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# Chaperone Policy and Guidelines

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## 1.0 Introduction

1.1 The Clifford Ayling inquiry (2004) made a number of recommendations about the use of chaperones in primary and community care settings, specifically about who should undertake the role of chaperone and the training for the role.

1.2 This document is the policy of Community Health Oxfordshire (CHO) about the use of chaperones and provides guidance as to how this might best be implemented.

1.3 This document applies to all healthcare professionals working in CHO, including medical staff, nurses, health care assistants, allied health professionals, medical students, radiographers and complementary therapists working with individual patients in surgeries, clinic situations, wards, departments and in the patient's home. This guidance also covers any non-medical personnel who may be involved in providing care.

## 2.0 Definitions

**Chaperone:** A chaperone is a person who is present during a physical examination as a safeguard for all parties (patient and practitioners) and is a witness to continuing consent of the procedure.

**CHO:** Community Health Oxfordshire

**Healthcare Professional:** All staff groups in CHO

The use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

### **3.0 Accountability and Responsibility**

3.1 The Head of Adult Services, the Head of Specialist Services and the Heads of Children Services for Community Health Oxfordshire are responsible for ensuring that staff adhere to this policy.

3.2 The individual Service Managers are responsible for monitoring the implementation of this policy.

3.3 The relevant Unit Managers are responsible for supporting the Service Managers to meet their obligations.

3.4 Individual members of staff are responsible for ensuring they implement this policy and that they report any concerns to their manager. It may be that staff need to use the Whistleblowing policy to achieve this effectively.

### **4.0 Policy**

4.1 All medical consultations, examinations and investigations are potentially distressing. Patients can find examinations, investigations or photography involving the breasts, genitalia or rectum particularly intrusive (these examinations are collectively referred to as "intimate examinations"). Also consultations involving dimmed lights, the need for patients to undress or for intensive periods of being touched may make a patient feel vulnerable.

4.2 For most patients respect, explanation, consent and privacy take precedence over the need for a chaperone. The presence of a third party does not negate the need for adequate explanation and courtesy and cannot provide full assurance that the procedure or examination is conducted appropriately

4.3 Patients undergoing examinations should only be required to uncover the part of the anatomy that requires investigation or imaging.

4.4 Adequate information and explanation as to why any examination or procedure is required should be provided (see also the PCT Policy on Consent to Examination and Treatment).

4.5 All patients should have the opportunity of having a chaperone during any consultation or procedure.

4.6 For some patients it may be appropriate to introduce a chaperone who is acceptable to the person to help them feel safe and secure. This will depend on the availability of an appropriate chaperone and the urgency of the treatment/intervention required.

4.7 If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe. (See guidance section for urgent and emergency situations).

4.8 On no account must a child under 16 years of age be used as a chaperone.

## **5.0 Guidelines**

### **5.1 Offering a Chaperone**

5.1.1 Staff should be aware that intimate examinations might cause anxiety for both male and female patients and whether or not the examiner is of the same gender as the patient. All patients should have the opportunity of having a chaperone during any consultation or procedure.

5.1.2 The offer of a chaperone can be made through a number of routes including the appointment letter, prominently placed posters, practice leaflets and verbal information prior to the actual consultation. The offer of a chaperone should be made especially clear to the patient prior to any intimate procedure, ideally at the time of booking the appointment.

5.1.3 It is not always clear ahead of the consultation that an intimate examination or procedure is required. The offer of a chaperone should be repeated at the time of the examination.

### **5.2 Patients who are offered and decline a chaperone**

5.2.1 If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined.

5.2.2 There are some cases where the clinician may feel unhappy to proceed. This may be where a male doctor is carrying out an intimate examination, such as cervical smear or breast examination. Other situations may be where there is a history of violent or unpredictable behaviour on behalf of the patient or their family member/friend.

5.2.3 In these situations it may be possible to arrange for the patient to see another clinician. This should be documented.

### **5.3 Where a Chaperone is needed but not available**

5.3.1 If the patient has requested a chaperone and none is available at that the relevant time, the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe.

5.3.2 If the seriousness of the condition dictates that a delay is inappropriate then this should be explained to the patient and recorded in their notes. A decision to continue or whether to reschedule the appointment should be reached in partnership with the patient.

