Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists

SERVICE STANDARDS FOR CONSULTATIONS IN SEXUAL AND REPRODUCTIVE HEALTH

2015
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SERVICE STANDARDS FOR CONSULTATION SKILLS

This standard provides guidance on the best practice for clinicians conducting Consultations in Sexual and Reproductive Healthcare to provide safe, efficient and effective healthcare that is patient centred and equitable.

It can be adapted and used in all clinical settings where patients request contraception. This includes Integrated Contraception and Sexual Health Services (CASH), Genitourinary Medicine Clinics, Outreach Services, General Practice, Pharmacy and Termination of Pregnancy Services.

This standard should be used by all healthcare professionals’ i.e. doctors, nurses and pharmacists, who are required to assess a patient’s Sexual and Reproductive Healthcare needs.

Unlike the specific guidance published by the Clinical Effectiveness Unit (CEU), this is not a tool to support clinical decision making, nor is it designed to be prescriptive in the information required to make such decisions. The role of this document is to address the factors required to create an environment conducive to both the clinician and patient to obtaining accurate, relevant and concise information. This will facilitate the clinical decision.

The standard may be used to assess consultation skills prior to a trainee entering into training for any of the FSRH qualifications.

The aim of this standard is to improve the care received by patients, and it should be used in conjunction with the following service standards to support clinical best-practice.

- Record Keeping
- Confidentiality
- Quality Standard for Contraceptive Services
- Risk Management
- Workload
- Obtaining Valid Consent
1. Standard Statement on Confidentiality

A service or practice policy on confidentiality should be displayed prominently in a patient area

1.1 It is a duty and core requisite of all employing organisations to adhere to the Caldicott principles of patient confidentiality. This is supported by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC)\textsuperscript{1,2,3,4,5}

1.2 Confidentiality is pivotal to trust between clinicians and patients. Without assurances about confidentiality, patients may be reluctant to seek medical care or to provide clinicians with the information required to offer safe, effective management which is essential for the individual patient and the wider community\textsuperscript{2,4}.

1.3 All patients should be offered the same level of respect and confidentiality.

1.4 A service or practice policy on confidentiality, applicable to all staff, should be displayed prominently. This will encourage the uptake of services, and has been highlighted as particularly relevant for young people\textsuperscript{6}.

1.5 Confidentiality is not absolute. Information in exceptional circumstances can be shared if:

- it is required by law
- the patient gives consent
- it is justified in the patient’s or the public’s best interest i.e Child or Adult Safeguarding concerns\textsuperscript{2,3,6,7}
  - it could prevent a serious crime e.g. terrorism

1.6 The limits of Confidentiality should be individually communicated to patients with vulnerabilities
2. Standard Statement on Clinical Environment

The environment should be conducive to respecting privacy and dignity

2.1 Every effort should be made to ensure the environment is comfortable and facilitates confidentiality and respect for patient dignity.\(^8,9,10\).

2.2 Interruptions to consultations should be kept to an absolute minimum\(^10\).

2.3 Consultation rooms should be designed to ensure any information shared cannot be overheard by others\(^10\).

2.4 Permission must be sought from a patient if observers/students are to be present during consultations\(^8\).

2.5 Any requests for a specific gender of clinician should be accommodated as far as possible or the patient referred to alternative services if the request cannot be met\(^10\).

2.6 Written patient information should be available to support the consultation\(^9\).

2.7 Locally written information should be ratified by the relevant committee prior to use.

2.8 Leaflets should be available in a variety of languages and formats relevant to individuals’ needs e.g. electronic, pictorial\(^8,13\).
3. Standard Statement on Verbal Communication Skills

Information should be communicated in a manner that is clear and understandable.

3.1 The consultation process should be explained in advance and patients should be informed that they will be asked for personal information.

3.2 All clinicians should have effective verbal communication skills.

3.3 For an effective consultation, clinicians should:

- introduce themselves to the patient
- check with the patient how they prefer to be addressed
- confirm the patient’s identity, i.e. check that the name and date of birth on the clinical record are correct
- use ‘open questions’ to initiate the consultation
- use ‘closed questions’ to obtain or clarify specific information
- adapt their language so that it can be understood by patients. Information shared may need to be clarified
- check back that the patient has understood, e.g. by asking them to reflect back
- discuss and agree a management plan, in partnership with the patient in a way which respects patient autonomy.

