8.40 If a detained patient refuses consent or lacks capacity to decide whether or not to consent to the search, their responsible clinician (or, failing that, another senior clinician with knowledge of the patient’s case) should be contacted without delay in the first instance, if practicable, so that any clinical objection to searching by force may be raised. The patient should be kept separated and under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. This is particularly important for individuals who may lack capacity to decide whether or not to consent to the search. Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else.

8.41 If a search is considered necessary, despite the patient’s objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary.

8.42 The policy should set out the steps to be taken to resolve any disagreement or dispute where there is a clinical objection to a search.

4 Separation of a patient under close observation in order to await the arrival of the responsible clinician is different to seclusion (which is defined at paragraph 26.103).

Privacy, safety and dignity

8.43 Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment, unless it is urgently required. A post-incident review should follow every search undertaken where consent has been withheld.

8.44 There should be support for patients and for staff who are affected by the process of searching. This may be particularly necessary where a personal search has had to proceed without consent or has involved physical intervention (see paragraphs 8.40 – 8.43 and chapter 26 on use of physical interventions).
8.45 Where a patient’s belongings are removed during a search, the patient should be told why they have been removed, given a receipt for them, told where the items will be stored, and when they will be returned.

8.46 The exercise of powers of search should be audited regularly and the outcomes reported to the hospital managers.

Hospital accommodation offering conditions of enhanced security

8.47 Some detained patients may be liable to present a particular danger to themselves or to others and therefore need to be accommodated in wards or units specifically designed to offer enhanced levels of physical security. For patients detained under part 3 of the Act, this may be a requirement of a court or of the Secretary of State for Justice, but in many cases the decision will lie primarily with the patient’s responsible clinician.

8.48 When considering whether patients should be placed in, moved to or remain in such a ward or unit, responsible clinicians should, in consultation with the multi-disciplinary team, ensure that:
   • they have carefully weighed the patient’s individual circumstances and the degree of risk involved, and
   • they have assessed the relative clinical considerations of placing the patient in an environment with enhanced physical security, in addition to or as opposed to providing care by way of intensive staffing.

8.49 Treatment in conditions of enhanced security should last for the minimum period necessary. Where responsible clinicians have taken the decision to transfer a patient within a hospital to a ward with enhanced security, they should ensure that arrangements are made to facilitate the patient’s prompt return to a less secure ward when that enhanced security is no longer required.

8.50 Where responsible clinicians believe that patients no longer require conditions of enhanced security (or the current level of security), they should take steps to arrange their transfer to more appropriate accommodation. Where necessary, this may involve identifying another hospital that is willing and able to offer the patient suitable accommodation.

8.51 In the case of restricted patients, it will be necessary to seek the consent of the Secretary of State for Justice for a transfer to another hospital or, where the patient’s detention is restricted to a particular unit, for a move within the same hospital.

8.52 Managers of hospitals offering accommodation with enhanced levels of security should ensure that:
   • accommodation specifically designated for this purpose has adequate staffing levels, and
written guidelines are drawn up, setting out the categories of patient for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate.

Physical security in other hospital accommodation
8.53 Hospital managers will need to consider what arrangements should be put in place to protect the safety of patients who are not subject to enhanced security.

8.54 Patients admitted to acute wards, whether or not they are formally detained there, will have complex and specific needs. In such an environment, ward staff will need to balance competing priorities and interests when determining what safety measures are necessary. This should not amount to a blanket locked door policy (see paragraphs 8.10 – 8.15 above).

8.55 The intention should be to protect patients, in particular those who are at risk of suicide, self-harm, accidents or inflicting harm on others unless they are prevented from leaving the ward. Arrangements should also aim not to impose any unnecessary or disproportionate restrictions on patients or to make them feel as though they are subject to such restrictions. It may also be necessary to have in place arrangements for protecting patients and others from people whose mere presence on a ward may pose a risk to their health or safety.

8.56 It should be borne in mind that the nature of engagement with patients and of therapeutic interventions and the structure and quality of life on the ward are important factors in encouraging patients to remain in the ward and in minimising a culture of containment.