5.3.3 In cases where the patient does not have mental capacity to make the decision to have the examination, the healthcare professional must use their own clinical judgement and record the decision demonstrating they are working in the patient's best interests.

### **5.4 Role of the Chaperone**

5.4.1 There is no common definition of a chaperone and their role varies considerably depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out. Broadly speaking their role can be considered in any of the following areas:

- Providing emotional comfort and reassurance to patients
- To identify unusual or unacceptable behaviour on the part of the health care professional
- To provide protection to healthcare professionals against unfounded allegations of improper behaviour

5.4.2 The chaperone may also be fulfilling other roles such as:

- assisting in the examination, for example handing instruments during IUCD insertion
- assisting with undressing patients
- acting as an interpreter
- helping the clinician manage aggressive behaviour

5.4.3 All parties should understand the expectations of the chaperone during the consultation and examination. It is for the lead clinician to ensure this common understanding exists.

5.4.4 A chaperone is present as a safeguard for all parties (patient and practitioners) and is a witness to continuing consent to the procedure.

5.4.5 The patient should always have the opportunity to decline a particular person as a chaperone for any reason.

5.4.6 In situations where the presence of a chaperone may intrude in a confiding clinician/patient relationship, their presence should be confined to the physical examination. One-to-one communication should take place after the examination.

5.4.7 The patient may decide to ask the chaperone to leave at any time. If the clinician is unhappy to continue with the consultation in this situation, then this should be explained to the patient and another appointment made.

## **5.8 Informal chaperone**

5.8.1 Many patients feel reassured by the presence of a familiar person and this request should be accepted unless there are specified reasons for refusing by the clinician. This should be documented.

## **5.9 Formal chaperone**

5.9.1 A formal chaperone implies a clinical health professional, such as a nurse, or a specifically trained nonclinical staff member, such as a receptionist. This individual will have a specific role to play in terms of the consultation and this role should be made clear to both the patient and the person undertaking the chaperone role. This may include assisting with undressing or assisting in the procedure being carried out. In these situations staff should have had sufficient training to understand the role expected of them and the knowledge and skills to undertake this role.

5.9.2 Protecting the patient from vulnerability and embarrassment means that the chaperone would usually be of the same sex as the patient. Therefore the use of a male chaperone for the examination of a female patient or of a female chaperone when a male patient was being examined could be considered inappropriate.

## **5.10 Use of Virtual Chaperones**

5.10.1 Virtual chaperone technology is not yet available in CHO. This technology enlists the support of electronic and digital recording techniques to provide a record of the consultation. Should a decision be made to introduce this, then consideration would need to be made of:

- Secure storage of the information
- Training
- Consent

## **6.0 Meeting National Criteria**

### **6.1 The Care Quality Commission state in Core Standard C20:**

“Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:

- a. a safe and secure environment which protects patients, staff, visitors and their property and the physical assets of the organisation;
- b. supportive of patient privacy and confidentiality.”

The implementation of this policy helps meet this standard and associated outcomes.

## **7.0 Training Requirements**

7.1 The competencies that a formal chaperone should meet are 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
- Their role and responsibility
- Policy and mechanism for raising concerns

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

## **8.0 Specific Issues**

### **8.1 Children**

8.1.1 Reference should be made to the Shared Care Protocols for Children 2010, Intimate Care Guidance.

8.1.2 In the case of children a chaperone will normally be a parent or carer or alternatively someone known and trusted or chosen by the child. For competent young adults the guidance relating to adults is applicable.

8.1.3 In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse.

8.1.4 Healthcare professionals should refer to the Child Protection Policy for any specific issues. The advice of the Named Nurses for Child Protection can also be obtained.

8.1.5 Children and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and understanding.

8.1.6 If a minor presents in the absence of a parent or guardian the healthcare professional must ascertain if they are capable of understanding the need for examination. In these cases it would be advisable for consent to be secured and a formal chaperone to be present for any intimate examinations.

