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Chaperone Policy

Policy Statement

Chaperone guidance is for the protection of both patients and staff and this guidance should always be followed. The key principles of communication and record keeping will ensure that the practitioner/patient relationship is maintained and act as a safeguard against formal complaints, or in extreme cases, legal action.

The most common cause of patient complaints is a failure on the patient's part to understand what the practitioner was doing in the process of treating them. It is essential that 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. The patient will then be able to give an informed consent to continue with the consultation or examination.

1. Introduction

1.1 Recent public inquiries, such as the Clifford Ayling Inquiry, have made a number of recommendations into the use of chaperones in primary care settings, specifically around who should undertake the role of chaperone and the training for the role.

1.2 A study looking at attitudes of patients towards the use of chaperones found that 90% of female patients and 78% of male patients thought that a chaperone should be offered for 'intimate' examinations.

1.3 All medical consultations, examinations and investigations are potentially distressing. Patients can find examinations or investigations 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.

1.4 In their Maintaining Boundaries Guidance, the General Medical Council (GMC) suggests, "wherever possible, you should offer the patient the security of having an impartial observer (a 'chaperone') present during an intimate examination."

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

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1.6 For some patients, the level of embarrassment increases in proportion to the number of individuals present.

1.7 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.

1.8 Intimate examinations should take place in a closed room or well-screened bay that cannot be entered while the procedure or examination is in progress.

1.9 The procedure or examination should not be interrupted by phone calls or messages.

2. Responsibilities

2.1 Person carrying out the examination

2.1.1 To provide information to the patient in a format which ensures that informed consent has been achieved.

2.1.2 To offer a chaperone and consider which type of chaperone is required based on the patients needs/request and the type of examination/investigation being undertaken.

2.1.3 Document whether a chaperone was present, requested and provided or offered and refused.

2.2 Informal chaperone

2.2.1 Provide moral support for patient

2.3 Formal chaperone

2.3.1 Act as witness

2.3.2 Assist patient as requested by patient

2.3.3 Possibly to assist with the procedure

3. Procedure

3.1 Information

3.1.1 Adequate information and explanation as to why the examination or procedure is required should be provided and where necessary, easily understood literature and diagrams can support this verbal information. In addition, careful and sympathetic explanation of the examination technique to be used should be given throughout the procedure being carried out.

3.1.2 It is unwise to proceed with any procedure or examination if the healthcare professional is unsure that the patient understands due to a language barrier.

3.2 Chaperone

3.2.1 For all intimate examinations a chaperone will be offered. Intimate examinations include examinations of breasts, genitalia and rectum.

3.2.2 If the patient declines this must be respected and documented in the patient's record. Patients decline the offer of a chaperone for a number of reasons: because they trust the clinician, think it unnecessary, require privacy, or are too embarrassed.

3.2.3 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. Patients undergoing examinations should be allowed the opportunity to limit the degree of nudity by, for example, uncovering only that part of the anatomy that requires investigation or imaging. Wherever possible, particularly in these circumstances, a female healthcare practitioner should be offered to perform the procedure. If an interpreter is available, they may be able to double as an informal chaperone.

3.2.4 Children and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and understanding. Young people are excluded from this contract (people under the age of 18).

3.2.5 The designation of the chaperone will depend on the role expected of them and on the wishes of the patient. It is useful to consider whether the chaperone is required to carry out an active role – such as participation in the examination or procedure or have a passive role such as providing support to the patient during the procedure.

3.2.6 The informal chaperone: Many patients feel reassured by the presence of a familiar person and this request in almost all cases should be accepted. The informal chaperone will

not take an active part in the examination, witness the procedure directly or witness the continuing consent.

3.2.7 The formal chaperone: A formal chaperone implies a clinical health professional, such as a nurse, or a specifically trained non-clinical 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.

A formal chaperone will have undergone training, please see training section below.

3.3 Consent

3.3.1 Implicit in attending a consultation it is assumed that that a patient is seeking treatment and therefore consenting to necessary examinations. However before proceeding with an examination, healthcare professionals should always seek to obtain, by word or gesture, some explicit indication that the patient understands the need for examination and agrees to it being carried out. Consent should always be appropriate to the treatment or investigation being carried out. It is advised that this consent is documented.

3.3.2 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.

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

3.3.4 If the healthcare professional plans to discuss the findings of the examination at the conclusion of the investigation, when the patient is fully dressed, the patient must be asked if they wish the chaperone to continue to be present

3.3.5 During an intimate internal examination it is strongly recommended that surgical gloves be worn. The glove acts as a physical barrier, keeping the examination on a clinical basis, limiting the possibility of sexual connotations.

3.3.6 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 should be abandoned and an assessment should be made of whether the patient can be considered competent or not.

4. Monitoring/Audit Process

4.1 The patient perception of how chaperoning has been achieved will be included in the patient interview documentation during provider inspections.

4.2 An audit tool will be used biennially to determine if the policy is being adhered to, supported by the findings of the provider inspection visit.

5. Documentation

5.1 A patient records audit supplemented by the provider inspection tool for patient interviews will be used.

5.2 It is important to record any discussion about using a chaperone in the patient’s record. If a chaperone is present, the GP should record the identity of that person. If the patient does not want a chaperone, the sonographer should record that the offer was declined.

6. Training

Members of staff who undertake a formal chaperone role should have undergone 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
- Their role and responsibility
- Policy and mechanism for raising concerns

7. Review

This policy will be reviewed every year unless the Department of Health or professional bodies issue further guidance in the meantime, which requires a review of the policy.

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Policy dissemination flowchart