3.4 Interpreting services should be available for all patients if required. Relatives and friends should only be used for translation as a last resort.
4. Standard Statement on Non-verbal Communication skills

<table>
<thead>
<tr>
<th>Clinicians should be welcoming, non-judgemental and put the patient at ease</th>
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<tbody>
<tr>
<td>4.1 A patient centred approach should be adopted i.e. care which is holistic, flexible and collaborative.(^{22})</td>
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<td>4.2 Body language should be open and appropriate.</td>
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<td>4.3 Clinicians should be alert to non-verbal signs of patient anxiety or distress(^9).</td>
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<td>4.4 Eye contact with the patient should be maintained, unless this would be deemed culturally unacceptable.</td>
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<tr>
<td>4.5 Patients should be made to feel comfortable.</td>
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5. Standard Statement on Use of a Chaperone

All patients should be offered a chaperone and this should be documented in the patient’s record

5.1 All patients should be given the option to have an impartial observer to act as a chaperone, wherever possible, for all intimate examinations. This is not dependent upon the gender of the clinician and is recommended for all clinical interactions of an intimate nature\textsuperscript{17,18,20}.

5.2 If a chaperone cannot be provided, the patient must be informed and asked whether they wish to continue with the examination or procedure. Their decision should be documented in the medical record\textsuperscript{19}.

5.3 A chaperone should usually be a health professional and you must be satisfied that the chaperone will\textsuperscript{18}

\begin{itemize}
\item be sensitive and respect the patient’s dignity and confidentiality
\item reassure the patient if they show signs of distress or discomfort
\item be familiar with the procedures involved in a routine intimate examination
\item stay for the duration of the examination and be in a position to comment on the clinicians interaction
\item be prepared to raise concerns if they are uncomfortable about the clinicians behaviour or actions
\end{itemize}

5.4 A relative or friend of the patient is not an impartial observer and therefore would not usually be a suitable chaperone. The FSRH recommends that the clinician should comply with a reasonable request to have such a person present as well as a chaperone\textsuperscript{18}.

5.5 Cultural or religious beliefs, which prohibit examination by a clinician of the opposite sex, or the presence of a chaperone of the opposite sex should be respected. Any preferences and/or objections should be identified as early as possible to eliminate unnecessary distress. The individual requirements of the patient should be respected and the preference documented\textsuperscript{19}.
5.6 If a chaperone is present, this should be recorded in the patient record, including their identity and role. If the patient does not want a chaperone, the offer being made and declined should be documented\(^{19,20}\).
6. Standard Statement on Special Groups

**All clinicians should have completed training in safeguarding of children and vulnerable adults**

6.1 Additional time should be allocated for consultations for individuals with specific communication needs \(^{8,9,10}\).

6.2 All clinicians should have access to a specific proforma designed for use in consultations with young people (under the age of 16). This will support the clinician to confidently assess for the following:
   - 6.2.1 Gillick Competence and Capacity to Consent
   - 6.2.2 Indicators of possible Child Sexual Exploitation (standard 7) \(^{10,11,12}\).

6.3 All clinicians should be aware of the additional needs of vulnerable adults and work collaboratively with partnership organisations (i.e. primary care and social care) to maintain an individual's safety as appropriate \(^{15}\).

6.4 Provision should be made for patients with physical disabilities including the availability of access to sign language services and/or disabled access to consultation rooms \(^{13,14}\).

6.5 Clinicians should be able to communicate effectively with patients who allege sexual assault and to refer them to a specialist sexual assault referral centre (SARC) or equivalent specialist service if necessary \(^{15,16}\).

6.6 Consultations in outreach services should be of the same standard and quality as those in the main clinical service \(^{8,10}\).

6.7 The clinician should use communication techniques and materials to help all patients get the most from the consultation \(^{13,14}\).

6.8 Clinicians should be aware of female genital mutilation (FGM) and provide support for victims. Reporting of FGM should be guided by the use of appropriate pathways eg those detailed in the safeguarding children flow chart.
7. Standard Statement on Child Sex Exploitation (CSE)

All Clinicians should complete training in Child Sex Exploitation (CSE)

7.1 Services should use a risk assessment matrix\(^2\) to quantify a hazard score for the child.

7.2 Points to consider should include:

- episodes of being missing from home
- education
- drug use
- relationship with carers
- accommodation
- alcohol use
- risk to others
- rights and risk awareness (sexual)
- engagement with services
- sexual health awareness
- sexual behaviour

7.3 Clinicians should be familiar with the local safeguarding children policies and referral pathways and report any concerns appropriately.

7.4 Services should encourage a culture of collaboration and information sharing with the police and other care agencies to protect vulnerable children.

7.5 Clinicians should deliver the risk assessment effectively, communicate sensitively and respond appropriately to any safeguarding concerns.
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