Leicestershire Partnership NHS Trust

Chaperone Policy for Adults and Children

This policy describes the process for offering a chaperone to patients where appropriate. This policy specifically applies to intimate examinations.

Key Words:	, Chaperone,	
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Adopted by:	Quality Assurance Committee	
Date Adopted:	21 February 2017	
Name of originator/author:	Debbie Whight	
Name of responsible committee:	Legislative commitee	
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Expiry date:	1 April 2021	
Target audience:	All Clinical staff	
Type of Policy	Clinical ✔	Non Clinical
Which Relevant CQC Fundamental Standards:	Regulation 13	

Contents

REFERENCES AND ASSOCIATED DOCUMENTATION

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	Feb 2009	First Comment
2	Jan 2012	Harmonisation
3	Oct 2014	Safeguarding Adults Contribution to address Capacity
4	Feb 2015	Change to first introduction paragraph to place more emphasis on privacy and dignity, and the service user. Rachel Garton
5	Feb 2015	Fourth paragraph of introduction changed to include sensitivity to victims of abuse. Rachel Garton
6	Feb 2015	Safeguarding Adults Policy, Mental Capacity Act 2005 Policy, Allegations against an employee that they may have harmed an adult or a child Policy all added.
7	July 2015	7.1 Informal Chaperone, the following added: 'Where younger children require informal chaperone parents/carers of either gender would be appropriate'.
8	July 2015	Introduction, the following added: This policy is intended to safeguard patients/service users and ensure that when treatment involves intimate or other examinations, privacy and dignity is given high regard. The policy also serves to reduce the likelihood of service users misinterpreting actions taken by staff as part of consultation, examination, treatment and care; however the focus of the procedure remains with the service user.

9	September 2016	Review of policy. Policy updated and circulated for comment to members of PCEG. Title – the words “this policy specifically applies to intimate examinations” added. Section 3.1 wording changed to “substantive, temporary or honorary contracts” added to incorporate staff working from bank/agency. Section 6.3.5 review and updating of risk assessment added. Section 10.3 “Risk assessments should be completed, reviewed and updated where appropriate to reflect any risks identified, either for the patient undergoing the procedure or for the staff in carrying out the procedure” added. Section 13 “Consent to treatment” was moved to section 12. Section 12 “Capacity to consent” had the words “to the procedure” added. The whole section was moved to section 13. The guide to capacity was moved to precede the information on capacity assessment for the procedure. Section 14.1 the hyperlink was renewed and translation providers updated. Section 20.1 “The patient should be informed that a student will be present for the examination and consent should be obtained” was added. Appendix 2 wording was changed to “The chaperone may be a family member, carer, friend or a nurse or other trained member of staff”. Added Appendix 1: NHS Constitution. Format changes to comply with new Policy Structure (March 2016). Other minor changes to wording. To be presented at PCEG October 2016

For further information contact:

Divisional Lead Nurse

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

The Due regard assessment template is Appendix 4 of this document

Definitions that apply to this Policy

Chaperone	There is no common definition of a chaperone and their role varies considerably depending on the needs of the patient/service user, the healthcare professional and the procedure being carried out. Chaperones should: a. Act as safeguards for patients against humiliation, pain, or distress; must offer protection against verbal, physical, sexual, or other abuse b. Use, or access, resources to enable the patient who communicates in a language other than English, uses Braille or Sign Language, or has other communication needs, to understand the procedure c. Provide physical (as agreed by the patient/service user) and emotional comfort and reassurance to patients during sensitive and intimate examinations or treatment d. Provide protection to healthcare professionals against unfounded allegations of improper behaviour or potentially abusive patients e. Offer practical support to patients f. IDENTIFY unusual or unacceptable behaviour by a healthcare professional.

THE POLICY

1.0 Purpose of the Policy

The aim of the policy is to:

1.1 To ensure that patients' safety, privacy and dignity is protected during intimate examinations
1.2 To minimise the risk of a clinician's actions being misinterpreted
1.3 To ensure the clinician's safety whilst carrying out intimate clinical examinations

2.0 Summary and Key Points

2.1 This policy applies to all clinicians directly employed on substantive, temporary or honorary contracts by the organisation and contractors whose contract specifies adherence to this policy.