8.57 All patients should have regular access to outside space. Locking doors, placing staff on reception to control entry to particular areas, and the use of electronic swipe cards, electronic key fobs and other technological innovations of this sort are all methods that providers should consider to manage entry to and exit from clinical areas to ensure the safety of their patients and of others.

8.58 If providers are to manage entry to and exit from the ward effectively, they will need to have a policy for doing so. A written policy that sets out precisely what the ward arrangements are and how patients can exit from the ward, if they are legally free to leave, should be drawn up and given to all patients in the ward. The policy should be explained to patients on admission and to their visitors. In addition to producing the policy in English, providers may need to consider drawing it up in other languages if these are in common use in the local area, as well as in accessible formats.

8.59 If managing entry and exit by means of locked external doors (or other physical barriers) is considered to be an appropriate way to maintain safety, the practice adopted should be reviewed regularly to ensure that
there are clear benefits for patients and that it is not being used for the convenience of staff. It is never acceptable to lock patients and others in clinical areas simply because of inadequate staffing levels. In conjunction with clinical staff, managers should regularly review and evaluate the mix of patients (there may, for example, be some patients who ought to be in a more secure environment), staffing levels and the skills mix and training needs of staff.
Appendix B

Provision of Single Sex Accommodation

What is a breach of the guidance?

Guidance for providers, commissioners, TDAs and regulators

Policy statement
Mixed-sex accommodation will be eliminated, except where it is in the overall best interest of the patient, or reflects their personal choice.

Definition
A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the terms of the policy.

What constitutes a breach?
Mixing may be justified (i.e. NOT a breach) if it is in the overall best interest of the patient, or reflects their personal choice.
These are separated out below for convenience, although in reality there will often be some overlap.

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 – 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. a 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. For instance, in a stroke unit, it may be acceptable to mix patients immediately following admission (life-threatening emergency, and in need of one-to-one nursing), but not to maintain mixing throughout the rehabilitation phase, simply on the basis that it is easier for staff, or because there are not enough people with the necessary skills.

Reflects patient choice
There are some instances where sharing accommodation with the opposite gender reflects personal choice and may therefore be justified. In all cases, privacy and dignity should be assured. Group decisions should be reconsidered for each new admission to the group, as consent cannot be presumed.

Acceptable justification – i.e. NOT a breach
☑ If an entire patient group has expressed an active preference for sharing (e.g. renal dialysis etc.)
☑ If individual patients have specifically asked to share and other patients are not adversely affected (e.g. children/young people who have expressed an active preference for sharing with people of their own age group, rather than gender).

Unacceptable justification – i.e. a breach
× “Take it or leave it” – i.e. the patient is asked to choose between accepting mixed-sex accommodation or going elsewhere
× “No-win situation” – i.e. the patient is asked to prioritise same-sex accommodation over another aspect of care (e.g. speed of admission, specialist staff etc.)
× Custom and practice – e.g. routine mixing of young people without establishing preferences
× If the patient said they didn’t mind (there should always be a presumption of segregation unless patients specifically ask to share)
× If the patient did not express a preference

It is important to note that the norm is always to aim for segregation – the circumstances in which patients choose to share are expected to be very much in the minority.

Footnote
Notwithstanding the above, there will be a very small set of circumstances where mixing is acceptable as an emergency response to extreme operational emergencies. This is limited to unpredictable events such as major clinical incidents e.g. a multiple road traffic accident or natural disaster, and major non-clinical incidents such as fire or flood requiring immediate evacuation of buildings.

Department of Health (2010)
Eliminating Mixed Sex Accommodation PL/CNO/2010/3
Decisions Matrix for Mixed Sex Accommodation

This matrix offers a framework to make sure that local decisions on mixing in sleeping accommodation reflect the national guidance. “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 cubicles.

