CHAPERONE POLICY

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

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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

The Isle of Wight NHS Trust 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.

Similarly, there is evidence that many patients are not concerned whether a chaperone is present or not. However, this should not detract from the fact that any patient of any gender is entitled to a chaperone if they feel one is required.

The relationship between a patient and a Healthcare Professional is based on trust. The Healthcare professional may not have any doubts about a patient they have known for a long time and feel it may not be necessary to offer a formal chaperone.

This policy is also for the protection of staff. The key principles of communication and record keeping will ensure that the Healthcare professional/patient relationship is maintained and will act as a safeguard against formal complaints, or in extreme cases, legal action against the Trust or the individual staff member.

This policy sets out the process to be followed in relation to the use of chaperones and procedures that should be in place for consultations, examinations, investigations and clinical interventions.

2 Introduction

The Trust recognises that clinical consultations, intimate examinations or procedures can have the potential to cause some patients distress and embarrassment. Health professionals must endeavour to ensure the patient's comfort, dignity and privacy.

The RCN (2002) states all patients should have the right, if they wish to have a chaperone present during an examination, procedure or treatment, and suggest, when the chaperone is a nurse or another member of the health team, they can act as advocate for the patient helping to explain what will happen during the examination and the reasons why. They can assess the patient's understanding of what they have been told and be a reassuring presence, safeguarding against any unnecessary discomfort, pain, humiliation or intimidation. The GMC (2014) provides *Good Medical Practice* guidance to support doctors in managing examinations and how the role of the chaperone can support the patient.

High profile local and national cases of alleged and/or proven inappropriate behaviour of health professionals towards patients highlighted the need to ensure clinical governance processes are in place for the benefit of patients and professionals.

This policy recognises the following principles:

- That 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, consultations, examinations or procedures may be threatening or confusing. A chaperone, particularly one trusted by the patient, may help the patient through the process with the minimum of distress.

- For most patient's respect, explanation, consent and privacy take precedence over the need for a chaperone.

- If there is no chaperone available or the patient refuses a chaperone the healthcare professional can delay/cancel the examination until such time as a chaperone can be located. This must be documented in the patient's record.

- 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.

- No family member or friend of a patient should be expected to undertake any formal chaperoning role in normal circumstances unless explicitly requested by the patient. Any instances of chaperoning by a relative should be recorded in the notes. Where an interpreter may be required to ensure a patient understands what is happening this will need to be planned carefully with the patient and information given via an interpreter prior to the clinical examination.

- A chaperone is not an interpreter. Where a patient requires an interpreter, be it sign language or foreign language interpreter an approved Trust interpreter must be used.

- The following type of examinations should always be considered for a chaperone; the patient must be offered a chaperone in these cases.

    - Breast examinations or procedures
    - Genitalia examinations or procedures
    - Rectal examinations or procedures
    - Internal examinations in women
    - Examinations requiring dimmed lights
    - Examinations where patients need to be undressed
    - Nursing and clinical care interventions e.g. insertion of urinary catheter

- The patient must at all times have the right to decline any chaperone offered. This must be documented in the patient's record.

- Chaperones are most often required or requested where a male examiner is carrying out an examination or procedure on a female patient. However, the Trust 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 patient.

- Reported breaches of the chaperoning policy should be formally investigated through the Trust's HR Processes and treated, if determined as deliberate, as a disciplinary and safeguarding matter.

3 Definitions

3.1 A Chaperone

Chaperone may refer to: Chaperone, a person who acts as a witness for a patient and a healthcare professional during a medical examination or procedure.

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. There is no clear definition of a chaperone since this role varies considerably depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out.

3.2 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 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 if deemed appropriate.

3.3 Formal Chaperone

This implies a health professional such as a registered nurse, or a specifically skilled non-registered staff member. Where appropriate they may assist in the procedure being carried out and/or hand instruments to the examiner during the procedure. Assistance may also include clinical interventions and support provided to the patient when attending to personal hygiene, toileting and undressing/dressing requirements.

