University Hospitals of Leicester NHS
NHS Trust

Chaperone UHL Policy

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V3 – review of V2 from September 2019 changes made are:

Removed statement 1 b) from appendix 1, removed legal liability statement –no longer required

Added 'Please also refer to the relevant UHL Safeguarding Children's Guidelines on Consent, Parenteral Consent, and Sexual Abuse available in PAGL'
Corrected nursing terminology

V4- review of V3 June 2024, changes made are:
This policy has undergone a full review with the addition of changes including a statement to the Introduction. Key objectives of policy added to Purpose of Policy instead of Introduction.
Added- National recommendations, to Policy Scope. Added- information on different levels of chaperone and consent information to Definitions. Additionally 'Gillick' competency and 'Fraser' guidelines added. Paragraph on Consent, Mental capacity and Midwives added to Section 6. Removed 'Role of the chaperone' and 'who can act as a chaperone' as incorporated in the definitions section 4.

KEY WORDS

Chaperone
Intimate examinations

1 INTRODUCTION

1.1 This policy provides guidance for University Hospitals of Leicester NHS Trust (UHL) staff working within all Trust settings on the use of chaperones.

UHL is committed to ensuring high standards of privacy and dignity for all its patients and their safety and welfare is of paramount importance. This policy upholds these commitments by providing guidance for staff on the use of chaperones in relation to all healthcare interventions. The Trust expects the highest standards of personal conduct and integrity from staff in order to maintain the confidence of patients, their families and carers.

This policy recognises that all healthcare interventions can be potentially distressing for a patient and that they may prefer to have a chaperone present in order to support them. It is good practice to offer all patients a chaperone for any healthcare intervention, or where the patient feels that one is required, however for most patients, respect, explanation consent and privacy take precedence over the need for a chaperone.

2 PURPOSE OF POLICY

2.1 The purpose of this policy provides UHL staff, and in particular healthcare professionals (HCPs), with effective guidance on the use of chaperones within all Trust clinical settings and for all types of healthcare interventions. The policy applies to all UHL employees who consult, examine, treat or provide care to patients.

The policy's key objectives are to:

a) provide protection and reassurance for patients and minimise the potential for a poor experience of care;
b) safeguard staff and patients in respect of any possible misinterpretation of actions taken as part of consultation, examination, treatment or care;
c) provide practical advice to Trust HCPs working in a variety of locations on the appropriate use of chaperones which facilitates good practice;
d) provide advice on what to do where the availability of a chaperone may not always be possible;
e) provide clarification around definitions and terminology relating to chaperoning;
f) ensure that all employees are clear as to the standards of behaviour expected of them in their dealings with patients and service users;
g) ensure openness and transparency for all patients, safeguarding their rights to make informed choices about being supported by a chaperone if required, and to be treated with dignity and respect at all times.

3 POLICY SCOPE

3.1 A number of inquiry reports have led to recommendations about the use of chaperones in health care settings. The role and use of chaperones in the NHS was examined in particular as part of Committee of Inquiry Investigation report into the conduct of Dr Clifford Ayling, (Pauffley, 2004) and recommendations were made as follows:

3.2 Each Trust should have its own chaperone policy and this should be made explicit to patients and resourced accordingly;

3.3 An identified managerial lead

3.4 The presence of a chaperone during clinical examination or treatment must be the clearly expressed choice of a patient and the patient has the right to decline any chaperone when offered;

3.5 Chaperones must receive appropriate training;

3.6 A family member or friend should not undertake a formal chaperone role.

3.7 Chaperone policies within NHS organisations have been further shaped by the independent investigation into governance arrangements within the paediatric and oncology service of Cambridge University Hospitals NHS Foundation Trust (Scott-Moncrieff & Morris, 2015). This inquiry was held following the conviction and imprisonment of Myles Bradbury for sexual offences against children in his care.

3.8 The findings of the Myles Bradbury investigation showed that, despite the provision of a chaperone policy, his manipulative and grooming behaviours and breaching of professional boundaries had gone unnoticed by families and professionals. The Myles Bradbury inquiry report found that some recommendations from the Ayling inquiry in respect of chaperones were either not implemented or enforced, were not applicable to children or were so restrictive that breaches were commonplace.

