



## Surrey & Sussex Healthcare NHS Trust

### An Organisation-wide Policy for Intimate Care

Version	2
Status	Ratified
Date Ratified	30/04/2013 (by Chair's Action) (MBQR approved 17/04/2013)
Name of Owner	Safeguarding Adults Lead
Name of Sponsor Group	Safeguarding Adults Group
Name of Ratifying Group	Management Board for Quality & Risk
Type of Procedural document	Policy
Policy Reference	0549
Date issued	10/05/2013
Review date	29/04/2016
Target audience	All Healthcare Staff
Human Rights Statement	The Trust incorporates and supports the human rights of the individual, as set out by the European Convention on Human Rights 1950 and the Human Rights Act 1998
EIA Status	Completed 30/04/2013
This policy is available on request in different formats and languages from the Policy Coordinator / PALS.	
The latest approved version of this document supercedes all other versions. Upon receipt of the latest approved versions all other version should be destroyed, unless specifically stated that the previous version(s) are to remain extant. If in any doubt please contact the document owner or Policy Coordinator.	

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<b>Change history</b>			
<b>Version</b>	<b>Date</b>	<b>Author/Procedure Lead</b>	<b>Details of change</b>
1	2007	Vikki Carruth	New Policy
2	April 2013	Fiona Crimmins Safeguarding Adults Lead and Jamie Moore Divisional Chief Nurse for Surgery	Policy Updated

## **1. Introduction**

Surrey and Sussex NHS Trust encompasses a core value of patient privacy and dignity and experience. Every member of staff has a duty to ensure that the privacy and dignity of all patients are respected (RCN 2006). Every nurse must treat each patient as an individual and respect their dignity (NMC 2008). Patients have the right to be treated with dignity at all times, to have their modesty protected and to remain autonomous and independent wherever possible (DH 2011).

This policy is designed to help avoid misunderstandings and to minimise embarrassment for all concerned during intimate examinations or procedures. The apparent intimate nature of many healthcare interventions, if not practised in a sensitive and respectful manner, can lead to misinterpretation and occasionally, allegations of abuse. This policy is to protect the interests of both patients and clinicians and should be applied in all circumstances where there is a requirement of intimate examination and in cases where the patient may feel vulnerable.

## **2. Purpose**

The purpose of this policy is to enable all Trust staff to provide high quality care ensuring that patients' dignity and privacy is maintained at all times. It applies to the care of patients who require clinical support of an intimate nature and it sets out guidance for staff who carry out or assist with this. Staff must also be mindful to each individual's needs, for example, what the patients perception and understanding of intimate care is and what that means to them.

## **3. Definitions**

The definition of an intimate examination may differ between individual patients for ethnic, religious or cultural reasons. In addition, some patients may have a clear preference for a health professional of specific gender due to their ethnic, religious or

cultural background, because of previous experiences, or in view of their age. Where possible Trust Staff need to take individual needs and preferences into consideration and position themselves during the course of the intimate examination to prevent any further embarrassment to the patient.

A chaperone is a person who is present during a physical examination. This person acts as a third party and as protection for both the clinician and patient. They can also act as a witness to consent to a procedure.

#### **4. Duties**

This policy applies to all employees working at Surrey and Sussex NHS Trust, including locum, bank and agency staff who are working on behalf of the Trust and are involved in the direct care of the patients.

All staff who are required to provide clinical care of an intimate nature are personally responsible and professionally accountable under their relative code of conduct for ensuring that their actions apply with this policy.

All new staff who are required to provide clinical care of an intimate nature will be made aware of this policy on their induction to the Trust.

#### **5. Intimate Care**

Intimate care is defined as the care tasks associated with the bodily functions, body products and personal hygiene which demand direct or indirect contact with or exposure of the body. This type of examination includes the examination of the breasts, genitalia or rectum, though it should be noted that other areas of the body may be classified as intimate by patients.

Please see the list below of procedures that may be described as intimate. Please note that this is not an exhausted list and all examinations, including any type of medical examination or procedure may be classed as intimate by either the patient or examiner.