3.4 Intimate examination

The term 'intimate examination' is recognised as subjective. It is used in this policy as a general term to describe examinations of the breasts, genitalia, rectum, and internal examinations. The term corresponds with literature to support nurses and doctors in understanding their requirements as professionals

4 Scope

Where all staff groups are relevant this will be referred to as the “healthcare professional”.

This policy applies to all healthcare professionals working within the Trust, including medical staff, nurses, midwives, healthcare assistants, allied health professionals, medical students, radiographers, ambulance staff when transferring patients to and from hospital and complementary therapists working with individual patients in clinic situations, wards, departments, and outpatient and in the patient’s home.

The policy applies to all clinicians directly employed on substantive or honorary contracts by the Trust and contractors whose contract specifies adherence to this policy.

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

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

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

- Equality and Diversity Policy
- Safeguarding Adults Local policy
- Safeguarding Children and Young People Policy
- Consent to Examination or Treatment Policy
- Lone Worker Policy
- Incident Management Policy
- Privacy and Dignity Policy
- Complaints, Compliments, Concerns and Comments Policy

5 Purpose

The purpose of this policy is:

- To ensure that patients’ safety, privacy and dignity is protected during intimate examinations or procedures and delivery of intimate clinical care interventions
- To minimise the risk of a Healthcare professional’s actions being misinterpreted
- To ensure the Healthcare professionals safety whilst carrying out intimate clinical examinations and interventions
- To uphold the Trust policies referenced in this policy and ensure policies are adhered to at all times

6 Roles and Responsibilities

6.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring effective clinical governance assurance within the Trust and therefore supports the Trust-wide implementation of this policy.

6.2 Executive Directors

Director of Nursing and Medical Director are responsible for endorsing the full implementation of this policy and its relevance to everyday practice within safeguarding, patient dignity, safety and delivery of quality care.

6.3 Line Manager

The Manager's role is to ensure implementation of this policy and that the staff understand how the Chaperone Policy applies to them and their patients. Managers are also responsible for ensuring that, where necessary, local processes are developed, and training given for planning staff rosters and skill mix to support the full implementation of this policy. Managers should review the effectiveness of the implementation and take appropriate remedial action when they become aware of any acts or omissions that contravene it.

6.4 Ambulance Crews/Paramedics

Ambulance crews and paramedics have the responsibility for ensuring chaperoning duties are completed within remit of the service as appropriate.

It is understood that the Ambulance Service will be limited in the implementation of chaperone duties however it is the responsibility of the attending crews to understand requirements and act in the best interests of the patient.

It is the responsibility of the crew to alert their supervisor to any concerns and to document any preferences or choices the patient has expressed.

6.5 Registered Nurses

Registered Nurses have the responsibility for ensuring chaperones are available within their respective areas, and that chaperones work within their scope of practice and are fully aware of this and associated policies. They also have 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. They have responsibility for ensuring all chaperones are aware of their responsibilities and the name of the chaperone is clearly documented with printed full name, date and time, concluded with a signature.

6.6 Students

6.6.1 Students can undertake the role of chaperone if the activity is deemed within their level of competence, commensurate with their stage of training and has a specific learning and development opportunity associated with the task. An assessment would be undertaken by their mentor / practice educator in discussion with the student to determine this. The student has the right to engage or refuse to

undertake the role as a chaperone in accordance with their code of professional conduct.

6.6.2 In line with best GMC guidance, medical students should only:

- Act as a chaperone for patients examined by the relevant clinical supervisor.
- Conduct non-intimate examinations on patients with their clinical partner present, or on their own during year 5 placements.

6.6.3 Medical students should not:

- Conduct intimate examinations on a patient without a clinically qualified chaperone being present (i.e. doctor or nurse).
- Act as chaperone to their clinical partner for intimate examinations.
- Conduct any intimate examination unsupervised even if the patient is happy for them to proceed with the examination.