3.9 The learning from the Myles Bradbury inquiry includes that:

3.10 Chaperone policies should be workable in all situations – a policy that is too restrictive will inevitably lead to breaches;

3.11 The policy must mention special provision for children;

3.12 A chaperone policy should offer guidance on maintaining professional boundaries with patients and families whilst at the same time fostering a relationship of trust and rapport;

3.13 The organisation must consider how best to enforce the policy;

3.14 The policy should be explicit to patients and their families;

3.15 The organisation should consider appointing an accredited managerial lead with responsibility for implementing the policy if not already in post.

3.16 All examinations, investigations and procedures are potentially distressing for patients and the presence of a chaperone must always be offered. In particular any consultations or procedures involving the need to undress, the use of dimmed light or intimate examinations involving the breasts, genitalia or rectum may make the patient feel particularly vulnerable.

3.17 Royal College of Nursing Guidance (RCN 2002) states that all patients should have the right, if they wish, to have a chaperone present during an examination or procedure, treatment or care irrespective of organisational constraints or settings in which they are carried out.

3.18 The General Medical Council (GMC) 2013, paragraph 8 recommends that whenever possible medical practitioners should offer the patient the security of having an impartial observer (a "chaperone") present during an intimate examination even if you are the same gender as the patient.

4 DEFINITIONS

4.1 Chaperone – There is no common definition of what a chaperone is; the role varies according to the needs of the patient, the HCP, and the examination or procedure being carried out.

The HCP must routinely offer a chaperone for any consultation or intervention, but the patient retains the right to decline and the choice of the individual must be respected.
It is mandatory that a staff (formal) chaperone is available for all intimate examinations. Where a friend, relative or carer wishes to be present during a procedure, this should be permitted with consent from the patient. The HCP is responsible for maintaining accurate documentation in respect of the offer of a chaperone or consent given by the patient to proceed without a chaperone.

4.2 Formal Chaperone - This will be an HCP who has undertaken appropriate chaperone training in accordance with this policy.

The formal chaperone plays an active part in the delivery of a healthcare intervention and will:

- be sensitive and respect the patient's dignity and confidentiality;
- reassure the patient if they show signs of distress or discomfort;
- be familiar with the practices involved in the consultation, procedure, intervention or examination being carried out;
- observe and stay for the whole examination;
- be able to identify any unusual or unacceptable behaviour on the part of the HCP;
- raise concerns immediately if they are worried in any way about the behaviour and actions of the health professional carrying out the consultation, procedure, intervention or examination;
- with regard to any concerns, the chaperone will complete an incident via the Trust's incident reporting system

4.3 Informal Chaperone – This is considered to be person who is familiar with the patient and can include family members, friends, a legal guardian, or someone known, trusted or chosen by the patient. An informal chaperone would not actively take part in any examination, procedure or investigation. Their role as person familiar to the patient, is to provide reassurance and emotional support. It is permissible for the informal chaperone to assist with practicalities, for example undressing or dressing the patient, but must not be used as a formal witness.

4.4 Intimate examinations – These are likely to include examinations of the breasts, genitalia and rectum but could also include any examination where it is necessary to touch or even be close to the patient. A patient's perceptions of what constitutes an intimate examination may differ from staff perceptions; sensitivity must always be shown in respect of the patient's prior life experiences, disability, age, social, ethnic and cultural perspectives.

4.5 Health care interventions - These can include consultations, examinations, investigations and clinical treatments and are not always of an intimate nature. Whenever a patient undergoes a healthcare intervention, staff must be sensitive to differing interpretations of what the patient think of as being intimate and act accordingly.

4.6 Added Consent - Consent is a patient's agreement for an HCP to provide care. Consent can be gained verbally non-verbally or in writing. An HCP must obtain always gain a patient's consent before they examine, treat or provide care.

For consent to be valid, the patient must:

- be competent to take the particular decision;

- have received sufficient information to fully inform their decision making
- not to be acting under duress.

The HCP carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done.

4.7 Communication – Poor communication between an HCP and a patient is often the root of complaints and incidents. The HCP must always greet the patient and introduce themselves by name and designation. It is essential that a clear explanation is always given to the patient about the nature of any procedure or examination, especially where an intimate examination is being proposed. The patient must be given an explanation, using communication methods appropriate to their need, of what is being proposed and why it is necessary. This enables the patient to raise any concerns or objections and give informed consent to continue with the examination.

4.8 Gillick competency and Fraser guidelines – Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a
child can consent to contraceptive or sexual health advice and treatment. There is no lower age limit for Gillick competence or Fraser guidelines to be applied; *however,* it would rarely be appropriate or safe for a child aged less than 13 years to consent to treatment without a parent's involvement.