<table>
<thead>
<tr>
<th>Category</th>
<th>Acceptable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ambulatory Care</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>• Emergency Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions units, eg:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical/surgical admissions</td>
<td>Almost Never</td>
<td>• Not acceptable for organisational convenience (eg to “park” patients whilst awaiting admission)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not acceptable as a routine occurrence</td>
</tr>
<tr>
<td>Acute wards:</td>
<td>Never</td>
<td>• All episodes of mixing in acute wards should be discussed individually with commissioners</td>
</tr>
<tr>
<td>• Alverstone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Appley</td>
<td></td>
<td></td>
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<tr>
<td>• CCU Stepdown</td>
<td></td>
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<td>• Colwell</td>
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<tr>
<td>• Lucombe</td>
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<td>• Mottistone</td>
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<tr>
<td>• St Helens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stroke Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Whippingham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Learning Disability</td>
<td>Never</td>
<td>• There is no acceptable justification for admitting a mental health patient to mixed-sex accommodation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May be acceptable, in a clinical emergency, to admit a patient temporarily to a single, en-suite room in the opposite-gender area of a ward. In such cases, a full risk-assessment must be carried out and complete safety, privacy and dignity maintained.</td>
</tr>
<tr>
<td>Critical care, levels 2&amp;3 eg:</td>
<td>Almost always</td>
<td>Not acceptable when patient no longer needs level 2 or 3 care, but cannot be placed in an appropriate ward</td>
</tr>
<tr>
<td>• ICU/coronary care units</td>
<td></td>
<td>The patient should be provided with same sex accommodation as soon as possible following decision to set down from critical care and WITHIN 4 HOURS OF DECISION.</td>
</tr>
<tr>
<td>• High dependency units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hyperacute stroke units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit</td>
<td>Frequency</td>
<td>Acceptability</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Recovery units attached to theatres/procedure rooms</td>
<td>Almost always</td>
<td>• Not acceptable in recovery units where patients remain until discharge (e.g. some day surgery/endoscopy units)</td>
</tr>
<tr>
<td>Rehabilitation Ward</td>
<td>Never</td>
<td>• All episodes of mixing should be discussed individually with commissioners</td>
</tr>
<tr>
<td>Day Surgery</td>
<td>Rarely</td>
<td>• Acceptable for very minor procedures (e.g. operations on hands/feet that do not require patients to undress)</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Rarely</td>
<td>• May be acceptable for pre/post-procedure waiting areas as long as high standards of privacy can be assured. • Not acceptable where dignity is likely to be compromised, e.g. if bowel prep is needed</td>
</tr>
<tr>
<td>Children/young people’s units (including Neonates)</td>
<td>Sometimes</td>
<td>• Children and young people should have the choice</td>
</tr>
</tbody>
</table>

NB: There will be a very small set of circumstances where mixing is acceptable as an emergency response to extreme operational emergencies. This is limited to unpredictable events such as major clinical incidents e.g. a multiple road traffic accident or natural disaster, and major non-clinical incidents such as fire or flood requiring immediate evacuation of buildings.
Appendix D

Extract from the Social Care Institute for Excellence

Practice guide 09: Dignity in care

http://www.scie.org.uk/publications/practiceguides/practiceguide09/overview/means.asp

Overview of selected research - What 'dignity' means

Despite being widely used and discussed, dignity has seemed a difficult term to pin down. It is often linked with respect from others and with privacy, autonomy and control, with self-respect and a sense of who you are. Threats to dignity have been identified with a very wide range of issues: with how you are addressed; with having to sell your house to pay for long-term care; with the kind of care patients receive at the end of life; or with inadequate help to clean or maintain your home. And the impact of factors linked to disadvantage and discrimination of all kinds further complicate the picture.

The provisional meaning of dignity used for this practice guide is based on a standard dictionary definition:

A state, quality or manner worthy of esteem or respect; and (by extension) self-respect.

Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference.

Or - as one service user put it more briefly: 'Being treated like I was somebody' (PRIAE/Help the Aged, 2001).

Aspects of dignity

Building on a long tradition in medical ethics, nursing research has explored and tested the concept of dignity. Analysis of existing literature from the UK, the rest of the EU, the USA and Australia has provided some clear themes. One article in the nursing press (Haddock, 1996) concluded that dignity depended both on the interaction between an internal sense of identity and self-esteem, and the external respect with which a person is treated by others. A nurse is able to maintain and promote dignity by treating patients 'as valid, worthy and important at a time when they are vulnerable'. A study by Jacelon and colleagues (Jacelon et al., 2004), based on a literature review and focus groups with older people, found that dignity was widely seen as somehow reciprocal: behave with dignity, and you are more likely to be treated with dignity. But it was also an inherent part of being human: 'It doesn’t
have to be an educated person: just being a human being we have worth. Every person has this basic value, and that value is dignity (focus group member).