## **8.2 Issues Specific to Religion/Ethnicity or Culture**

8.2.1 The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, for example, Muslim and Hindu women have a strong cultural aversion to being touched by men other than their husbands. Wherever possible, particularly in these circumstances, arrangements should be in place that a female healthcare practitioner should perform the procedure.

8.2.2 It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a language barrier. If an interpreter is available, they may be able to double as an informal chaperone if the patient consents and the interpreter agrees.

8.2.3 It is best practice that where an interpreter is required, the interpreter is a paid interpreter who is not a member of the person's family or community.

## **8.3 People with Learning Disability**

8.3.1 We have a responsibility to ensure that all mainstream health services are accessible to people with a learning disability.

8.3.2 Where the person with a learning disability lacks the mental capacity to make a decision about having a chaperone the clinician is the decision maker and makes the decision in the best interests of the patient. This should be documented.

8.3.3 By checking the person's Health Action Plan and/or hospital passport information the person with learning disability's preferred communication method and choice of carer can be established. There will also be reference to any consent issues which may help with assessing the person's mental capacity.

## **8.4 Lone Working**

8.4.1 Where a health care professional is working in a situation away from other colleagues e.g. home visit, out-of-hours centre, the same principles for offering and use of chaperones should apply.

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

8.4.3 In cases where a formal chaperone would be appropriate, the healthcare professional should reschedule the examination to an appropriate location.

8.4.4 In cases where this is not an option, for example due to the urgency of the situation or because the patient is unable to travel, then decisions as to what should

be done are made with the patient. Where the patient lacks mental capacity then all decisions are made in the patient's best interests. Decisions should be communicated to relevant parties and documented.

## 8.5 Communication and Record Keeping

8.5.1 As part of the normal procedure for consent, the healthcare professional explains the nature of the examination to the patient and offers them a choice whether to proceed with that examination at that time with or without a chaperone. The patient will then be able to give an informed consent to continue with the consultation.

8.5.2 Details of the examination including presence/absence of chaperone and information given must be documented.

## 9.0 References

- Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling (2004).  
[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4088996&chk=mLRN1X](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4088996&chk=mLRN1X)
- Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale  
[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4088995&chk=pkiaaG](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4088995&chk=pkiaaG)
- [www.the-shipman-inquiry.org.uk](http://www.the-shipman-inquiry.org.uk)
- Department of Health: Reference guide to consent for examination or treatment, second edition 2009
- Mental Capacity Act 2005: Code of Practice (2007). TSO London
- Shared Care Protocols for Children 2010, Intimate Care Guidance.
- The General Medical Council offers further guidance to doctors about maintaining boundaries:  
[www.gmc-uk.org/static/documents/content/Maintaining\\_Boundaries.pdf](http://www.gmc-uk.org/static/documents/content/Maintaining_Boundaries.pdf)
- The Royal College of Nursing offers further guidance to nurses regarding dignity and raising concerns:  
[www.rcn.org.uk](http://www.rcn.org.uk)

## 10.0 Consultation

<b>Internal Stakeholders</b>	
<b>Name</b>	<b>Title</b>
Jayne Matthews	Service Manager Community Nursing
Chris Hewitt	Service Manager Urgent Care
Karen Campbell	Service Manager Community Hospitals
Philip Joyce	Service Manager Podiatry and Musculoskeletal Therapy
Carole Middleton	Service Manager Nutrition and Dietetics, Adult Speech and Language Therapy
Lucia Winrow	Service Manager CASH and Luther Street
Gail Gurses	Matron for Offender Health, Bullingdon Prison
Wendy Howard	Strategic Health Facilitator
Catherine Riddle	Service Manager Safeguarding Children
Karen Brombley	Lead Nurse for Children with Complex Health Needs
Mandy McKendry	Clinical Risk and Patient Safety Manager
Rosalind Mitchell	Service Manager Dentistry
Pete McGrane	Clinical Lead Urgent Care

External Stakeholders	
Name	Title/organisation
Helen Bloomfield	OADG
Maggie Scott	General Public
Toby Wright	General Public
Dal Warburton	General Public
Bev Smith	Ley Community
Louise Wiggins	General Public

## 11.0 Process for review of the document

This policy will be reviewed in line with the processes in place following the amalgamation of CHO and OBMH.