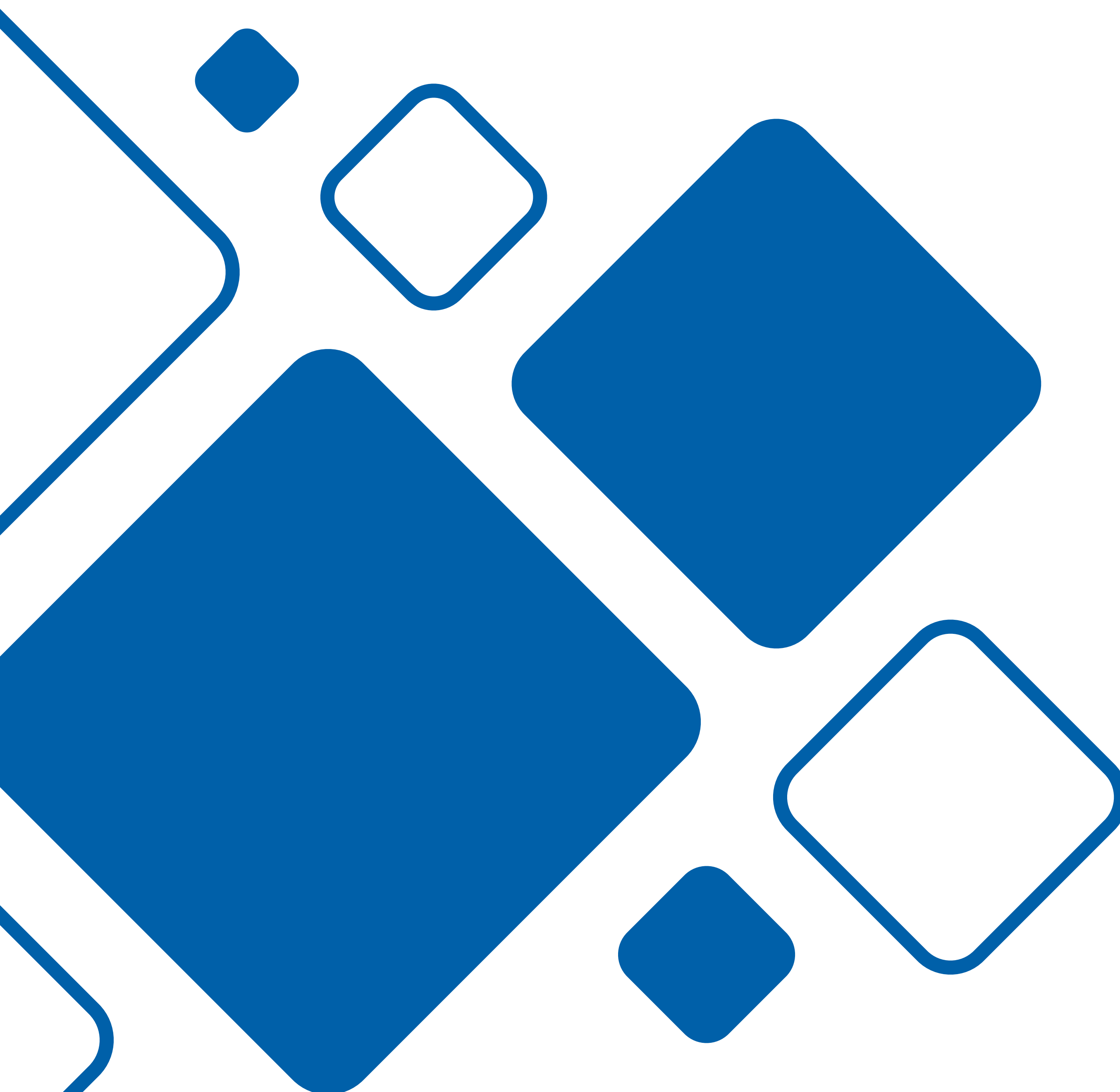
NURSDOC

POLICY NUMBER: **89**
POLICY TITLE: **CHAPERONE**
WHO MUST ABIDE BY THIS POLICY? **ALL STAFF**



CHAPERONE POLICY

CONTENTS

1. **Practice Statement** 2
2. **Introduction** 2
3. **What is a Chaperone?** 2
   3.1 Informal Chaperone 2
   3.2 Formal Chaperone 2
4. **Who may Chaperone** 2
5. **Training for Chaperones** 2
6. **Offering a Chaperone** 2
7. **Where a Chaperone is needed but not available** 3
8. **Consent** 3
   8.1 Capacity 3
   8.2 Issues Specific to Religion, Ethnicity, Culture or Sexual Orientation 3
   8.3 Issues specific to learning difficulties/ mental health problems 3
   8.4 Issues specific to children 3
9. **Suspicion of Abusive Relationships** 3
10. **Lone Working** 3
11. **References** 4

APPENDICES

1. **Chaperone Procedure** 4
2. **Sources** 4

1. PRACTICE STATEMENT

Nursdoc 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 that the safety of everyone is of paramount importance.