Another concept analysis, by Griffin-Heslin (2005), finds all the characteristics of dignity listed above, and adds a set of 'defining attributes' - aspects of a person's situation which tell you that dignity is present:

- respect
- autonomy
- empowerment
- communication

A wide range of other aspects are listed under each attribute, including privacy, choice, self-esteem and taking time with the person.

The Dignity and Older Europeans study

Dignity and Older Europeans (DOE) (Cardiff University, 2001 - 2004) - a three-year international study involving researchers from six countries (Spain, Ireland, Slovakia, Sweden, France and the UK) - was funded by the European Commission. The first phase of the project involved a review of relevant philosophical and professional literature. The research team identified four 'types of dignity' on the basis of this review (see box) and were then tested in a series of studies in each of the countries involving older people, people of all ages, and health and social care professionals.

The four types of dignity identified by the DOE research team

- merit
- moral status
- personal identity
- the universal worth of human beings

Nearly 400 older people were involved in focus groups and interviews (Bayer et al., 2005), and there was 'substantial agreement' across the partner countries about the significance of dignity: 'Dignity was seen as a relevant and highly important concept which, if maintained, enhanced self-esteem, self-worth and well-being'. Older people across Europe identified three key themes:

- respect and recognition, broadly similar to the 'internal' and 'external' aspects described above
- participation, linked to views about autonomy and equality, choice and control
- dignity in care, including the importance of maintaining independence, being fully informed, and of fighting ageism

'It is in care that human dignity is consolidated... You feel more valued, when someone takes care of you.'

Focus group member, France

Other major issues included staff and family attitudes, and patronising and disrespectful ways of addressing older people; the embarrassment and humiliation
caused by exposure and the denial of privacy; and the importance of treating people with dignity when they were dying, and of respecting ‘living wills’.

In the discussions and interviews with older people, research team members found that of the four types of dignity identified, the last two - relating to personal identity and universal human worth - were the most often mentioned.

Similar but not identical results were reported by Woolhead and others (Woolhead et al., 2004), following analysis of the UK data alone. The 72 older (aged 65+) British people also confirmed the importance of dignity, although it was easier to describe its absence than its presence. Findings fell into three categories:

• Dignity of identity Issues here concerned maintaining self-respect, which could be undermined by disrespectful address or labelling; by neglect of patients’ appearances and clothing; by exposure, lack of privacy in personal care, and mixed wards. Dignity was put at risk by suffering, and dying with dignity involved control of suffering, maintenance of a ‘respectable’ appearance, and not dying alone.

• Human rights Participants emphasised the intrinsic dignity of all human beings, and the importance of being treated as an equal, regardless of age. Older people want to choose how they live, and how they die (for example, through the use of living wills): ‘euthanasia was highlighted as an example of the right to end a life deprived of dignity’.

• Autonomy Participants wanted to retain independent control over their lives for as long as possible. Some felt that resisting the inevitable - nursing home care, for example - was itself undignified. For those who had accepted the necessity of nursing home care, their priorities shifted to maintaining their dignity by being helped to remain clean and tidy.

Other parts of the Dignity and Older Europeans study provide the opportunity to compare the views of older participants with the general public:

More than five hundred people in the six countries, aged between 13 and 59 years, took part in focus groups and discussed their views on old age, and caring for older people. Once again, ‘dignity’ emerged as an important element in older people’s lives, which lack of time and resources could undermine. Many participants had negative views of the health and social care available to older people (Stratton and Tadd, 2005).

And with professionals involved in caring:

In interviews and discussion, providers of care came up with definitions of dignity which were broadly similar to those of service users, and agreed that dignity and respect were important for people of all ages. However, the standard of care was not always what it should be. Levels of training, staff and other shortages, and lack of time were all cited as reasons for dignity becoming a low priority. Others believed the ‘system’ was to blame - an emphasis on performance targets was discouraging staff from providing personalised care: ‘There is a great pressure of time getting things done and it is because of what the system values, which is getting off trolleys, getting them sorted out quickly, getting them through quickly and not being delayed - it’s a
factory’ (focus group member). Another participant said, 'It’s very easy to focus on problems, rather than people’ (Calnan et al., 2005).