In 1982, Victoria Gillick challenged Department of Health (DoH) guidance which enabled doctors to provide contraceptive advice and treatment to girls aged less than 16 years without their parents knowing. In 1983, the judgement from this case laid out criteria for whether a child under 16 has the capacity to provide consent to treatment; the so-called 'Gillick test'.

It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child is considered to be 'Gillick competent', consent is only valid for that particular treatment or intervention; each individual decision requires assessment of Gillick competence.

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985) and specifically relate to contraception and sexual health. The guidelines state that advice can be given provided the HCP is satisfied in the following criteria:

1. He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment.
2. He/she cannot be persuaded to tell his/her parents or to allow the HCP to tell them.
3. He/she is likely to begin or continue having sexual intercourse with or without contraceptive treatment.
4. His/her physical or mental health is likely to suffer unless he/she receives the advice or treatment.
5. The advice or treatment is in the young person's best interests.

Professionals working with children must always balance children's rights and wishes with their responsibility to keep children safe from harm. Underage sexual activity should always be seen as a possible indicator of child sexual exploitation (NSPCC)

5 ROLES AND RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive has overall accountability for ensuring that the Trust meets its obligations in respect of delivering care to our patients that is of a high quality with an emphasis on ensuring privacy, dignity and safety. The Chief Executive devolves the responsibility for monitoring and

compliance to the Chief Nurse and Medical Director.

5.2 Chief Nurse and Medical Director

The Chief Nurse and Medical Director are responsible for ensuring that Trust staff uphold the principles of chaperoning, and that appropriate policies and procedures are developed maintained and communicated throughout the organisation in co-ordination with other relevant organisations and stakeholders. The Medical Director and Chief Nurse are responsible for ensuring implementation of this policy across the Clinical Management Groups (CMG).

5.3 Clinical Management Group Heads of Nursing and Clinical Directors

CMG Heads of Nursing and Clinical Directors are responsible for ensuring that the requirements of this policy for the chaperoning of patients during examination are managed within their CMG and that staff are aware of, and implement, those requirements.

5.4 CMG Heads of Service and Matrons

The CMG Head of service and Matrons are responsible for ensuring that chaperoning principles are communicated and implemented within their areas of responsibility.

CMG Heads of Service and Matrons will take a leading role in the implementation of this policy and any associated training within their clinical areas. They will also take a leading role in the investigation of incidents arising from the chaperoning of patients.

5.5 Ward Leaders and Lead AHPs

It is the role of Ward Leaders and Lead AHPs to locally implement this policy. They should make provision for mechanisms to be in place to ensure that their staff have read and understood this policy, publicise the chaperone check list, and to ensure that strategies are in place to ensure that training is available to assist with the implementation of this policy. Any incidents relating to the chaperoning of patients must be reported via the Trust's incident reporting system.

5.6 Staff who request a chaperone

It is the responsibility of clinicians who examine patients or undertake intimate procedures to ensure that they seek the presence of a chaperone when undertaking the relevant examination or procedures. They are responsible for risk assessing the situation and seeking a chaperone if felt necessary. They are responsible for recording in the notes that a chaperone was present, their name and if offer of a chaperone was declined. It is their responsibility to ensure that if a chaperone is not available that an appointment is rescheduled for the patient.

5.7 Staff undertaking the procedure or acting as a chaperone

Staff who are undertaking examinations, investigations or clinical recording are accountable for their own actions. Staff who act as a chaperone are responsible for safeguarding the both the interests of the patient when undergoing an examination or the practitioner undertaking the examination. The chaperone is a witness to continuing consent for the procedure or examination being undertaken. The chaperone also acts as an advocate for the patient can re-iterate information given during the consultation. It is their responsibility to ensure that the patient remains comfortable and supported throughout the examination. Staff must be familiar with the contents of this policy and adhere to the guidance within. All staff should report any incidents relating to the chaperoning of patients via the Trust's incident reporting system. The member of staff's line manager and the manager of the ward or department must be informed of the incident.