**5.1 Some example include**

- Dressing and undressing
- Helping a person to use the toilet
- Changing continence pads
- Providing catheter care
- Management of stoma
- Bathing & Showering
- Washing intimate parts of the body
- Changing sanitary wear
- Inserting suppositories
- Giving enemas
- Inserting and monitoring pessaries
- Applying /changing dressings to intimate parts of the body

**5.2 Before conducting an intimate examination/procedure the health care professional must:**

- Act with propriety and in a courteous and professional manner.
- Communicate sensitively and politely using professional terminology.
- Explain to the patient why an examination is necessary and give the patient the opportunity to ask questions and confirm understanding.
- Explain what the examination will involve, in a way that the patient can understand (consider using the Communication Book or language services as appropriate), so that the patient has a clear idea of what to expect, including any pain or discomfort which they may possibly experience.
- Where a patient is not able to fully understand the information given, it is the responsibility of the member of staff to explore ways of presenting the information in a more accessible manner.
- Valid consent must be given voluntarily by an appropriately informed person prior to any procedure or intervention. No one can give consent on behalf of another adult who is deemed to lack capacity regardless of whether the impairment is temporary or permanent. However such patients can be treated if it is deemed to be within their best interest. This must be recorded within the patient's health records with a clear rationale stated at all times.

- If a patient has capacity and decides to decline intimate care or examination, this must be respected and documented in the patient notes.
- Obtain consent from the patient prior to the intervention/procedure and document within the patient's healthcare records that consent has been obtained.
- Give the patient privacy to undress and keep the patient covered as much as possible to maintain their dignity. Closing curtains or doors in areas where patients are expected to undress and also where the procedure will be performed utilising the "Do not disturb" signage.
- Do not assist the patient in removing clothing unless it has been clarified with them that assistance is required - this must be documented within the patient's healthcare records.
- A chaperone may be present during an intimate examination. Please refer to the Trust Chaperoning Policy for further advice and guidance.
- The patient should also be offered a choice as to who is present during the procedure.

**5.3 During an intimate examination/procedure the health care professional must :**

- Maintain the patient's privacy and dignity at all times throughout the Intervention/procedure which should be conducted without interruption.
- Patients undergoing any procedure or intervention should be allowed the opportunity to limit the degree of exposure by, for example, uncovering only the part of anatomy that is required.
- Explain the procedure before it happens and, if this differs to what the patient thinks is to happen, then an explanation must be given and further on going consent from the patient should be sought.
- The intervention/procedure must be discontinued if the patient requests for this to happen.
- All discussions must be kept relevant and no personal comments made towards the patient. All Trust staff should avoid personal conversations with co-workers that exclude the patient during the intervention / procedure.

**5.4 Following an intimate examination/procedure the health care professional must:**

- Following the procedure, patients should have the opportunity to re-dress before the consultation continues.
- Ensure the patient's privacy and dignity continues to be respected.
- Address any queries or concerns relating to the examination / procedure.

### **5.5 Good practice principles:**

- Verbal consent is sufficient for most examinations, however if a proposed procedure carries significant risk, it will be appropriate to seek written consent.
- Consent should always be appropriate to the treatment/investigation being carried out.
- Before conducting any intimate examination it is essential to explain to the patient why an examination is necessary and give them an opportunity to ask questions.
- Explain what the examination/procedure will include in a way that the patient can understand, so the patient has a clear idea of what to expect including any potential pain or discomfort.
- Time should be allowed for the patient/client to consider the implications, followed by a check to ensure that the information has been understood. All Trust staff must uphold patient's rights to be fully involved in decisions about their care (CQC 2010; DH 2010).
- Obtain the patient's permission before proceeding with any examination/procedure and discontinue if the patient asks you to do so.
- If there is more than one clinician involved, the patient's consent should be sought after giving a thorough explanation of the need for their presence (DH2001). For some patients the level of embarrassment increases in proportion to the number of individuals present.
- Valid consent must be documented within the patient's healthcare records and evidenced using the appropriate Trust Consent forms located within the patient's notes.
- Please refer to the Trust's Consent Policy for further guidance.