2. INTRODUCTION

It is recognised that clinical consultations, examinations and investigations have the potential to cause some people distress. Sometimes consultations can cause people to feel vulnerable, for example where lights are required to be dimmed, there is close proximity, or where patients need to undress or be touched for intensive periods of time. Many patients find examinations and investigations of the rectum, genitalia or breasts particularly intrusive.

Chaperoning may help reduce distress, but must be recognised as part of a package of respectful behaviour which includes explanation, informed consent and privacy.

This policy takes into account the recommendations of the Clifford Ayling Inquiry in September 2004. It presents the principles and outlines the procedures that should be in place for appropriately chaperoning patients, during consultation, examination, treatment and care.

For the purpose of this policy and procedure the term "consultation" covers consultations, examinations, investigations, treatment and care.

3. WHAT IS A CHAPERONE?

3.1 Informal Chaperone

Many patients feel reassured by the presence of a familiar person [family member or friend], and this may be appropriate in certain circumstances. However, it is inappropriate to expect this type of chaperone to take any active part in the consultation, witness the procedure directly or be relied upon to act as a witness to the conduct or continuing consent of the procedure.

Under no circumstances should a child be expected to act as a chaperone. However, if the child is providing comfort to the parent and will not be exposed to unpleasant experiences it may be acceptable for them to stay.

3.2 Formal Chaperone

A formal chaperone is a member of the practice team who is present during the consultation to act as a safeguard for all parties (patient and health professionals).

Although the precise role of the chaperone varies depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out it is primarily to act as a witness to the conduct and continuing consent of the procedure.

It may also include:

- Providing a degree of emotional support and reassurance to patients;
- Assisting in the examination or procedure, for example handing instruments during IUCD insertion;
- Assisting with undressing, dressing and positioning patients;
- Acting as an interpreter.

4. WHO MAY CHAPERONE

A 'formal' chaperone can be either a clinical health professional [e.g. a nurse or Health Care Assistant] or a specifically trained non-clinical staff member. The specific role of the chaperone should be made clear to both the patient and the person undertaking the chaperone role prior to the examination being undertaken.

Protecting the patient from vulnerability and embarrassment means that the chaperone should- usually be of the same sex as the patient. Although there will be occasions when this is difficult to achieve, the use of a male chaperone for the examination of a female patient or a female chaperone when a male patient is being examined could be considered inappropriate and should be discussed with the patient before proceeding.

The patient should always have the opportunity to decline a particular person as a chaperone if that person is not acceptable to them for any reason.

The surgery does not have the facility to accommodate virtual chaperones.

5. TRAINING FOR CHAPERONES

It is important that chaperones have had sufficient training to understand the role expected of them. Staff who undertake a formal chaperone role should undergo training such that they develop the competencies required for this role. These include an understanding of:

- What is meant by the term chaperone
- What is an "intimate examination"
- Why chaperones need to be present
- The rights of the patient
- The role and responsibility of the chaperone
- Policy and mechanism for raising concerns

Induction of new clinical staff should include training on the appropriate conduct of intimate examinations and care. All staff should have an understanding of the role of the chaperone and the procedures for raising concerns.

6. OFFERING A CHAPERONE

It is good practice to offer all patients a chaperone of the same sex as the patient for any consultation, examination or procedure. This does not mean that every consultation or procedure needs to be interrupted to ask if the patient wants a third party present.

The offer can be made through a number of routes including prominently placed posters, practice leaflets and verbal information prior to the event; it may be particularly useful to raise the issue at the time of booking an appointment.

It is not always clear ahead of the event that an intimate or close proximity examination or procedure is required. It may be wise, especially where a male clinician examines a female patient, to repeat the offer of a chaperone at the time of the examination.

Most Patient(s) will not take up the offer of a chaperone, especially where a relationship of trust has been built up or where the examiner is the same gender as them.