2.2 All healthcare professionals have a responsibility to ensure they work in line with their own professional code of conduct.

2.3 This policy specifically applies to intimate examinations; these are defined as any examination or procedure involving the rectum, genitalia or breasts. It also includes examinations involving the complete removal of outer clothing down to underwear or less. Other examinations could also be deemed intimate by some patients and clinicians need to be aware of cultural differences and what may constitute an intimate examination.

This policy should be read in conjunction with the following policies:

- Equality and Diversity Policy
- Safeguarding Children Policy
- Consent to Examination and Treatment
- Safeguarding Adults Policy
- Mental Health Act Policy
- Clinical Audit Policy
- Policy on Fraud
- Personal Safety & Lone Worker Policy
- Incident Reporting Policy & Toolkit
- Privacy and Dignity Policy
- Mental Capacity Act 2005 Policy
- Allegations against an Employee that they may have harmed an Adult or a Child Policy

3.0 Introduction

This policy is intended to safeguard patients/service users and ensure that privacy and dignity is given high regard when treatment involves intimate or other examinations. The policy also serves to reduce the likelihood of service users misinterpreting actions taken by staff as part of consultation, examination, treatment and care; however the focus of the procedure remains with the service user.

It is good practice to offer all patients a chaperone for any consultation, examination or procedure, including the administration of medication, where the patient feels one is required. This offer can be made through a number of routes including prominently placed posters, practice leaflets and verbal information prior to the actual consultation.

All medical consultations, examinations and investigations are potentially distressing and those involving the breasts, genitalia or rectum, or those requiring dimmed lights or the need to undress may make patients feel particularly vulnerable.

For some people who use our services, whether because of mental health needs and/or learning disabilities, or where a service user may have experienced abuse, consultations, examinations or procedures may be threatening or confusing. This may also be the case for babies, children and young people in relation to their ability to understand procedures from a developmental perspective, and individuals who may have dementia/health condition/learning disability affecting their ability to fully understand situations. Staff should be sensitive to the impact of the experience on an individual. A chaperone, particularly one trusted by the patient, may help the patient through the process with the minimum of distress.

For most patients respect, explanation, consent (where patient has got mental capacity to do so) and privacy take precedence over the need for a chaperone.

The presence of a third party does not negate the need for adequate explanation and courtesy and cannot provide full assurance that the procedure or examination is conducted appropriately

4.0 Process/Background

4.1 Outcomes following public inquiries, such as the Richard Neale Inquiry (Department of Health 2004), and Clifford Ailing Inquiry (Department of Health 2004), made a number of recommendations regarding the use of chaperones in primary or community care settings. These do however need to be considered, in the light of practicality and suitability within the care delivery setting.

4.2 Chaperones are most often required or requested where a male examiner is carrying out an intimate examination or procedure on a female patient. However, the organisation considers it good practice to offer all patients a chaperone for any examination or procedure where the patient feels one is required, regardless of the gender of the examiner or patients.

5.0 Roles and Responsibilities of the Chaperone

A chaperone is present as a safeguard for all parties (patients and practitioners), and is a witness to continuing consent of the procedure. In order to protect the patient (male or female) from vulnerability and embarrassment, a chaperone should be of the same sex as the patient. An opportunity should always be given to the patient to decline a particular person if that person is not acceptable to them for any reason.
The designation of the chaperone will depend on the role expected and the wishes of the patient i.e. either a passive/informal role or an active/formal role. Equality team may be consulted regarding the wishes of transgender patients in their choice of chaperone.

5.1 Informal Chaperone

An informal chaperone would not be expected to take an active part in the examination or witness the procedure directly. An example is a family member, carer or friend i.e. a familiar person who may be sufficient to give reassurance and emotional comfort to the patient; who may assist with undressing the patient and who may act as an interpreter.

Where younger children require informal chaperone parents/carers of either gender would be appropriate.

5.2 Formal Chaperone

5.2.1 This implies a health professional such as a Nurse, or a specifically skilled non-medical staff member e.g. health care support worker (HCSW). Where appropriate they may assist in the procedure being carried out and/or hand instruments to the examiner during the procedure. Assistance may also be given to the patient when undressing/dressing or in assisting the patient to position themselves appropriately for the procedure.

