

CHAPERONING POLICY

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DOCUMENT CONTROL

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Amendments To provide a policy that relates to the Chaperoning of any patient during any clinical procedure. Adapted from Taunton & Somerset Foundation Trust Guidance			
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1. INTRODUCTION

- 1.1 Undertaking intimate examination, treatment and care is integral to many aspects of patient care. Ensuring a chaperone is present not only provides reassurance and support to patients but also protects staff.
- 1.2 Staff should be sensitive to differing expectations associated with race, ethnicity, culture, sexuality, age and gender and, wherever, possible staff of the same cultural background should be available to chaperone.
- 1.3 This policy acknowledges in situations of extreme urgency care will be delivered in the best interests of the patient and support offered by senior clinical staff after the situation has resolved.
- 1.4 Where there are delays in appropriate chaperones being available due to organisational constraints, this will be reviewed by the Ward Manager / Sister/Team leader and appropriate Matron / Assistant Divisional Manager.

2. PURPOSE AND RATIONALE

- 2.1 The aim of this policy is to safeguard the dignity and rights of the patients and staff during consultation, treatment and the provision of care. Irrespective of gender, all patients have the right, if they wish, to have a chaperone present during an examination or procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out. The practitioner may feel that they would like a chaperone present for their own protection. For procedures involving children and young people it may not be appropriate for the family to be the sole chaperone (see section on chaperoning children).

3. POLICY STATEMENT

- 3.1 Somerset Partnership NHS Foundation Trust is committed to ensuring that Irrespective of faith, religion or gender, including transgender people and anyone in transition, all patients should have the right, if they wish, to have a chaperone present during an examination or procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out.

4. DEFINITIONS

- 4.1 **Chaperone** - There is no suitable common definition of a chaperone and the role of the chaperone may vary considerably depending on the needs of the patient, the needs of the healthcare professional and the examination or procedure being carried out.
- 4.2 **Intimate care and examination** - Intimate care or examination is defined as the care tasks associated with the sexual parts of the body, with bodily functions and personal hygiene, which demand direct or indirect contact with or exposure of the sexual parts of the body, (although other body parts may also be classified as intimate relating to the patient's religious/cultural beliefs).

5. DUTIES/RESPONSIBILITIES

- 5.1 The Trust Board, via the Chief Executive has overall responsibility for procedural documents and delegates responsibility as appropriate.
- 5.2 The Executive Lead is the Director of Care (Community) with delegated responsibility to ensure this policy is reviewed at least once every three years or sooner if national or local procedures change.
- 5.3 All managers are responsible for ensuring that staff who provide care for patients are aware of this policy, and that any training and competency needs are identified and addressed. They are also responsible for local monitoring of this policy.
- 5.4 All staff who provide care for patients as part of their role are responsible for complying with the guidance set out in this document.
- 5.5 Ward Managers/Sisters/Operational Managers are responsible for considering the needs of patients, when planning duty rotas e.g. to ensure male and female staff are on duty, where possible, so that patients' preferences can be accommodated.

6. THE POLICY

6.1 General Principals

- 6.1.1 Irrespective of faith, religion or gender, including transgender people and anyone in transition, all patients have the right, if they wish, to have a chaperone present during an examination or procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out.
- 6.1.2 The role of a chaperone:
- Provides physical and emotional comfort and reassurance to a patient during sensitive examinations or treatment;
 - Provides a safeguard for a patient against humiliation, pain or distress during an examination and to protect against verbal, physical, sexual or other abuse.
 - Identifies unusual or unacceptable behaviour on the part of the health care professional.
 - Provides support for the health care professional from potentially abusive patients.
- 6.1.3 The practitioner may feel they would like a chaperone present for their own protection. If the patient refuses this request the procedure should be postponed until a satisfactory solution is found. This process should be clearly documented in the patient's record.
- 6.1.4 A chaperone is usually a clinical health professional such as a nurse. Non-registered members of staff, such as healthcare assistants, receptionists, secretaries, can act as chaperones, but this should only be when that member

of staff has received instruction and is deemed by a registered practitioner to be competent to carry out this role.