6 POLICY STATEMENTS

6.1 When to use a chaperone

a) These principles apply irrespective of the gender of the practitioner or the patient. The use of a chaperone falls into two categories: where a chaperone is strongly recommended and where a chaperone should be offered to the patient.

b) A Chaperone must be considered for the following situations irrespective of the patient's ability to request a chaperone (e.g., they are unconscious, lack capacity, a child)

c) A Chaperone must be offered to the patient in the following situations:

i. All intimate examinations

ii. Whenever requested by the patient

iii. Whenever requested by the clinician/practitioner
d) A chaperone is strongly recommended in the following situations:

i. Difficult psychiatric interviews

ii. Where there may be a risk of the patient becoming violent or difficult to control

iii. Where a minor presents for examination in the absence of a parent or guardian (SeeAppendix1)

iv. During the care of a prisoner (prison officer may act as chaperone)

v. Patient intoxicated with alcohol, is under the effect of illicit substances or is unconscious

6.2 Consent

a) Consent is a patient's agreement for a health professional to provide care. Before HCPs examine, treat or care for any person they must obtain their valid consent.

There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand, retain, weigh up and communicate information in relation to the proposed medical intervention reliably.

b) Consideration must be made of the needs of patients who may not be able to consent to the examination (e.g., they lack capacity, are confused or unconscious) and that where possible consent is gained from next of kin / carer as per the UHL Consent Policy (Trust Reference B35/2024).

c) Key Considerations in Consent are:

i. Consent on behalf of a child (see also Appendix 1)

ii. Adult Patients who are unconscious

iii. Adult patients with capacity issues

iv. Adult patients with communication difficulties

d) When patients do not have the ability to consent for themselves, HCPs must undertake an assessment of mental capacity and make the decision in the patient's best interests in line with the Mental Capacity Act 2005

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and Trust Policies. This must be clearly documented in the patient's notes.

e) For any procedure where consent is required prior to intimate examinations or procedures, staff should refer to the UHL Consent Policy (Trust Reference B35/2024).
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. In situations where abuse is suspected, great care and sensitivity must be used to allay fears of repeat abuse. In such cases, HCPs must refer to the Safeguarding Adults Policy and Procedures (Trust Reference Number B26/2011)
Safeguarding Children Policy (Trust Reference Number B1/2012) and/or seek advice from the Trust Safeguarding team.

6.3 Issues Specific to Religion, Ethnicity or Culture

HCPs must always be sensitive to cultural differences and treat every patient in a way that respects their views and wishes and preserves their dignity. Cultural differences can affect people's perceptions of what is intimate or appropriate. The ethnic, religious and cultural background of patients may also have particular significance to intimate examinations. For example, some patients may have strong cultural or religious beliefs that restrict being touched by others. Wherever possible, particularly in these circumstances, a same sex healthcare practitioner should perform the procedure. It would be unwise to proceed with any examination if the HCP is unsure that the patient understands due to a communication barrier. If an interpreter is available, they may be able to double as an informal chaperone, but it should be noted that this individual will most likely not be trained as a formal chaperone. HCPs should assess in each circumstance if this would be appropriate. In an urgent or acute situation, every effort should be made to communicate with the patient effectively; the HCP will need to use their professional judgement to consider whether it is in the patient's best interests, before proceeding with the examination.

6.4 Issues Specific to Learning Disabilities/Mental Health

Patients with a specific learning disability or mental health problem who resist any intimate examination or procedure may need more time to process the information or may need reasonable adjustments. If they resist, abandon the procedure or examination and seek advice from members of the relevant specialist teams. In an urgent or acute situation, the HCP must use professional judgment, assess the individual's capacity and if required follow the Principles of the Best Interest.

All decisions and discussions must be clearly documented in the clinical records as per the Trust Patient Health Records - Documenting UHL Policy (B30/2006).
The level of understanding of the person should be clarified and consent obtained, or best interest decision made regarding examination as per the Trust and National guidance.

A careful, simple and sensitive explanation of the technique is vital in these circumstances. These patient groups are more at risk of vulnerability and as such, will experience heightened levels of anxiety, distress and misinterpretation.

Patients who resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. In an urgent or acute situation, the HCP must use professional judgment and where possible must discuss and seek advice from members of the relevant specialist teams.

6.5 Where a Chaperone is needed but not available or declined

a) All patients must routinely be offered a chaperone prior to any consultation or procedure. It is not always clear ahead of a healthcare interaction that a chaperone may be required. If this becomes apparent, or where a patient requests a chaperone and none is immediately available, the patient must be offered the choice of:

- waiting until a chaperone is available;
- re-scheduling the appointment for another day (and within a reasonable timeframe) so that arrangements for a chaperone can be put in place.

b) If the seriousness of the situation would dictate that a delay is inappropriate, then this must be explained to the patient and recorded in the clinical record. A decision to continue or otherwise must be reached jointly.