6.7 Healthcare Professional undertaking medical examinations

It is the responsibility of the healthcare professional to:

- ensure that patients are offered a chaperone and for respecting the individual's choice to request or decline a chaperone, whether in an outpatient or inpatient setting.
- responsible for maintaining the accurate documentation including the take up of the offer of a chaperone, or consent given to proceed without a chaperone.
- responsible for escalation of concerns should these emerge during this process.

5.8 Chaperone

It is the responsibility of the chaperone to

- Act as a safeguard for all parties and be a witness to the continuing consent process
- Support the provision of privacy and dignity of the patient
- Keep chaperone duties confined to the physical examination part of the consultation or procedure unless the patient requests otherwise. Confidential clinician/patient communication should take place on a one to one basis after the examination/procedure unless the patient requests otherwise.
- To follow the usual safeguarding procedure should any concerns be identified e.g. unexplained bruising or possible domestic abuse concerns.
- To access information and training required to support their role as a chaperone which may include any of the following:

7 Policy detail/Course of Action

7.1 Process for using a chaperone

The Chaperone Policy staff checklist is at Appendix A to support decision making.

The clinician should establish that there is a genuine need for the examination and discuss this with the patient. Adequate information and explanation should be given to the patient prior to the examination

Consent must be obtained and recorded in the patients notes and the clinician must discontinue the examination at any time the patient requests this. This should be considered as a withdrawal of consent.

A chaperone can be requested by the patient at any time for any procedure and the attending clinician should comply with this request. It is best practice to offer a patient a chaperone for any intervention or procedure

Examinations where a formal chaperone must be available. This includes:

- Breast examinations or procedures
- Genitalia examinations or procedures
- Rectal examinations or procedures
- Internal examinations in women
- Examinations requiring dimmed lights
- Examinations where patients need to be undressed
- Nursing and clinical care interventions e.g. insertion of urinary catheter

Other situations where a formal chaperone should be considered

- Where a patient is semiconscious or unconscious.
- Where a patient is intoxicated with alcohol or who has taken drugs particularly those with a hallucinogenic affect
- Where English is not the patients first language. An interpreter should always be used for patients who do not speak English, to ensure they understand the procedure and are able to consent.
- For patients with a history of difficult or unpredictable behaviour, this may or may not be attributable to mental health illness.
- For vulnerable adults who lack capacity including those with a learning disability
- Where there is a history of abuse.
- For unaccompanied children.

If a patient declines a chaperone this must be documented in the patients notes. If a chaperone is declined the clinician cannot insist that one is present. If the clinician is unhappy to proceed then another clinician can be sought, and/or a patient specific solution sought.

Consideration should be given to the gender of the chaperone if the patient requests this.

The chaperone should be confident that they are able to perform the required duties.

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.

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 and being informed of the time this may take to locate one or rebooking for another day when arrangements for a chaperone can be put in place. A friend or relative should be used in preference to no chaperone at all.

Where a suitable formal chaperone cannot be provided, in any circumstance a Trust incident form should be completed outlining the reasons and action taken.

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 be recorded in the patient's medical/nursing notes documenting the reasons for this and full explanation provided as soon as possible after the procedure.

7.2 Consent

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

By attending a consultation implied consent is assumed because the patient is attending for treatment. The patient is still required to consent to the examination or procedure. Clear information should be provided in order for the patient to understand the examination and the rationale for it, and the patient consent to go ahead with the examination should be documented by the clinician in the patient's notes. This should be documented alongside the discussion about the need for a chaperone.

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 information presented in a clear way. Staff must refer to the relevant consent and mental capacity policies in relation to this.

When patients are not able to consent for themselves the healthcare professional should make the decision in the patients best interests in line with Trust Policies and this must be documented in the patient's notes. In this case a chaperone MUST be used.

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 Trusts Consent to Examination or Treatment Policy.