## **5.6 Special Circumstances**

There may be situations where more explicit consent is required prior to intimate examinations or procedures, such as where the individual concerned is a minor, has special educational needs or does not have the capacity to consent (DH 2001). In these circumstances staff must refer to the Trust's Consent Policy for specific details relevant to their working environment and discuss with their line manager for further advice and Safeguarding Team if required.

## **5.7 Issues specific to religion, culture and / or ethnicity:**

The ethnic, religious and cultural background of some individuals can make intimate examinations particularly difficult. Patients undergoing examinations should be allowed the opportunity to limit the degree of exposure by, for example, uncovering only that part of the anatomy that requires investigation or imaging. It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a language barrier communication difficulties.

## **5.8 Issues specific to patients with a Learning Disability, Learning difficulty and / or a mental health concern:**

Adults who resist any intimate intervention or procedure must be interpreted as refusing to give consent and the procedure should be abandoned and an assessment should be made of whether the patient can be considered as having capacity or not. If the patient has capacity, the investigation or treatment cannot proceed. However, if the patient lacks capacity, they should be treated according to his or her own best interests. Assessing best interests must take into account the potential for physical and psychological harm but in some situations it may be necessary to proceed in an appropriate manner (DH 2001). All Trust staff must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of the decision making process and are fully safeguarded (DH 2010). Provision of health care in the patient's best interests needs to be considered with other key health and social care professionals or carers. Please refer to the Mental Capacity Assessment Tool and the Best Interest Proforma which can be accessed via the Adult Safeguarding Intranet page.

### **5.9 The anaesthetised / unconscious patient**

Consent for intimate examinations must be obtained prior to the patient being anaesthetised. This must be documented in the patient notes. The rationale for the intimate examination and the need for it to be done under anaesthetic, must be explained in detail to the patient. If the examination can be done when the patient is not under anaesthetic, this must be considered as the first option, so full informed consent can be given by the patient at the time.

If students are being supervised undertaking an intimate examination/procedure, the supervising consultant/registrar must ensure that valid consent has been obtained from the patient prior to them being anaesthetised.

If a patient is unconscious and it is medically indicated that an intimate examination should be carried out, it would be in the patient's best interests to do the examination. However, consent must be obtained at the earliest opportunity and the rationale for the examination must be explained in detail to the patient as soon as possible.

All examinations must be chaperoned when the patient is either unconscious or anaesthetised. Under no circumstances, should an intimate examination be carried out without a chaperone on a patient who is under anaesthetic or unconscious.

### **5.10 Recording**

It is essential that Trust staff explain the nature of any examination/procedure to patients and offer them a choice of whether to proceed with the examination at that time. The patient is then able to give valid consent to continue with the procedure/intervention. Details of any procedure/intervention including the presence/absence of a chaperone and information given must be documented within the patient's health care records. It must be documented if the patient expresses any doubts or reservations about the procedure being undertaken and any reassurance given.

The following must be recorded in the patient's healthcare records:-

- The patient has given permission for the examination to take place.
- The fact that a chaperone was offered and accepted or declined.
- The presence and identity of the chaperone including their name, status and their designation.
- The result of any discussion regarding delaying an examination until the chaperone can be present.
- Any other information that the health care professional performing examination/procedure feels relevant or necessary.
- It must be explicit from the health records that the examination or procedure was necessary.
- In any situation where or an incident has occurred or concerns are raised by either Trust staff or the patient, an incident report must be completed as soon as possible following the incident and the appropriate Line Manager informed.

#### **5.11 Member of staff providing the care**

Intimate care should normally be provided by a member of staff of the same gender as the patient. On occasions when this is not possible the following should be considered

- The wishes of the person requiring the care.
- The consequences of the person not receiving the care and implications of this to their health.
- Whether the urgency of the care needed makes it an immediate necessity (e.g. incontinence)
- The length of time before a same gender member of staff is available.

Any personal care support being offered by a member of staff who the opposite gender should, if all possible, be given in the presence of another person of the same gender as the person receiving the care. If the patient refuses a chaperone, staff may refuse to give personal care (except in immediate necessity). Staff must give their reasons to the person concerned. This must be documented and line manager informed.