If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined. If a chaperone is refused a healthcare professional cannot usually insist that one is present and many will examine the patient without one.

However, there are some cases where the (usually male) doctor may feel unhappy to proceed. This may be where a male doctor is carrying out an intimate examination, such as a cervical smear or breast examination. Other situations are where there is a history of violent or unpredictable behaviour on behalf of the patient to see another doctor or health professional.

In this case, the practitioner must make his/her own decision and carefully document this with the rationale and details of any procedure undertaken. This may include refusing to meet with the patient alone.

7. WHERE A CHAPERONE IS NEEDED BUT NOT AVAILABLE

If the patient has requested a chaperone and none are available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable time-frame. If the seriousness of the condition would dictate 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. In cases where the patient is not competent to make an informed decision then the healthcare professional must use their own clinical judgement and be able to justify this course of action. The decision and rationale should then be documented in the patients' medical record.

It is acceptable for a doctor (or other appropriate member of the healthcare team) 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' medical records.

8. CONSENT

8.1 Capacity

A fundamental value of Nursdoc is equity of access to its services. The aim is that everybody, irrespective of their gender, age, disability, race, colour, nationality, ethnicity, religion or sexuality will have equal access to services. Furthermore our services will, as far as possible, be sensitive to their individual needs.

There is the 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.

It can be assumed that by attending a consultation a patient is seeking treatment, and has therefore given implied consent. However, before proceeding with an examination it is vital that the patient's informed consent is obtained. This means the patient must; be competent to make the decision; have received sufficient information to make it and not be acting under duress.

In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination, and when patients are not able to consent for themselves they should always be treated in their best interests.

8.2 Issues Specific to Religion, Ethnicity, Culture or Sexual Orientation

The healthcare professional should not proceed with any examination if they are unsure that the patient understands due to a language barrier.

The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others.

Similarly, a lesbian woman may have a strong aversion to intimate examinations performed by a male, or a gay man may not wish to be examined by another man. These considerations should be taken into account and discussed, not presumed. We must all recognise that each individual has very different needs and procedures should be performed by a mutually agreed healthcare professional.

8.3 Issues specific to Learning Difficulties/Mental Health Problems

For patients with learning difficulties or mental health problems that affect capacity, a familiar individual such as a family member or carer may be the best chaperone. A careful simple and sensitive explanation of the technique is vital. This patient group is a vulnerable one and issues may arise in initial physical examination, 'touch' as part of therapy, verbal and other 'boundary-breaking' in one to one 'confidential' settings and indeed home visits.

Adult patients with learning difficulties or mental health problems who resist any intimate examination or procedure must be interpreted, as refusing to give consent and the procedure must be abandoned.

In life threatening situations, the healthcare professional should use professional judgement. Where possible discuss with a member of the Mental Health Care Team and/or the Mental Capacity Act Guidelines.

8.4 Issues Specific to Children

Children and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and understanding. If a minor presents without a parent or guardian the healthcare professional must ascertain if they are capable of understanding the need for examination.

Children over 16 years of age can consent for themselves without their decision being referred to their parents or guardians. It is, however, good practice to involve parents, although this must be decided by the young person.

A child under the age of 16 years can consent for themselves, if they are deemed to be "Gillick competent". If not, a person with parental responsibility should consent on their behalf.

A formal chaperone should always be present for intimate examinations on children.

In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse. In these situations the healthcare professional should refer to the local child protection policies and seek specialist advice from the Child Protection Team as necessary.

9. SUSPICION OF ABUSIVE RELATIONSHIPS

The patient has a right to have freedom and space to express worries, concerns and potential abuse as well as an examination in a non-controlling atmosphere. The onus is on the professional to use tact and diplomacy to exclude the oppressor from the room and to use an independent chaperone.

It is important to have a chaperone in such cases as the documented case notes may be called on at a later date. In the event of the examination of a potentially abused child any extensive examination should only be undertaken by an expert in this field.

In the situation of a non-English speaking person being examined the use of an independent interpreter should be enlisted; on no account should family members be used.

10. LONE WORKING

Where a healthcare professional is working in a situation away from other colleagues, e.g. home visit, the same principle for offering and use of chaperones should apply. Where it is appropriate family member/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 may be required to risk assess the need for a formal chaperone and should not be deterred by the inconvenience or complexity of making the necessary arrangements. However, where an examination has to be made due to the urgency of the situation, it is imperative that details are clearly documented in the patient's medical record.