The study produced a number of policy and practice documents, all of which can be found on the Dignity and Older Europeans study website.

Autonomy, privacy and informed consent

Another EU-funded study (Scott et al., 2003) explored the meanings of patient autonomy, privacy and informed consent in five countries. One part of this looked specifically at the views of older people who were living in long-term care homes in Scotland, and compared them with the views of nursing staff. The study found significant differences of view on the extent to which patients were given enough information on some topics, and on patients' opportunities to take decisions about their care. On privacy, the evidence was mixed. Encouragingly, both nurses and patients agreed on the importance of privacy, and there was strong agreement about the extent to which privacy was protected in some situations. But in others - for example, in relation to protecting privacy while giving an enema - nurses felt that they successfully protected privacy, but patients disagreed. There was also disagreement about informed consent. In general, nurses reported that they were satisfied that informed consent had been sought and given in appropriate situations. Patients were much less certain that this was the case.

The meanings of dignity: a summary

This section has brought together a range of ideas derived from research and policy documents about how dignity is seen and described by older people, their carers, practitioners and analysts. The validity of the research depends, of course, on the extent to which all potential shades of opinion and cultural difference are represented among the people interviewed. Despite some gaps in the research and identified differences of emphasis depending on ethnicity and culture, extensive research in the EU and the USA has uncovered a number of consistent overlapping themes, as summarised below.

The meanings of dignity

Research with older people, their carers and careworkers has identified four overlapping ideas of dignity:

- Respect, shown to you as a human being and as an individual, by others, and demonstrated by courtesy, good communication and taking time. (1)
- Privacy, in terms of personal space; modesty and privacy in personal care; and confidentiality of treatment and personal information. (2)
- Self-esteem, self-worth, identity and a sense of self, promoted by all the elements of dignity, but also by ‘all the little things’ - a clean and respectable appearance, pleasant environments - and by choice, and being listened to. (3)
- Autonomy, including freedom to act and freedom to decide, based on clear, comprehensive information and opportunities to participate. (4)

Footnotes:
1. Birrell et al., 2006, Davies et al., 1997, Woolhead et al., 2004, Woogara, 2005, Calnan et al., 2005, Bayer et al., 2005

References:


Appendix E

Expected Good Practice Guides

A. PERSONAL CONSIDERATION AND RESPECT

Examples of good practice to achieve personal consideration and respect include:

- Staff introducing themselves on initial contact with patients, including phone conversations, and stating their name and role
- Staff wearing identification badges at all times
- Staff asking each patient how they wished to be addressed e.g. Mrs / Ms and avoid lapsing into over familiarity, using colloquial titles such as “dear” or “petal” unless this is acceptable to, and agreed by the patient first
- Staff working with children and young people in all settings, should promote and protect their individual rights of where they receive care and treatment. This involves being cared for in a culturally sensitive environment; and ensuring privacy and confidentiality during all episodes of care (RCN, 2003)
- Dealing with a patients request for assistance promptly.
- Avoiding personal conversations with co-workers that exclude the patient e.g. talking to a colleague about the rest of the day’s workload or answering their mobile phone while caring for the patient. Staff who are required to carry and respond promptly to a work mobile phone should do so with sensitivity e.g. ensuring the phone is switched off during meetings with parents and families.
- Knocking before entering a room or attaching a notice to curtains saying “do not enter” when the patient is being examined and waiting for a reply before opening curtains. Curtain clips should be used to secure curtains.
- Discussing with a patient whether they have any objection to healthcare professionals not directly involved in their care being present at ward rounds, outpatient consultations etc. prior to these events occurring so that the patient has the opportunity to refuse
- Being aware of how body language may be interpreted by a patient / carer; standing at the foot of a patient’s bed, with folded arms and avoidance of eye contact, may lead a patient to feel that the interaction was impersonal and / or intimidating
- Ensuring that a patient who does not speak or understand English has access to interpretation services in a timely manner
- Ensuring patients never share a bay with patients of the opposite sex unless in an emergency, whilst waiting to be moved, or whilst being cared for in a Critical Care or assessment area where segregation is not possible.
- On a case by case basis adolescents’ needs should be assessed and if indicated they should be cared for in a single sex bay or cubicle
- Ensuring patients who are admitted to mixed sex accommodation are moved to single sex accommodation as a matter of urgency and within 24 hours. Where there is a delay beyond this time, or if the patient declines, this must be recorded in their Nursing documentation
Where mixed sex bays occur, incident forms must be completed
- Obtaining patients consent before admitting them to mixed sex accommodation advising them of their right to defer admission, should they find this unacceptable
- Ensure patients have access to segregated toilet and washing facilities
- Practitioners in a patient’s home will act as a guest, ensuring entering the property and using the facilities are with the patient's permission
- Patients and relatives should be communicated with not at and no assumptions should be made about pace, level or format. Staff should always be ready to alter speed, check and repeat or explain information in a different way to ensure understanding
- If appropriate staff should make use of advocacy services to support patients