7.3 Application of chaperoning duties within the Ambulance service

The attending clinician may attempt to utilise appropriate chaperones on scene if this is required. This may be in the form of a relative, a Police officer or other professionally appropriate person and will take into consideration the age, gender and condition of the patient when deciding on the appropriateness.

The use of a chaperone, the availability of a chaperone and who that chaperone will be is to be discussed with the patient and consent obtained prior to any examination or treatment. If the patient does not have capacity the attending clinician will act in the best interests of the patient.

The Ambulance Service are required to maintain dignity of the patients at all times, however, it is recognised that professional judgement and rapid risk assessment is required in extreme emergency circumstances. Where professionals deem that a chaperone was required but not available, or privacy and dignity may have been breached, this should be documented and alerted to their supervisor.

There is CCTV available in the back of IW Ambulance Service front line vehicles. The CCTV only record when activated by the crew where they have recognised a need to do so, for their or the patient's safety and protection. This CCTV can be obtained and reviewed via the Trust Fleet Manager and should be reviewed in all cases where ambulance crew have reported a chaperone was not possible or privacy and dignity was breached.

7.4 Patients with Learning Disabilities, Mental Health problems or vulnerable adults

Staff must consider that in these patients, capacity may be affected, and careful consideration should be given to ensure the best outcome for the patient.

A familiar individual such as a family member or carer may be the best person to chaperone the patient and be able to act as an advocate as they understand the patient's behaviours responses and needs

Patients with a learning disability in need of a planned examination or procedure should be organised in conjunction with the Learning Disability Liaison Nurse. The Learning Disability Liaison Nurse will, in conjunction with the patient and carer advise on the best person to chaperone the patient.

Adult patients who resist any intimate examination or procedure must be considered as a refusal to consent and the procedure must not take place or be stopped.

7.5 Children and Young People

Parents will not be automatically used as chaperones for their children. A Registered Children's Nurse/Nursery Nurse should always be present.

In the event a child does not wish for the nurse to be present a parent can act as a chaperone for their child.

7.6 Mental Capacity

There is a basic assumption 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 informed consent is gained. This means that the patient must:

- Have capacity to make the decision.
- Have received sufficient information
- Not be acting under duress

Under the Mental Capacity Act 2005 any action taken must be in a patient's best interests and the least restrictive course of action.

Staff should refer to relevant Trust guidance and policy to support their decision making.

- Consent policy – on Trust policy intranet page
- Mental Capacity Act guidance – on Safeguarding Vulnerable Adults intranet page
- Deprivation of Liberty Standards (DoLS) guidance - on Safeguarding Vulnerable Adults intranet page

7.7 Lone Working

Where a healthcare professional is working in a situation away from other colleague's e.g. home visit, out-of-hours activity, the same principles for offering and use of chaperones should apply.

Where it is appropriate family members/friends may take on the role of informal chaperone only.

In cases where a formal chaperone would be appropriate, i.e. intimate examinations, the healthcare professional would be advised to reschedule the examination to a more convenient location. However, in cases where this is not an option, for example due to the urgency of the situation or because the health professional is community based, then procedures should be in place to ensure that communication and record keeping are treated as paramount

Healthcare professionals should note that they are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present

7.8 During the Examination / Procedure

Appropriate facilities should be made available for patients to undress in a private, undisturbed area in order to maintain their dignity and privacy.

There should be no undue delay prior to examination once the patient has removed any clothing. Delays due to any unforeseen circumstances must be communicated to the patient and appropriate use of blankets etc. to cover up.

Intimate examination should take place in a closed room or, in ward settings, in screened bays which must not be entered without consent while the examination is in progress. Examination should not be interrupted by phone calls or messages.

Where appropriate a choice of position for the examination should be offered for example left lateral, dorsal, recumbent and semi-recumbent positions for speculum and bimanual examinations. This may reduce the sense of vulnerability and powerlessness complained of by some patients.