5.2.2 A chaperone will be able to identify any unusual or unacceptable behaviour on the part of the health care professional, and should immediately report any incidence of inappropriate behaviour to their line manager or senior manager and the appropriate Safeguarding Team. HR should be informed where appropriate and incident form completed.

5.2.3 They will also provide protection to healthcare professionals against unfounded allegations of improper behaviour.

5.2.4 In all cases the presence of the chaperone should be confined to the physical examination part of the consultation.

5.2.5 Confidential clinician/patient communication should take place on a one to one basis after the examination.

5.2.6 Facilities should be provided to ensure the privacy of the patient without interruption whilst undressing and during the examination, either in a dedicated examination room or behind a screen. Sheets or gowns should be available to use during the examination to minimise the extent of the nudity.

5.2.7 Intimate should ideally take place at premises where adequate arrangements for the examination can be made along with the chaperone requirements.

5.2.8 Patients should be advised of their rights and notices displayed in all clinical areas. (See Appendix 3)

6.0 Offering a Chaperone

6.1 All patients should routinely be offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted in order to ask if the patient wants a third party present. The offer of a chaperone should be made clear to the patient prior to any procedure.

The organisation advises that use of a chaperone is considered particularly:

- During gynaecological/intimate examinations or procedures.
- When examining the upper torso of a female patient.
- For patients with a history of difficult or unpredictable behaviour.

- For unaccompanied children.
- For adults who lack mental capacity to consent to the procedure. For further information refer to the Mental Capacity Act 2005 Codes of Practice and Trust MCA policy.
- For patients who have a history of being abused
- For patients who may have a history of making allegations

6.2 If the patient requests a chaperone when attending a clinic, and there is no one immediately available, they should be offered the choice of waiting until a chaperone can be found, or rebooking for another day when arrangements for a chaperone can be put in place.

6.3 Where an intimate examination needs to be carried out in a situation which is life threatening, or where speed is essential in the care of the patient, this may be done without a chaperone. It should, however be recorded in the patients record. Consideration must be given to a less restrictive approach in line with the Deprivation of Liberty Safeguards or to an alternative procedure that is less invasive.

7.0 Communications and Record Keeping

7.1 Poor communication between a health professional and a patient is often the root of complaints and incidents. It is therefore essential that an explanation is given to the patient on the nature of any intimate examination i.e. what examination is proposed and the reasons why it is necessary. This will enable the patient to raise any concerns or objections and give informed consent to continue with the examination. Information should be given in a format and language that is accessible and appropriate to support the patient to make the decision

7.2 Details of the examination, including the presence or absence of a chaperone (name to be recorded if present) must be documented in the patient's record. The notes should also record if a chaperone has been offered, but declined by the patient.

7.3 Risk assessments should be completed, reviewed and updated where appropriate to reflect any risks identified, either for the patient undergoing the procedure or for the staff in carrying out the procedure.

8.0 Children

8.1 A chaperone would normally be a parent or carer, or someone trusted and chosen by the child. However, good practice would indicate a staff member should act as chaperone in all settings, where intimate or complicated examinations are being undertaken, as parents do not always have an understanding of procedures. The age of consent is 16 years, but for a minor who is assessed as competent to make the decision, the guidance relating to adults applies.

8.2 In situations where Child Protection issues are a concern, health professionals should refer to Local Safeguarding Children's procedures.

8.3 Wherever possible a chaperone should be available, however, if one cannot be provided a careful explanation of procedures carried out should be given to the parents, and documented.

9.0 Consent

Consent is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must:

- Be assessed as having the mental capacity to take the particular decision
- Have received sufficient information to make it; and
- Not be acting under duress

Valid consent must be obtained relevant to the procedure being undertaken. The health professionals carrying out the procedure is ultimately responsible for ensuring that the patient is making a capacitous decision to consent to what is being done.

For children under the legal age of consent (16years), they and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and consent. There is a legal requirement to obtain consent from their legal guardian. However, in light of the Children Order (1995) and the Frazer principle, regard must be given to the 'ascertainable' wishes and feelings of the child concerned considered in light of their age and understanding.