B. CONFIDENTIALITY

Examples of good practice to achieve confidentiality include:
- Patients’ information should only be shared according to the Trust’s Confidentiality and Information Sharing policies
- Only sharing information that a patient discloses, with the staff who are directly involved with the patient’s care and with the patient’s verbal consent
- Obtaining a patient’s consent prior to disclosing information to family and friends. If appropriate, ask patients on admission to nominate 1 key person who will be responsible for liaising directly with the nursing and medical staff
- Being aware of and alert to anyone who may overhear staff conversations, e.g. when handing over, at the bedside and when on the telephone. It is not acceptable to discuss clinical information in public areas even if a patient’s name is not used.
- Ensuring written patient information e.g. ward handover sheets, ward round changes and medical data, which contain confidential details are disposed of correctly, in confidential waste bags, and are not left in public areas
- Precautions are taken to prevent information being shared inappropriately, e.g. computer screens being viewed and white boards being read.
- Staff should avoid displaying patient’s personal information on wards or in clinics, unless this information is required for maintaining and promoting patient safety.
- Young people (under 18) have the right to receive confidential health care as soon as they reach an age where they can fully understand the issues and implications of their actions. All healthcare professionals should refer to the Fraser Guidelines (Gillick Competence) when a young person attends for healthcare (Gillick vs West Norfolk, 1985)
- Patients may read their own care plans, but visitors may only read them at the discretion of the patient

C. PRIVACY, DIGNITY AND MODESTY

Examples of good practice to achieve Privacy, Dignity and Modesty include:
- Closing curtains fully and positioning screens correctly in all areas where patients are required to undress
Not asking a patient to take off more clothing than is necessary
Following physical examination, patients should have an opportunity to re-dress before the consultation continues
Checking with a patient that they give their permission to be washed or examined by a person of the opposite sex, and respect their wishes where this is possible
Offering a chaperone to patients as appropriate and giving them a choice as to who is present during examinations and treatment (See Chaperone Policy)
Obtaining written consent from patients requiring clinical photography (including the use of digital cameras), having first informed the patient of what to expect
Patients not having to wait in a consulting room for prolonged periods of time alone, either before or during a consultation
Encouraging patients to dress in their own clothing during the day
Encouraging patients to wear their own night attire to sleep in. When this is not appropriate or possible, patients should have access to hospital clothing that protects their modesty and is acceptable to them
Adequately covering a patient if they do not have their own clothing or is too unwell to be dressed prior to leaving the ward
Expecting patients to be transported out of the hospital to be dressed if going home, or adequately covered if too unwell to get dressed.
Arrangements are made so that patients can have private telephone calls
Patients and carers should have access to an area for complete privacy; this should be considered both in hospital settings and in the community. In hospital patients and their relatives / carers should be advised of how to access safe, quiet private space on the hospital site.
Patients incapable of helping themselves must never be left without a covering to maintain their modesty and dignity, even during bed bathing and changing of bed linen/night attire
Every effort will be made to ensure patients who continually expose themselves are shielded from the view of others
Care plans will be in place for all patients within 24 hours of admission and these will be reviewed regularly to ensure they remain up to date
Use of specific care pathways including the end of life care pathway should be actively promoted throughout the Trust
Protected meal times will be available on all inpatient wards in line with the Trust's Nutrition Policy
Carers and relatives will be involved in decisions regarding care, with the consent of the patient