Whilst it is accepted that the presence of a chaperone must be the clearly expressed wish of the patient or that the patient must have the right to decline any chaperone offered, this will not apply in the case of younger patients.

c) Older aged children, those in transition and young adults may be seen without their parents or carers at their request; however in these circumstances these young people must be examined in the presence of an alternative chaperone. If children and young people specifically request a review without an informal or formal chaperone, this must be fully discussed and documented in detail within the clinical records.

d) In the event of the parent, carer, friend or someone already known and trusted by the child or young person, being seen to not have the capacity to undertake the role of informal chaperone, then the patient should be supported by an additional HCP.

e) If a patient refuses to have a staff chaperone where the situation warrants one, this must be documented in their notes along with the reason for their refusal. The patient should be informed of the consequences or possible alternatives as well as the effects on, or delays to, treatment or diagnosis.

f) If an examination is to take place without a formal chaperone this must be discussed with a fellow HCP and the reason for carrying out the examination without a chaperone clearly documented in the clinical record. The documentation should include the details of the HCP with whom the discussion took place with.

6.6 Mental Capacity

a) There is a legal presumption that every adult has the capacity to decide whether to consent to or refuse a proposed medical intervention, before proceeding with an examination it is vital that the patient's valid consent is gained. This means that the patient must:

- have capacity to make the decision;
- have received sufficient information and;
- not be acting under duress.

Staff should refer to the Mental Capacity Act Policy (Trust Reference Number B23/2007) and guidance in all situations relating to any adult who does not have capacity. If in doubt contact the safeguarding team for advice.

6.7 Lone Working

a) The principles of offering and using a chaperone apply to 'lone working' (home visits, out of hours care, etc.) situations.

b) The decision on who can act as chaperone rests with the clinician providing the care. They may consider it appropriate for limited support (provide emotional comfort and support to the patient) to be provided by family members / friends. The presence of family members / friends must be

documented in the case notes.

c) Where there are no alternatives and in a lone working situation it is acceptable for family members / friends to provide emotional comfort and support but should not be expected to act as a formal chaperone.

d) If a chaperone would usually be offered, e.g., for intimate examination, consider rescheduling the examination at a more convenient location. The patient may also decline the presence of a chaperone. All discussions and decisions must be documented in the case notes.

e) In emergency / urgent situations it may not be possible or appropriate to reschedule the examination. This is acceptable but must be carefully discussed with the patient and documented in the case notes.

6.8 Midwives

a) The Policy recognises that the "relationship between the Midwife and the mother is unique and that providing verbal consent has been undertaken and documented, then the use of a chaperone is not always appropriate". Midwives should, when chaperoning patients, practice within their Code of Practice.

b) Consent should be obtained and documented for all "intimate examinations", on pregnant and post-partum women. In gaining consent there should be an acknowledgement of the intimate nature of the procedure and the potential for women to request a formal chaperone. In most cases an informal chaperone, usually their partner, is present. Equally some women may not want their partner to be present for such an examination and this request should be respected.

6.9 During examination/procedure

a) There should be adequate facilities provided to enable the patient to get undressed in private, and suitable coverings should be available to protect the patient's dignity. Only the part of the patient's body that is being examined should be exposed and for the shortest time possible. Do not help the patient to remove clothing unless they have asked you to do so, or you have checked with them that they want you to help.

b) The examination or procedure should be performed in a closed room or a well screened area, with no interruptions for example phone calls or messages. Once the patient has undressed there should be no delay in commencing the examination or procedure.

c) During the examination or procedure, the staff chaperone should be able to offer reassurance, be always respectful of the patient's privacy and dignity and avoid any irrelevant discussion or personal comments.

d) The formal chaperone should always remain alert to verbal and non-verbal signs of distress from the patients.

e) Throughout the examination/procedure the HCP must always give clear information to the patient, explaining what they are going to do before they do it. If this differs from what the patient has been told beforehand, the HCP must explain why and seek the patient's permission.

f) The HCP must stop the examination/procedure if the patient requests this.

g) Surgical gloves must be worn for intimate examinations. The glove provides a physical barrier separate to hygiene / infection control purposes and helps to keep the examination on a clinical basis.