Once the patient is dressed following an examination or investigation the findings should be communicated to the patient. The Healthcare professional must consider (asking the patient as necessary) if it is appropriate for the chaperone to remain at this stage.

Any requests by the patient that the examination be discontinued during the examination should be respected. The reasons must be documented and implications of this sensitively explained to the patient.

Any concerns raised by the patient regarding conduct or procedures used by the Healthcare professional must be escalated immediately to the appropriate line managers and incident form completed.

It is advisable that during an intimate examination, the health care professional should: -

- Offer reassurance
- Keep discussion relevant
- Avoid unnecessary personal comments
- Encourage relevant question and discussion regarding the process
- Remain alert to verbal and non-verbal indications of distress from the patient
- Discontinue the process if there is any severe pain or distress evident from the patient
- Allow the patient time to respond to instructions given during the procedure
- Remain compassionate, courteous and mindful of the intimacy of the procedures the patient is undergoing

7.9 Communication and Record Keeping

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 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.

Details of the examination must be documented in the patient's medical/ nursing record.

Details of the presence or absence of a chaperone should be documented in the clinical notes. The chaperone should clearly document their name, which should be signed and dated.

If the patient expresses any doubts or reservations about the procedure and the healthcare professional feels the need to reassure them before continuing then it would be good practice to record this in the patient's notes. The records should make clear from the history that an examination was necessary.

In any situation where concerns are raised, or an incident has occurred, and a report is required this should be completed immediately after the consultation

8 Consultation

This policy has been shared for comment with

- Director of Nursing Team
- Matron's Action Group
- Clinical Nurse Leaders Forum (Ward Managers)
- Mental Health Act Lead and Mental Capacity Act Lead
- Clinical Risk and Claims Manager Lead for consent
- Assistant Director for Health and Security Lead

9 Training

All staff should have an understanding of the role of the chaperone and the procedures for raising concerns.

Staff who undertake a formal chaperone role should have undergone local training and achieve competencies and skills required for this role.

This training should form part of the local ward / departmental induction programme and be facilitated by their respective line manager. Induction of new clinical staff who would act as formal chaperones must include the key principles listed below:

- Mental Capacity training
- Dementia awareness training
- Safeguarding training for both adults and children
- 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 e.g. advocate, the appropriate conduct during intimate examinations
- Policy and mechanism for raising concerns and accurate recording

10 Monitoring Compliance and Effectiveness

The policy is not intended to measure achievement against a set target, rather to provide guidance on the role and use of chaperones. When an incident occurs relating to a chaperone problem, an incident report form must be completed.

Non-compliance or effectiveness of the guidance can therefore be monitored by the Matron or Ward Manager responsible for the area raising the concern, through the number of incident forms completed. Additional sources of monitoring can be obtained through patient survey comments, complaints and Patient Experience Team

11 Links to other Organisational Documents

- Consent to Examination or Treatment Policy
- Raising Concerns (Whistle blowing) Policy
- Risk Management Strategy
- Lone and Isolated Worker guidelines
- Escort of Patients Including Internal Transfer Policy
- Safeguarding Adults Multi-Agency Policy, Guidance and Toolkit: Southampton, Hampshire, Isle of Wight and Portsmouth: May 2015
- Safeguarding Children and Young People Policy.

12 References

12.1 RCN (2002) - Royal College of Nursing, Chaperoning: The Role of the Nurse and the Rights of Patients *Guidance for Nursing Staff* 2002, reprinted 2006

12.2 GMC (2013) - Good Medical practice – Intimate examinations and chaperones (2013) Revised 2014. http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp

12.3 The Code, Professional Standards and Behaviour for Nurses and Midwives. NMC 2015

12.4 NHS Clinical Governance Support Team - Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings: June 2005

12.5 *No secrets:* Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health 2000