- 6.1.5 Patients may express a preference to be attended by a female or male staff member. The possibility of agreeing to these requests should be considered and where possible accommodated. If it is not possible to fulfil this request, this must be explained to the patient and they must be given the choice of proceeding with the care, treatment or examination or not.
- 6.1.6 All professional staff should be able to demonstrate an understanding of the role of the chaperone and the procedures for reporting concerns.
- 6.1.7 The designation of the chaperone will depend on the role expected of them and on the wishes of the patient and staff member. 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 less involved role such as providing support to the patient during the procedure.
- 6.1.8 In order for patients to exercise their right to request the presence of a chaperone, a full explanation of the examination, procedure or treatment to be carried out should be given to the patient in a language or format they can easily understand, followed by a check to ensure the patient has understood the information and the reasons for undertaking the procedure. The patient should then be informed of the job title or professional status of the potential chaperone in order that the patient is able to make an informed decision regarding whether they would like that person present.
- 6.1.9 If the patient has not requested, or has refused the offer of the presence of a chaperone in the past, it should not be assumed that they do not require a chaperone for consequent consultations. Healthcare professionals should check at regular intervals, as identified within the patient's care plan, whether the patient would prefer a chaperone. This offer and the outcome should then be recorded in the patients' notes and reviewed on a regular basis with the patient.

6.2 During the Examination / Procedure/Care

- 6.2.1 Appropriate facilities must be made available for patients to undress in a private, undisturbed area in order to maintain their dignity and privacy.
- 6.2.2 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.
- 6.2.3 Intimate examination must 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, and appropriate signage must be displayed on the door.
- 6.2.4 Examination should not be interrupted by other staff, phone calls or messages.

- 6.2.5 The patient should be encouraged to dress following an examination or investigation prior to the findings or treatment requirements being discussed with them.
- 6.2.6 Any requests by the patient that the examination be discontinued during the examination must be respected. The reasons must be documented and implications of this sensitively and clearly explained to the patient.
- 6.2.7 During an intimate examination or care, the staff member must:
- Obtain informed consent for the procedure to be undertaken;
 - 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 the patient withdraws their consent, there is any severe pain or distress evident from the patient;
 - Allow the patient time to respond to requests given during the procedure or care;
 - Remain compassionate, courteous and mindful of the intimacy of the procedures the patient is undergoing.
- 6.2.8 During an intimate examination the chaperone must:
- Provide emotional support and reassurance to the patient;
 - Maintaining the patient's dignity by only exposing the area requiring examination / treatment by using clothing, gowns, sheets or couch roll;
 - Ensuring bed areas are appropriately screened / curtains drawn, doors closed & engaged signs used;
 - Ensuring interruptions by other staff are only for emergency situations;
 - Offer assistance during the examination / procedure/care, e.g. handling of equipment / instruments;
 - Support the safety and wellbeing of both the patient and the health care professional;
 - Identify and report any unusual or unprofessional behaviour on the part of the professional or the patient;
 - Ensure the patient understands why you are in attendance.
 - Listen, observe and verify what is discussed and carried out.

6.3 Lone Working

- 6.3.1 Where a healthcare professional is working in a situation away from other colleagues, e.g. home visit, out of hours, the same principles for offering the use of chaperones should apply. Where appropriate and if deemed necessary,

family members or friends may take on the role, but this should not be expected of them.

6.4 Where a Chaperone is Needed and Not Available

6.4.1 Where a suitable formal chaperone cannot be provided for a specific intimate procedure, the patient must be advised of this and the procedure rearranged for when a chaperone is available.

6.4.2 A Datix form should be completed outlining the reasons and action taken

6.4.3 The immediate line manager must be notified and of any adverse implications this will have on the patient's care and/or treatment discussed with them. In all circumstances the patient must be notified that a chaperone is not available and noted in their record.

6.5 Children and Young People

6.5.1 In the case of children all intimate examinations must have a chaperone.

6.5.2 Where an examination to a child is taking place due to an allegation of abuse or neglect, a Social Worker may be required to act as chaperone.

6.5.3 If a professional suspects a child or young person to have suffered from or be at risk of interfamilial sexual abuse, child sexual exploitation, female genital mutilation, breast ironing and other "culturally" violent practices (i.e. perpetrated by the families), they should be seen on their own and not in the presence of any individual who is suspected to be the alleged perpetrator of that abuse. However as per point 6.5.1 above any intimate examination must still take place in the presence of a chaperone that will be an adult unconnected to the child or the suspected abuse as per point 7.2 above.

6.5.4 When assessing the need for a parent to be present at an appointment or to chaperone an intimate examination, professionals must consider the following:

- The nature of the appointment;
- The age and competence of the child;
- The presence or likelihood of any child protection issues
- To determine whether a child should be seen alone or with their parent/carer.