D. EQUALITY AND DIVERSITY

Examples of good practice to recognise Equality and Diversity include:

- Barriers to services are identified and removed and that no person is treated less favourably on the grounds of their race, ethnic group, religion or belief, impairment, age, gender, sexual orientation, or mental health status. Where barriers cannot be removed, adjustments will be made.
- Staff will work with patients and families in ways that, wherever possible, take into account that they may have different attitudes, values and beliefs about
health and healthcare. Where it is not possible to take this into account clear information and explanations will be given.

☑ Culturally sensitive meals should be available 24 hours a day and to achieve this snack boxes and food held on wards should reflect a wide range of dietary needs
Appendix F

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

<table>
<thead>
<tr>
<th>Document title</th>
<th>Privacy &amp; Dignity Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totals</strong></td>
<td>WTE</td>
</tr>
<tr>
<td>Manpower Costs</td>
<td>0</td>
</tr>
<tr>
<td>Training Staff</td>
<td>0</td>
</tr>
<tr>
<td>Equipment &amp; Provision of resources</td>
<td>0</td>
</tr>
</tbody>
</table>

Summary of Impact: This is a policy update therefore no significant impact

Risk Management Issues: Nil

Benefits / Savings to the organisation: Neutral

Equality Impact Assessment

- Has this been appropriately carried out? YES/
- Are there any reported equality issues? NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

<table>
<thead>
<tr>
<th>Manpower</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Operational running costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Training Impact</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Equipment and Provision of Resources

<table>
<thead>
<tr>
<th>Equipment / Provision</th>
<th>Recurring £ *</th>
<th>Non-Recurring £ *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation / facilities needed</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Building alterations (extensions/new)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IT Hardware / software / licences</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Medical equipment</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stationery / publicity</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Travel costs</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Utilities e.g. telephones</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Process change</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rolling replacement of equipment</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Marketing – booklets/posters/handouts, etc</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Totals:</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

- Capital implications £5,000 with life expectancy of more than one year.

| Funding /costs checked & agreed by finance: | -          |
| Signature & date of financial accountant:  | -          |
| Funding / costs have been agreed and are in place: | - |
| Signature of appropriate Executive or Associate Director: | - |
Appendix G

Equality Impact Assessment (EIA) Screening Tool

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Privacy &amp; Dignity Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of document</td>
<td>To ensure all patients are treated with dignity and respect wherever they are cared for within the organisation</td>
</tr>
<tr>
<td>Target Audience</td>
<td>All IOW NHS staff</td>
</tr>
<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
<td>Matron Clinical Support Cancer and Diagnostic Business unit</td>
</tr>
</tbody>
</table>

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British People</td>
<td></td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
</tr>
<tr>
<td>Black or Black British People</td>
<td></td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
</tr>
<tr>
<td>Chinese people</td>
<td></td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
</tr>
<tr>
<td>Category</td>
<td></td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People of Mixed Race</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White people (including Irish people)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with Physical Disabilities, Learning Disabilities or Mental Health Issues</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexuality Orientation</td>
<td>Transgender</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lesbian, Gay men and bisexual</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Children</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Older People (60+)</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Younger People (17 to 25 yrs.)</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>Faith Group</td>
<td>✓</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>✓</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>Equal Opportunities and/or improved relations</td>
<td>✓</td>
<td>Will ensure that all staff are aware how to manage and treat people with regard to Privacy and dignity</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.
3. **Level of Impact**

If you have indicated that there is a negative impact, is that impact:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal</strong> (it is not discriminatory under anti-discriminatory law)</td>
<td></td>
</tr>
</tbody>
</table>

**Intended**

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:

3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

<table>
<thead>
<tr>
<th>Scheduled for Full Impact Assessment</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of persons/group completing the full assessment.</td>
<td></td>
</tr>
<tr>
<td>Date Initial Screening completed</td>
<td></td>
</tr>
</tbody>
</table>