11. REFERENCES

- Maintaining Boundaries
www.gmc-uk.org/guidance/ethical_guidance/maintaining_boundaries.asp
- Practice Nursing 2010, Vol 21, No 7 Clinical Governance - Chaperones

APPENDICES

APPENDIX 1

CHAPERONE PROCEDURE

1. Establish there is a genuine need for an intimate examination
1.1 Explain to the patient why an examination is necessary
1.2 Explain what the examination will involve, in a way the patient can understand, and they have a clear idea of what to expect, including any pain or discomfort
1.3 Give the patient the opportunity to ask questions.

2. Offer a Chaperone
2.1 If the patient is with a family member or friend, and an informal chaperone is appropriate, offer the patient this option.
2.2 If a formal chaperone is required, offer this to the patient. This should be a Health Care Assistant or Nurse, if available. If not it must only be a non-clinical member of staff who has received chaperone training.
2.3 If the patient does not want a chaperone, record that the offer was made and declined in the patient's notes.
2.4 If the patient wants a chaperone and there is not one available – if the examination is clinically urgent – discuss this with the patient and agree between you whether to proceed.
2.5 If the examination is not clinically urgent, offer to reschedule the examination at a date and time when one is available.

	CTV3
Chaperone offered	
Chaperone present	
Chaperone refused	
Nurse chaperone	
Chaperone not available	

3. Consent
3.1 Obtain the patient's consent before the examination
3.2 Record it in the notes and be prepared to discontinue the examination at any stage at the patient's request.

	CTV3
Verbal consent for examination	
Gillick competent for consent	
Young person consent given medical examination	
Parental consent given medical examination	
Consent of guardian obtained medical examination	
Consent refused by parent	
No consent for examination received	

4. THE EXAMINATION

When the chaperone has entered the room:

4.1 Ensure the chaperone and the patient understand the role the chaperone will perform
4.2 Give the patient privacy to undress and dress and keep the patient covered as much as possible to maintain their dignity [the chaperone should not assist the patient in removing clothing unless they have clarified with the patient that assistance is required]
4.3 The healthcare professional whilst wearing gloves should not delay the examination once the patient has removed their clothing
4.4 An intimate examination should take place in a closed room and should not be interrupted by telephone calls or other messages
4.5 During the examination the healthcare professional should:
- Explain what they are going to do before it is done and, if this differs from what has already been outlined to the patient, explain why and seek the patient's permission;
- If necessary, reassure the patient during the procedure and if necessary record this in the notes
- Be prepared to discontinue the examination if the patient requests it
- Keep discussion relevant and do not make unnecessary personal comments

4.6 Once the patient is dressed following examination or investigation, consider [asking the patient as necessary] if it is appropriate for the chaperone to remain
4.7 Communicate the finding to the patient and explain any further investigations, referral, and treatment options.

APPENDIX 2

SOURCES

With the recent high profile local and national cases of alleged and/or proven inappropriate behaviour of health professionals towards their patients a review on the guidance for chaperoning was sought.

NHS Safety, Privacy and Dignity guidance (2000) suggests doctors, nurses and other health care professionals should consider being accompanied by a chaperone when undertaking intimate examinations and procedures to avoid misunderstandings and, in rare cases, accusations of abuse.

The GMC Relationships with Patients - maintaining trust guidance available on the website makes recommendations that doctors "should always make arrangements for a chaperone to be present if intimate clinical examinations are carried out in situations that are open to misinterpretation."

Further GMC guidance, published in December 2001, Intimate Examinations suggests doctors "offer a chaperone or invite the patient to have a relative or friend present. If the patient does not want a chaperone (the doctor) should record that the offer was made and declined. If a chaperone is present (the doctor) should record that fact and make a note of the chaperone's identity. If for justifiable practical reasons (the doctor) cannot offer a chaperone (the doctor) should explain that to the patient, offer to delay the examination to a later date. The doctor should record the discussion and its outcome."

The RCN's guidance Chaperoning: The role of the nurse and the rights of patients (2002) describes the role of chaperone as an advocate for the patient, helping with explanations during the examination or procedure. The RCN suggest the nurse can assess the understanding of what the patient has been told and be a reassuring presence, safeguarding against any unnecessary discomfort, pain, humiliation or intimidation.

The NMC publication: Practitioner client relationships and the prevention of abuse (NMC 2002) refers to the "appropriate use of chaperones when undertaking intimate procedures."

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