6.10 Communication and Record Keeping

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a) The purpose and nature of the examination should be clearly and sensitively explained in terms that the patient can understand, and patients should be given an opportunity to ask questions.

b) Record keeping specific to chaperoning must include:

- details of the examination or procedure and informed consent;
- the offer of a formal chaperone and whether accepted or declined;
- reason for refusal of any chaperone;
- the presence or absence of a formal chaperone – this must include their details i.e., name, designation, contact details;
- the presence of an informal chaperone including name and relationship to the patient.

Where a Health Passport or similar patient-held record is available it is good practice to also make notes within these documents.

6.11 Notifying Concerns about Staff Conduct

a) Any patient / staff / relative / carer(s) with concerns following the episode of care must be documented in the case notes and addressed as soon as possible.

b) Information about the Trust's complaints process should also be made available.

c) An incident form must be completed.

7 EDUCATION AND TRAINING REQUIREMENTS

7.1 The chaperone should have knowledge and understanding of the following:

i. What is meant by the term chaperone
ii. What is an 'intimate examination'
iii. Why chaperones need to be present
iv. The rights of the patient
v. Their role and responsibility
vi. Policy and mechanism for raising concerns
vii. Communicating with children and young people(if applicable)

7.2 Registered health care professionals will have gained knowledge and skill in acting as a chaperone during their pre-registration training.

7.3 Non-Registered staff such as Health Care Assistants will have the role of chaperone included in their trust induction and this will be reinforced in local induction in their areas.

8 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Method	Frequency	Reporting arrangements
Episodes where an examination was re-scheduled due to a Chaperone not being available	Departmental managers	Datix	Monthly	Clinical Management Group (CMG) Q&S Board
Incidents/complaints where an accusation of inappropriate behaviour is made against a staff member	Individual staff	Datix or complaints	When arises	Line Manager to investigate. CMG Q&S Board to review themes / trends

9 EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

10.1 UHL Policies

Consent to Examination or Treatment UHL Policy (Trust Reference Number B35/2024)
Domestic Abuse and Violence - Adult Patients (Trust Reference Number B8/2015)
Lone Worker Policy (Trust Reference Number B27/2008)
Preventing and Managing Violence and Aggression in UHL Policy (Trust Reference Number B11/2005)
Mental Capacity Act Policy (Trust Reference Number B23/2007)
Safeguarding Adults Policy and Procedures (Trust Reference Number B26/2011)
Safeguarding Children Policy (Trust Reference Number B1/2012)
Patient Health Records - Documenting UHL Policy (B30/2006).
Policy for the Management of Complaints (Trust Reference Number B27/2024

10.2 References

Royal College of Nursing (2017) Protection of nurses working with children and young people (guidance for nursing staff) RCN London
Royal College of Nursing (2002) Chaperoning: The role of the nurse and the rights of patients (guidance for nursing staff). RCN. London.
DOH (2001b) Seeking consent: working with children Department of Health London
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Rights of the Child (1989) (20.Xi.1989; TS 44; Cm 1976)
RCPCH Child Protection Companion 2006
http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/ChildProtCompL.pdf
RCPCH Paediatrician's Handbook 2016
NMC 2015, The Code; Professional standards of practice and behaviour for nurses and midwives, London, NMC.
NSPCC, Gillick competency and Fraser guidelines,
Scott-Moncrieff, L & Morris, B. (2015), Independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case, London, Verita.
Skills for Care and Skills for Health (2013), Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England, www.skillsforcare.org & www.skillsforhealth.org

11 Process for Version Control, Document Archiving and Review

11.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.
11.2 This document will be reviewed every three years, or sooner in response to reported risks or incidences.

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Appendix 1:

Chaperones and children / young people

University Hospitals of Leicester NHS
NHS Trust

Appendix 1

Please also refer to the relevant UHL Safeguarding Childrens Guidelines on Consent, Parenteral Consent, and Sexual Abuse available in PAGL

1. Role of the chaperone working with children and young people

a) Respect for privacy and dignity is a right for all children regardless of age, sex, ethnic background or culture. The intimate nature of many clinical interventions, if not practised in a sensitive and respectful manner, could lead to misinterpretation and occasionally to allegations of abuse. Guidance from the

b) To be present where a minor presents for examination in the absence of a parent or guardian.