For patients with learning difficulties or mental illness a familiar individual such as a family member or carer may be the best chaperone. A careful and sensitive explanation of the technique is vital. Adult patients with a learning difficulties or mental illness who cannot give consent or consequently resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned, and the principles of MCA (2005) applied

When a patient attends a clinic, surgery or allows a health professional into their home, it can be implied that consent to the recommended treatment by the health professional is given. However, informed consent should always be obtained by word or gesture before any examination takes place.

Where more explicit consent is required prior to intimate examinations or procedures, such as an individual who is a minor or has special educational needs, staff should refer to the Consent Policy.

In the case of any victim of an alleged sexual attack, valid written consent must be obtained for the examination and collection of forensic evidence. Any forensic evidence or examination must only be carried out once the police have confirmed actions to be taken – it should be considered if this evidence is required should the patient be transferred to a more suitable facility such as Jupiter House. In situations where abuse is suspected, great care and sensitivity must be used to allay fears of repeat abuse – this disclosure must be shared appropriately in line with the LPT Safeguarding Policy and discussed with the relevant agencies such as Police, Social Care and the relevant Safeguarding Team.

Consideration must be given to patients that may have been previously subjected to abuse that additional measures may be required to support the individual for any intimate procedures.

10.0 Adults who lack capacity to consent to the procedure

Capacity is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed treatment/intervention unless it is shown that they cannot understand information presented in a clearway.

It is essential that the principles from the MCA 2005 are applied:

1. Assume Capacity - It must be assumed that a person has capacity until this is proved otherwise. It is necessary to demonstrate 'on the balance of probabilities' that a person lacks capacity to make the decision in question. A lack of capacity for one decision does not mean that a person lacks capacity to make other decisions that affect them.
   Assumptions cannot be made based on a person's age, appearance, illness or condition (mental health, dementia, learning disability etc)

2. All practicable steps must be taken to support the involvement of the individual in the decision-making process. All information relevant to the decision must be presented in a way that the person can understand. This may include the use of different means of communication or the provision of information in an accessible format.

3. Individuals have the right to make decisions that others may consider to be unwise or eccentric as this does not indicate that the person lacks capacity. Having the right to take risks is an individual choice. However, a pattern of unwise decisions might prompt staff to consider whether a Capacity Assessment is appropriate.

4. Decisions that are made on behalf of someone lacking capacity must be made in their best interests. The Act defines what is meant by 'best interests' and the Code provides a "Best Interests Checklist" which needs to be referred to when making these decisions.

5. When making a best interest decision on behalf of a person who lacks capacity, the decision maker must seek the option that is least restrictive of their rights and freedoms. However, in some instances the chosen option may not necessarily be the least restrictive one, if a more restrictive option is considered to be in their best interests. When a patient lacks capacity to this particular decision the person carrying out the procedure becomes the decision maker and is responsible for making a best interest decision in accordance with the Mental Capacity Act (2005).

10.1 A familiar individual such as a family member, friend or carer may be considered to act as an informal chaperone.

10.2 A careful, simple and sensitive explanation of the technique for the examination/procedure is vital.

10.3 Any resistance to an intimate examination by an adult who is assessed as lacking capacity to consent to this procedure should be interpreted as a refusal to give consent. In such circumstances the procedure must be abandoned.

10.4 Decisions that are made on behalf of someone assessed as lacking capacity to consent to the procedure must be made in their best interests. The Act defines what is meant by 'best interests' and the Code provides a "Best Interests Checklist" which needs to be referred to when making these decisions.

11.0 Religion, Ethnicity or Culture

11.1 http://www.leicspart.nhs.uk/Library/NHSStaffMultifaithResourceFINALhyperlinked.pdf

11.2 Health professionals should seek to reassure patients, and limit the degree of nudity and uncover only the part of the anatomy that is to be examined.

11.3 Language barriers may also be an issue if the healthcare professional is unsure of the patient's understanding. An interpreter, if available, could act as an informal chaperone. Interpreter services for the Trust are provided by Ujala. Phone: 0116 295 4747 Email: requestsujala@leicspart.nhs.uk.

11.4 In every case the health professional should be able to demonstrate, if challenged, that they have taken all reasonable steps to protect themselves and the patient from allegations of improper behaviour.