When intimate care is required and a member of staff of the same gender has been requested and is not available, this must be brought to the attention to

Nurse/ Midwife in charge. In addition, it should be documented in the notes each time this occurs, stating:

- Date
- Time
- Care given
- Immediate necessity which led to a member of staff of the opposite sex providing intimate care
- Reason why a member of staff of the same gender was not available.

It is the responsibility of the team, through record keeping, to monitor the frequency of same gender staff not being available for intimate personal care needs. Record keeping will highlight staffing or procedural implications and enable line managers to take considered and responsive action.

## **6. Consultation and Communication with Stakeholders**

This policy has been developed as part of the quality assurance procedures.

This policy was circulated for consultation purposes to representatives from the nursing, medical and other healthcare professional groups and the feedback received was incorporated into the final document.

The policy was circulated to the Safeguarding Adults Group for comments.

## **7. Approval and Ratification**

This policy was ratified by the Management Board for Quality and Risk.

## **8. Review and Revision**

This policy will be reviewed in line with the Trust Policy on management and development of procedural documents. It will be reviewed in 2016, but updated when necessary.

## **9. Dissemination and Implementation**

The Trust process for dissemination and implementation for policies will be described in the Organisational Policy for the Management and Development if Procedural Documents. This is also included and disseminated through safeguarding training sessions.

## **10. Archiving**

This policy will be held in the Trust database and archived in line with the arrangements in the Organisation wide policy for the management of procedural documents.

## **11. Monitoring compliance**

The overall effectiveness of this policy will be monitored through complaints, PALS, Datix and alerts or concerns raised with the Safeguarding Team

## **12. References**

Care Quality Commission (2010) Essential standards of quality and safety.

Department of Health (2001) Reference guide to consent for examination or treatment.

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_103653.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103653.pdf)

Department of Health (2010) Essence of Care.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_119969](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119969)

Department of Health (2011) *The Operating Framework for the NHS in England* 2012/13.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_131360](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360)

Royal College of Nursing (2006) *Defending Dignity – Challenges and Opportunities for Nursing*.

NMC (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*.

<http://www.nmc-uk.org/Documents/Standards/The-code-A4-20100406.pdf>

### **13. Associated Documents**

Best Interests Proforma

Mental Capacity Assessment Tool

The Mental Capacity Act 2005

Trust policy for Allegations against staff

Trust policy for Chaperoning

<file:///iis1/ppg/clinical/0525ChaperonePolicy.pdf>

Trust Policy for Consent

<file:///iis1/ppg/risk/0015consent.pdf>

Trust policy for Privacy and Dignity

Trust Policy for Safeguarding Adults

Intimate Care

## Appendix 1

### Equality Impact Assessment Tool

<p><b>Names of assessors carrying out the screening procedure (min of 2- author / manager and staff member / patient representative)</b></p> <ul style="list-style-type: none"> <li>• Fiona Crimmins</li> <li>• Sally Knight</li> </ul>	<p><b>Name of lead author /manager &amp; contact number</b></p> <p>Fiona Crimmins X 2839</p>
<p><b>1. Name of the strategy / policy / proposal / service function</b></p> <p style="text-align: center;"><b>Policy for Intimate care</b></p>	<p><b>Date last reviewed or created &amp; version number.</b></p> <p>V.2 reviewed policy</p>
<p><b>2. Who is the strategy / policy / proposal / service function aimed at?</b></p> <p>All Staff including locum, bank and agency</p>	
<p><b>3. What are the main aims and objectives?</b></p> <p>The purpose of this policy is to enable all Trust staff to provide high quality care ensuring that patient' dignity and privacy is maintained at all times.</p>	
<p><b>4. Consider &amp; list what data / information you have regarding the use of the strategy / policy / proposal / service function by diverse groups?</b></p> <p>Patient data- age, gender, ethnicity, disability</p> <p>Department of Health (2010) Essence of Care.</p> <p><a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119969">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119969</a></p> <p>Royal College of Nursing (2006) <i>Defending Dignity – Challenges and Opportunities for Nursing.</i></p>	
<p><b>5. Is the strategy / policy / proposal / service function relevant to any of the protected</b></p>	