2. Strategies for minimising risk when the contact with the child requires care of an intimate and personal nature.

a) Care of this kind should not be undertaken without training, or negotiation with and explanation to the child and the child's main carer.

b) Staff must be aware that actions with a particular child could be misinterpreted by that child or others

c) When touching children or spending time with them, staff must be aware of the accepted cultural and social norms for that child and family.

d) Staff need to be sensitive about inappropriate places, times and situations for touching. In a multicultural society, what is considered normal behaviour differs from individual to individual and between different communities.

e) Some children are likely to prefer either a male or female carer. This usually reflects social, religious and cultural preferences, and should be respected wherever possible

f) Care should be negotiated between staff, parent/carer and child. Assessment is the key to ensuring effective care. Usual practices for intimate, personal care should be established and form the basis for any care provided.

g) Self-care should be promoted where possible involving the child's main carer.

h) Staff should be responsive to the child's reactions. If the child appears uncomfortable, unusually shy or overtly precocious, this must be brought to the attention of other members of the clinical team and recorded.

i) The results of staff actions should be documented and concerns reported.

j) In cases of suspected child abuse, specifically sexual abuse, consideration should be given to the gender of the staff allocated to that child's care.

k) Staff should be aware of the potential for misinterpretation within the context of a wide range of intimate care procedures- including catheter care, administration of rectal medication or bathing. Where appropriate consent should be obtained from the child and/or parents or carers.

3. Consent issues relating to children or young people

a) When dealing with any intimate care procedures, the purpose and nature of the care should be clearly explained in terms and language that the child or young person can understand. Information must be given in such a way that is accurate, truthful and easily understood in accordance with their age and developmental needs.

b) It should be recognised that cognitive understanding changes and that children's understanding of and reaction to their health needs will change as they mature.

c)Strategies for obtaining informed consent need to be adapted for each child or young person and may involve the use of alternative communication methods such as play preparation.

d) If a child or young person under the age of 16 years has sufficient understanding to be able to make an informed decision about their treatment or care they can legally give consent. However, good practice is to involve and negotiate consent between child/young person and adult with parental responsibility.

4. Parental Responsibility

Unless parental responsibility has been taken away legally, the child's mother always has parental responsibility. If the child was born before December 2003 the father of the child has parental responsibility if he was married to the mother of the child at the time of the child's birth or he has applied for parental responsibility through the court. If the child was born after December 2003 the father has parental responsibility if he was present at the time the child's birth was registered.

5. Who should act as a chaperone for children and young people

It may not always be appropriate for parents or carers to act as a chaperone for children and young people, in these cases staff able to support the child should be used:

a) For children and young people undergoing examination for child protection, perineal and genito-urinary disorders.

b) For pubertal young people.

c) For those who are not accompanied by an adult with parental responsibility or where this person in ineffectual or unreliable.

6. Guidance from the Royal College of Paediatricians and Child Health states that:

The child should be examined in the presence of a suitable chaperone in order to safeguard the child, ensure the child is at ease, assist the doctor and to safeguard the doctor from any allegations of impropriety.

The child should be asked who they would like to be present at the examination to support them, for example their parent/carer. On some occasions it may not be appropriate for the parent or carer to be present for example if the parent/carer is the alleged perpetrator or parental distress will compromise the examination.

The chaperone should be present throughout the assessment and should be a trained, experienced member of staff who is familiar with the special aspects of these assessments, including the need for psychological support of the child and family, assistance with the examination and investigations and an understanding of confidentiality.

Paediatricians working in private practice should check that their workplace is registered and inspected under the Care Standards Act 2000 (9). It is also recommended that they avoid seeing patients at their home without good clinical reason, or in the practitioner's home, in isolated facilities or without a chaperone.

7. Guidance from GMC:

You should make it clear that you are available to see children and young people on their own if that is what they want. You should avoid giving the impression (whether directly, through reception staff or in any other way) that they cannot access services without a parent. You should think carefully about the effect the presence of a chaperone can have. Their presence can deter young people from being frank and from asking for help.

Appendix 2

Chaperone Policy

This organisation is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.
All patients are entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. You may wish to have a family member or friend present to provide support and comfort, but they do not fulfil the role of a chaperone.

Wherever possible we would ask you to make this request at the time of booking appointment so that arrangements can be made, and your appointment is not delayed in any way. Where this is not possible, we will endeavour to provide a formal chaperone at the time of request. However occasionally it may be necessary to reschedule your appointment.

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.

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