6.5.5 Professionals must consider the need to provide confidential consultations for children accessing Sexual Health Services and Child and Adolescent Mental Health Services.

6.5.6 A child must never act as a chaperone for an adult regardless of the circumstances. This is to ensure all children are safeguarded from witnessing potentially distressing examinations and from providing emotional support to the adult who is being examined.

6.6 Issues Specific to Learning Disability, Mental Health Problems or Neurological Disorder

- 6.6.1 For patients with cognitive deficits, learning difficulties or mental health problems which affect capacity, a familiar person such as a named family member or professional carer / healthcare professional may be the best formal chaperone. This must be agreed and documented with the patient and the family member/ carer as part of the overall best interest decision making process.
- 6.6.2 A careful, simple and sensitive explanation of the procedure 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. This could potentially lead to a risk of concerns that may arise in initial physical examination such as “touch”, one to one “confidential” settings in line with their existing or previous treatment plans history of therapy, verbal and other “boundary-breaking” circumstances.
- 6.6.3 Adult patients with learning difficulties or mental health problems who refuse or resist any intimate examination or procedure may be interpreted as refusing to give consent and the procedure must not proceed. However, if the patient lacks the capacity to grant consent, any resistance or objections made must be managed via the Best Interest process. In life threatening situations the healthcare professional should use professional judgment and where possible always discuss and engage with members of the relevant specialist teams within mental health and learning disabilities and Trust leads. In all circumstances the named mental health team members and learning disability nurse should be contacted where ever possible in advance to provide advice and specialist input regarding the planning of intimate procedures and the support individuals will require.

6.7 Mental Capacity

- 6.7.1 There is a basic assumption 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 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.
- 6.7.2 Under the Mental Capacity Act 2005 there is legal protection for people who care for or treat someone who lacks capacity but any action taken must be in a patient’s best interests and the least restrictive course of action.
- 6.7.3 Staff should refer to the Consent and Capacity to Consent Policy, and Deprivation of Liberty Safeguards Policy in all situations relating to any adult who does not have capacity.

6.8 Issues Specific to Religion, Ethnicity or Culture

- 6.8.1 The ethnic, religious, sexuality and cultural background of patients can make the needs of intimate examinations unique, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others. Patients undergoing examinations should be allowed the opportunity to limit the degree of nudity by, for example, uncovering only that part of their body, which requires investigation or imaging. Wherever possible, particularly in these circumstances, a same faith or sexuality healthcare practitioner should perform the procedure.
- 6.8.2 The examination cannot proceed if the healthcare professional is unsure that the patient understands due to a communication barrier. Where a barrier in communication is anticipated, every effort should be made to have an interpreter available. If the interpreter is also acting as chaperone, they must be aware of this and in full agreement but this may not always be appropriate.

6.9 Anaesthetised / Unconscious Patients

- 6.9.1 Informed consent must be obtained prior to the patient being anaesthetised, usually in writing for the intimate examination / undertaking of intimate procedures. If students are being supervised, undertaking an intimate examination/procedure, the supervising Consultant / Registrar must ensure informed consent has been obtained from the patient prior to them undertaking any intimate examination / procedure under anaesthesia and that this is clearly documented.
- 6.9.2 If the patient is unconscious their privacy and dignity must still be maintained. Consideration should be given to ensure staff who are conducting intimate procedures do so when a colleague is present. It is likely in these circumstances assistance will be necessary e.g. assisting with catheterising the patient / administering an enema.

6.10 Communication and Record Keeping

- 6.10.1 Poor or no communication between a health professional and a patient can create anxiety and distress for patients. It is therefore essential an explanation is given to the patient on the nature of any intimate examination in a language and format they can easily understand, 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.
- 6.10.2 Details of the examination (including the presence or absence of a formal chaperone and their details which includes full name, role and contact number) must be documented in the patient's record.

6.11 Raising Concerns

- 6.11.1 If the chaperone or patient becomes concerned during the examination they have the right to ask the procedure is ended.