11.5 There may be some cases where the health professional (usually male) feels unhappy to proceed without a chaperone. This may be where a male doctor or nurse is carrying out an intimate examination, such as cervical smear or breast examination. In these situations it may be possible to arrange for the patient to see another health professional.

11.6 Similarly, male nurses are sometimes required to perform intimate tasks on female patients, such as bathing or catheterisation. The patient's consent should be sought prior to the procedure and a female nurse sought if the patient objects to a male nurse carrying out the procedure.

12.0 Where a Chaperone is requested but not available

12.1 If the patient is attending an outpatient appointment and has requested a chaperone but none is available at that time, the patient must be given the opportunity to reschedule their appointment.

12.2 If the seriousness of the condition means that a delay is inappropriate then this should be explained to the patient and recorded in their notes. A decision to continue or otherwise should be jointly reached. A less restrictive option needs to be considered and recorded

12.3 It is acceptable for a health professional to perform an intimate examination without a chaperone if the situation is life threatening or speed is essential in the care or treatment of the patient. This should be recorded in the patients' records.

13.0 A Patient's first intimate Examination

The conduct of a first intimate examination or procedure may influence a patient's confidence for future examinations and procedures and will require particular sensitivity from the examining doctor, chaperone and anyone else involved.

14.0 Anaesthetised or Sedated Patient's

Consent to intimate examinations must be sought before the patient is anaesthetised or sedated, except where this is implicit in the procedure to be undertaken. The Trust's Consent Policy must be followed including the use of the appropriate Consent Form.

15.0 Lone Working

15.1 Healthcare professionals are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present. Risk assessments must be completed and should include risks to patients and risks to staff.

15.2 Where a healthcare professional is working in a situation away from other colleagues e.g. home visit, the same principles for offering and use of chaperones should apply.

15.3 Where it is appropriate family members/friends may take on the role of informal chaperone. In cases where a formal chaperone would be appropriate, i.e. intimate examinations, the healthcare professional should reschedule the examination to a more appropriate location such as a health care setting.

15.4 Where this is not an option, for example due to the urgency of the situation, or because the practitioner is community based, then good communication and record keeping is paramount.

16.0 During the Examination or Procedure

16.1 Facilities should be available for patients to undress in a private undisturbed area. There should be no undue delay prior to examination once the patient has removed any clothing.

16.2 During an intimate examination the patient should be offered a gown or some sort of cover for themselves.

- Offer reassurance
- Be courteous
- Keep discussion relevant
- Avoid unnecessary personal comments
- Encourage questions and discussion
- Remain alert to verbal and non-verbal indications of distress

16.3 Intimate examination should take place in a closed room or well-screened area that cannot be entered while the examination is in progress. Examination should not be interrupted by phone calls or messages.

16.4 If possible a choice of position should be offered for speculum and bimanual examinations. This may reduce the sense of vulnerability and powerlessness complained of by some patients.

16.5 Any requests that the examination be discontinued should be respected.

17.0 Student Health/Medical Professionals acting as Chaperones

Consideration must be given to how student / trainee health professionals carry out intimate procedures and observation of practice as this has to be acknowledged that this is a requirement as part of their training:

- The patient should be informed that a student will be present for the examination and consent should be obtained.
- The procedure must be carried out in an appropriate structured, supervised and consented way
- No more than one student should be present for an intimate examination
- The chaperone on these occasions should always be a member of staff
- Date, time, location of the examination, names of the students, the supervisory chaperone and the consent obtained should be recorded in the patients' records.

18.0 Training for Chaperones

18.1 All members of staff who undertake a formal chaperone role must have read this policy and developed the competencies required for this role. These include an understanding of:

- Equality and diversity issues when chaperoning
- What is meant by the term chaperone
- What is an "intimate examination"
- Why chaperones need to be present
- The rights of the patient
- Their role and responsibility
- Guidelines and mechanism for raising concerns
- Guidelines for safeguarding concerns capacity and consent.

18.2 Induction of new clinical staff should include training on the appropriate conduct of intimate examination. Trainees should be observed and given feedback on their technique and communication skills in this aspect of care.

19.0 Duties within the Organisation

19.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

19.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

19.3 Divisional Directors and Heads of Service are responsible for ensuring implementation of this policy and the relevance to everyday practice in safeguarding the patient and the clinician.