13 Appendices

13.1 Appendix A Staff Checklist
13.2 Appendix B Resources impact assessment
13.3 Appendix C Equality Impact Assessment

APPENDIX A

CHAPERONE POLICY

STAFF CHECKLIST: for consultation involving intimate investigations/procedures

- Establish there is a genuine need for an intimate examination and discuss this with the patient prior to the procedure taking place.
- Explain to the patient why an examination is necessary and give the patient an opportunity to ask questions, and full explanation of what this involves.
- Offer a formal chaperone to support them through this or invite the patient to have a family member/friend present to act in informal chaperone capacity if this is relevant (i.e. leading up to the intimate procedure) If the patient does not want a chaperone, record that the offer was made and declined by the individual in the patients' notes.
- Obtain the patients consent before the examination and record that permission has been obtained in the patients' notes. Follow relevant policies where there are issues relevant to patient capacity.
- Be prepared to discontinue the examination at any stage should the patient request this and record the reason.
- Children should be given the opportunity to have parents present if they wish during the whole procedure. If a child does not wish a nurse to be present during an intimate examination then the parents can act as chaperones if this is deemed in his/ her best interest, ensuring that the role is fully explained, and consent sought and recorded.
- Chaperone must at all times allow patient privacy to undress and dress through the use of drapes, screens, blankets.
- Explain what you are doing at each stage of the examination, the outcome when it is complete and what you /or the HCP propose to do next. Keep discussion relevant and avoid personal comments at all times.
- If a chaperone has been present throughout the process, record that fact and the identity of the chaperone in the patient's notes.
- Record any other relevant issues and escalate concerns immediately following the consultation.
- Ensure the individual is supported to dress fully after the procedure maintaining his/her full dignity and privacy at all

Appendix B

Financial and Resourcing Impact Assessment on Policy Implementation

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

Document title	**Chaperone Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs - not assessed			
Training Staff – not assessed			
Equipment & Provision of resources	**Nil**		

Summary of Impact: There are no obvious cost implications, this policy relates to best practice which is in place currently.

Risk Management Issues: Potential risk of not adequate staff to enable chaperoning when required.

Benefits / Savings to the organisation: Nil financial

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? YES

If "YES" please specify: **Patients who do not have English as a language, patients with dementia, patients with learning disabilities will not be able t communicate desire for chaperone as easily as others.**

Use additional sheets if necessary.

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

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**

Operational running costs	Not assessed		
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals: not assessed		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals: not assessed		

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

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

Appendix C

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Chaperone Policy
Purpose of document	To ensure privacy and dignity of patients
Target Audience	Clinicians undertaking examinations, Healthcare staff chaperoning patients, Managers supervising staff.
Person or Committee undertaken the Equality Impact Assessment	Sarah Johnston, Deputy Director of Nursing

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

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

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

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

		Positive Impact	Negative Impact	Reasons
Gender	Men			
	Women			
Race	Asian or Asian British People			
	Black or Black British People			
	Chinese people			
	People of Mixed Race			
	White people (including Irish people)			

	People with Physical Disabilities, Learning Disabilities or Mental Health Issues		✓	*Potential inability to understand choice for people with MH issues or learning disabilities*
Sexual Orientation	Transgender			
	Lesbian, Gay men and bisexual			
Age	Children		✓	*Not always able to make own choices – dependant on age, competence and the situation.*
	Older People (60+)			
	Younger People (17 to 25 yrs)			
Faith Group				
Pregnancy & Maternity				
Equal Opportunities and/or improved relations				

Notes:

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

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

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)		✓	
Intended		✓	

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

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
Ensuring clinicians have full understanding of mental capacity act, and best interest actions. Clinicians should be aware of and use learning disability nurses for support and chaperones where possible

and/or required. This resource is available. Children are chaperoned by parents and under safeguarding processes if required. Policies support parental support of children as much as possible i.e. in transfer to theatres. Paediatric nurses are available.	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
Ensuring good awareness amongst clinicians of available resources to support good patient choice	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not, why not?	
N/A	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	2nd December 2015