characteristics or human rights below?			
If <b>YES</b> please indicate if the relevance is <b>LOW, MEDIUM or HIGH</b>			
•			
	<b>Protected Characteristics</b>	<b>Patient, their carer or family</b>	<b>Staff</b>
	• <b>Age</b>	Yes- low positive	No
	• <b>Disability</b>	Yes- low positive	No
a	Physical		
b	Learning disability	Yes- low positive	
c	Sensory impairment, Hearing, sight		
d	Speech or communication difficulty	Yes- low positive	
e	Mental ill health	Yes- low positive	
f	People with HIV / AIDS		
g	Head injury, cognitive loss		
h	Other		
	• <b>Gender Reassignment</b>	No	No
	• <b>Race/ Ethnic Communities / groups</b>	Yes- low positive	No
	• <b>Religion or belief</b>	Yes- low positive	No
	• <b>Sex</b> (male female)	Yes- low positive	Yes-- low positive
	• <b>Sexual Orientation</b> (Bisexual, Gay, heterosexual, Lesbian)	No	No
	• <b>Marriage &amp; Civil Partnership</b>	No	No
	• <b>Pregnancy &amp; Maternity</b>	No	No

	• <b>Human Rights</b>	<b>Yes- low positive</b>	<b>No</b>
6.	<p><b>What aspects of the strategy / policy / proposal / service function are of particular relevance to the protected characteristics?</b></p> <p>Intimate care of patients – applies to all characteristics in positive way</p> <p>Communication and understanding-positive impact for communication needs</p> <p>The human rights-</p> <p>the right not to be tortured or treated in an inhuman or degrading way</p> <p>the right not to be discriminated against</p>		
7.	<p><b>Does the strategy / policy / proposal / service function relate to an area where there are known inequalities? If so which and how?</b></p> <p>None known</p>		
8.	<p><b>Please identify what evidence you have used / referred to in carrying out this assessment.</b></p> <p>See q4 and authors knowledge</p>		
9.	<p><b>If you identify LOW relevance only can you introduce any minor changes to the strategy / policy / proposal / service function which will reduce potential adverse impacts at this stage? If so please identify here.</b></p> <p>Not applicable</p>		
10.	<p><b>Please indicate if a Full Equality Impact Assessment is recommended.</b></p> <p>(required for <b>all</b> where there is <b>MEDIUM &amp; HIGH</b> relevance)</p>		<b>NO</b>
11.	<p><b>If you are not recommending a Full Equality Impact assessment please explain why.</b></p> <p>This policy will have a positive impact for all groups relating to their privacy &amp;</p>		

	dignity. It follows national guidance and good practice.	
12.	<b>Signature of author / manager</b> Fiona Crimmins	<b>Date of completion and submission</b> 30/04/2013

Please send completed form to [sally.knight@sash.nhs.uk](mailto:sally.knight@sash.nhs.uk)

### Definitions of relevance

#### Low

- The policy **may not be relevant** to the Equality General Duty\* as stated by law
- Little or no evidence is available that different groups may be affected differently
- Little or no concern raised by the communities or the public about the policy etc when they are consulted – (recorded opinions, not lack of interest)

#### Medium

- The policy **may be relevant** to parts of the Equality General Duty\* in the policy etc regarding differential impact
- There may be some evidence suggesting different groups are affected differently
- There may be some concern by communities and the public about the policy

#### High

- There **will be relevance** to all or a major part of the Equality General Duty\* in the policy regarding differential impact.
- There will be substantial evidence, data and information that there will be a significant impact on different groups

There will be significant concern by the communities and relevant partners on the potential impact on implementation of the policy etc.

•	<b>Human Rights</b>
1	the right to life
2	the right not to be tortured or treated in an inhuman or degrading way

3	the right to be free from slavery or forced labour
4	the right to liberty
5	the right to a fair trial
6	the right to no punishment without law
7	the right to respect for private and family life home and correspondence
8	the right to freedom of thought, conscience and religion
9	the right to freedom of expression
10	the right to freedom of assembly and association
11	the right to marry and found a family
12	the right not to be discriminated against
13	the right to peaceful enjoyment of possessions
14	the right to an education
15	the right to free elections