19.4 Managers and Team Leaders are responsible for:

It is the responsibility of the Line Manager to ensure chaperones are available, and be aware of this policy and the types of individuals who can be identified as suitable chaperones.

The Line Manager also has a responsibility to ensure accurate records are kept of the clinical contact, which also include records regarding the acceptance or refusal of a chaperone. They also have responsibility for informing the senior manager if no suitable chaperone is available.

19.5 Responsibility of Staff

It is the responsibility of the health care professional to ensure that patients are offered a chaperone whether in an outpatient or inpatient setting. Where a chaperone cannot be provided an incident form should be completed and the line manager informed. Consideration must be given for the procedure to be delayed or postponed.

It is the responsibility of the health care professional to ensure that any concerns they have regarding the examination or procedure are reported immediately to their line manager or senior manager

It is the responsibility of the health care professional to ensure that accurate records are kept of the clinical contact, which also include records regarding the acceptance or refusal of a chaperone

It is the responsibility of the health care professional to access any information provided on being a chaperone.

It is the responsibility of the health care professional to ensure that any concerns, risks or other considerations for the safety of the patient or of health care professionals are detailed in the risk assessment, which should be regularly reviewed and updated.

20.0 Training needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

Training will be relevant competency based assessments of individuals identified as needing to act as a Chaperone. Training and assessment will be provided by lead clinician or health care professional requesting a Chaperone.

A record of the event will be recorded on locally held records

The governance group responsible for monitoring the training is PCEG

21.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for self-assessment	Process for monitoring	Responsible Individual/group	Frequency of Monitoring
1	To ensure privacy, dignity are respected during intimate examinations	Patients consent to procedures	Any complaints linked to chaperones	PCEG	Annually
	Monitoring of Complaints linked to Chaperones	Number of complaints	Any complaints linked to Chaperones to be raised at PCEG and monitored.	PCEG	Annually
	All clinicians to be aware of policy	Staff authorise document receipt signed and completed in each area.	Spot checks that sheets are completed	Members of PCEG	Annually

22.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Dignity and Respect	All patients are treated with dignity and respect
Consent	Patients consent to undergo procedures. If capacity to consent is in doubt, Mental Capacity Act (MCA) guidance is followed.
Safeguarding from abuse	Staff adhere to policy
Staff	Staff are aware of the policy and understand the role of a chaperone

References & Bibliography

Committee of inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale. (Department of Health September 2004).

Committee of inquiry to investigate how the NHS handled allegations about the conduct of Clifford Ayling. (Department of Health July 2004).

Chaperoning: the role of the Nurse and the rights of patients (RCN, July 2002) Guidance on the Role and Effective Use of Chaperones in Primary and Care settings
(DOH Clinical Governance Support Team, June 2005) No 3, 4, 5, and 6

GMC (2006) Maintaining Boundaries www.gmc-uk.org

DOH (2005) Mental Capacity Act, London DOH

www.dh.gov.uk/PublicationsAndStatistics/ChiefExecutiveBulletin or
www.cgsupport.nhs.uk/PrimaryCare/Resources.asp#chaperoneframework

Intimate Examinations – General Medical Council, December 2001 www.gmc-uk.org/standards/intimate.htm

Offering Chaperones – Medical Defence Union, November 2004 www.the-mdu.com/gp/advice

Intimate Examinations: Report of a Working Party – Royal College of Obstetricians and Gynaecologists, September 1997

Gynaecological examinations: Guidelines for Specialist Practice – Royal College of Obstetricians and Gynaecologists, July 2002.