- 6.11.2 If the patient wants to raise any concerns at the time, about the procedure they should be referred to the most senior member of staff in the department/ward/team who has not been involved in the procedure.
- 6.11.3 If the patient wants to raise concerns after the procedure/examination/care they should be sign posted to the PALs team.
- 6.11.4 If the chaperone has any concerns about the procedure they should raise them with the most senior member of staff in the department/ward/team who was not involved with the procedure, and they should complete a Datix form.
- 6.11.5 Each Trust employee has a responsibility to inform their manager if they have concerns another worker is or has been mistreating a child or adult. All such concerns must be immediately reported to the line manager or senior manager/executive director. The procedures laid out in the Staff / Patient Relationships and the Prevention of Abuse Policy and the Whistleblowing Policy will then be followed.

7 MONITORING COMPLIANCE AND EFFECTIVENESS

- 7.1 The PALS/Complaints Department will monitor for any concerns raised where application of this guidance would have improved patient experience and will address these with the relevant departments.
- 7.2 Ward /Department/team managers must locally review their staff knowledge and application of this policy through spot checking staff knowledge, documentation and use of chaperones. Information from this spot check will be reviewed by local Best Practice Groups and feedback to the Divisional Governance Groups, for learning and further action planned if required.
- 7.3 All incidents and feedback related to chaperoning will be reviewed and discussed at the Directorate Governance Groups and learning and good practice fed back to the appropriate Best Practice Groups.

8 TRAINING AND COMPETENCY REQUIREMENTS

- 8.1 All staff involved in chaperoning patients must be aware of this policy.
- 8.2 All healthcare support workers who undertake chaperoning duties as part of their role must have a comprehensive introduction to the role by the healthcare professional they are supporting. Their understanding of the process must be assessed using the competency assessment in Appendix A.

9 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling.

Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale.

The Shipman Inquiry.

General Medical Council Intimate examinations and chaperones (2013)
www.gmc-uk.org/guidance/ethical_guidance

Attitudes of patients towards the use of chaperones in primary care - Whitford DL, Karin M, Thompson G. British Journal of General Practice 2001; 51:381-3.

Clinical Governance Support Team - Guidance on the Role and Effective Use Chaperones in Primary and Community Care settings - Model Chaperone Framework (June 2005).

Patient Dignity & Privacy-Intimate examination/procedures (DoH, Letter from Liam Donaldson, Jan 2003)

Royal College of Nursing (2006) Chaperoning the role of the nurse and the rights of patients Guidance for nurses

NHS Clinical Governance Support Team (2005) - Model chaperone framework

Myles Bradbury report (2015) Verita Consultations LLP

Cross reference to other procedural documents

Being Open and Duty of Candour Policy

Complaints, Concerns and Compliments

Consent and Capacity to Consent to Treatment Policy

Deprivation of Liberty Safeguards Policy

Privacy, Dignity and Respect Policy

Staff/Patient Relationships and the Prevention of Abuse Policy

Untoward Events Reporting Policy

Whistleblowing Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

COMPETENCIES FOR CHAPERONING

The competencies are to be used in conjunction with: NA

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners, to ensure safe practice in Chaperoning.

Once the practitioner has reached a satisfactory level of competence following a period of supervised practice, ensure they are formally competency assessed within three months of completing the initial theoretical/practical training.

The self-rating scale is to be used by the individual practitioner for self-assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Only Registered Practitioners can be identified as assessors for chaperoning.

Author: Operational Service Manager, Somerset-wide Integrated Sexual Health Service

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Assessment of Competence in the use of Chaperoning

I confirm that I have self-assessed as competent to practice (insert skill) as below:

Practitioner Name:

Practitioner Qualification:

Practitioner Signature: Date:

I confirm that I have assessed the named practitioner above as competent to perform the above skill.

Name and Title:

Signature: **Date:**

Upon successful completion of your assessment of competency please give a copy to your line manager and retain a copy for your records.

Knowledge and Skills for Chaperoning		Self Assessment	Formal Assessment	
		Date and Comments	Signature	Date and Comments
1	What is meant by the term chaperone?			
2	What is your understanding of equality and diversity issues in relation to chaperoning?			
3	What is an intimate examination?			
4	Explain why a chaperone may need to be present and how this would be documented			

Knowledge and Skills for the use of Chaperoning		Self Assessment	Formal Assessment	
		Date and Comments	Signature	Date and Comments
5	What are the rights of the patient in relation to having a chaperone?			
6	What is your role and responsibilities in relation to chaperoning?			
7	What is your understanding of capacity and consent in relation to chaperoning and how would this be documented?			
8	What is the mechanism for raising any concerns regarding chaperoning and how would this be documented?			