Appendix 1

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay.
The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	x☐
Respond to different needs of different sectors of the population	x☐
Work continuously to improve quality services and to minimise errors	x☐
Support and value its staff	x☐
Work together with others to ensure a seamless service for patients	x☐
Help keep people healthy and work to reduce health inequalities	x☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	x☐

Leicestershire Partnership NHS
NHS Trust

Policy Training Requirements

The purpose of this template is to provide assurance that any training implications have been considered Training topic:	Non-specified
Type of training:	☐ Mandatory (must be on mandatory training register) ☐x Role specific ☐ Personal development
Division(s) to which the training is applicable:	☐x Adult Learning Disability Services ☐x Adult Mental Health Services ☐x Community Health Services ☐x Enabling Services ☐x Families Young People Children ☐ Hosted Services
Staff groups who require the training:	All relevant clinical staff
Update requirement:	No
Who is responsible for delivery of this training?	Senior clinicians within Teams
Have resources been identified?	Competency based assessment
Has a training plan been agreed?	Competency based assessment
Where will completion of this training be recorded?	☐ Trust learning management system ☐x Other (please specify) On site recording of competency assessment
How is this training going to be monitored?	Through PDP and site based record of assessment

Appendix 3 – Patient Notification

Chaperone Policy

Do you need someone to be with you during your examination?

All patients are entitled to have a chaperone present for any consultation, examination or procedure if you would like one. The chaperone may be a family member, carer, friend or a nurse or other trained member of staff.

Your healthcare professional may also require a chaperone to be present for certain consultations in accordance with our chaperone policy.

If you would like to see a copy of our Chaperone Policy or have any questions or comments regarding this please contact the Manager.

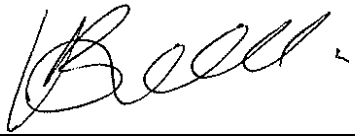
The information on this poster is available in other formats by telephoning 0116 295 4747

Appendix 4: Due Regard Screening Template

Section 1	
Name of activity/proposal	Review of Chaperone policy
Date Screening commenced	26th September 2016
Directorate / Service carrying out the assessment	FYPC
Name and role of person undertaking this Due Regard (Equality Analysis)	Debbie Whight
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To review the Chaperone Policy	
OBJECTIVES: To provide an updated Policy	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	NA
Disability	NA
Gender reassignment	NA
Marriage & Civil Partnership	NA
Pregnancy & Maternity	NA
Race	NA
Religion and Belief	NA
Sex	NA
Sexual Orientation	NA
Other equality groups?	NA

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No x	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Policy is being reviewed and updated, therefore is not new material			
Signed by reviewer/assessor	Debbie Whight	**Date**	26.9.16
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	2.11.2016

Appendix 5: Stakeholders and Consultation

Key individuals involved in reviewing the document

Name	Designation
Jane Martin	Senior Matron LD
Elizabeth Compton	Senior Matron AMH
Debbie Whight	Deputy Lead Nurse FYPC (Secondment)
Kathy Feltham	Lead Nurse MHSOP

Circulated to the following individuals for comment

Name	Designation
Vicky McDonnell	Trust Lead for Risk & Patient Safety
Victoria Peach	Head of Professional Education & Practice
Zoe Gilbert	Senior Matron Prison Health
Sharon Hames	Specialist Nurse Safeguarding Adults
Bal Johal	Deputy Chief Nurse
Adrian Childs	Chief Nurse
Deanne Rennie	Allied health Professionals Lead FYPC
Helen Burchnall	Clinical Director FYPC
Michelle Churchard	Head of Nursing AMH/LD
Susan Corr	Head of Rsearch & Development
Jude Smith	Head of Nursing
Victoria Spencer	Clinical Governance lead FYPC
Richard Apps	Head of Assurance & performance
Fern Barrell	Risk Manager
Jacqueline Burden	Clinical Governance Lead
Heather Darlow	Governance Lead CHS
Avinash Hiremath	Consultant Psychiatrist
Nicola Hurton	NICE & Effectiveness Officer
Sam Kirkland	Head of Information Governance
Satheesh Kumar	Medical Director
Girish Kunigri	Consultant Psychiatrist
Carl Lomas	Quality and Data Analyst
Jacqueline Moxon	Senior Project Manager
Saquib Muhammed	Consultant Psychiatrist
Fabida Noushad	Consultant Psychiatrist
Zeibun Patel	Lead Pharmacist
Claire Rashid	Clinical Effectiveness Lead
Anita Patel	Project Officer, Professional Practice
Lynne Birchall	Patient Experience and Improvement Lead (Chair)
Becky Millward	CQUIN, Quality & Patient Experience Coordinator
Sara Lowe	CHS Patient Experience and Learning Manager
Jenny Dolphin	Clinical Governance Manager, AMH