CHAPERONE POLICY

POLICY

Reference	CPG-TW-CP		
Approving Body	Maternity and gynaecological governance		
Date Approved	11th October 2021		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	4th November 2021		
Version	6.0		
Summary of Changes from Previous Version	Scheduled review/ update undertaken, no practice changes.		
Supersedes	v5.0, Issued 28th March 2018 to Review Date Oct 2021 (ext[1])		
Document Category	• Clinical		
Consultation Undertaken	Maternity and gynaecological governence		
Date of Completion of Equality Impact Assessment	October 2021		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	Not Applicable		
Target Audience	Trustwide		
Review Date	October 2024		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Ward Leader, Gynaecology – Louise Morgan		
Lead Division/ Directorate	Women and Children		
Lead Specialty/ Service/ Department	Gynaecology		
Position of Person able to provide Further Guidance/Information	Ward Leader, Gynaecology		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
None	N/A
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

It is a duty of the Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) to ensure that patients and the public are protected and cared for in a safe and appropriate environment.

This policy specifically applies to all patients undergoing 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 Health Care Professionals need to be aware of cultural differences and what may constitute an intimate examination.

2.0 POLICY STATEMENT

This policy is intended to safeguard the dignity, rights, safety & well-being of patients and staff throughout consultation, examination, treatment and care.

This clinical document applies to:

Staff group(s)

- This policy is applicable to all health professionals and carers directly employed by Sherwood Forest Hospitals NHS Foundation Trust whether working on Trust premises or in the community. Registered Health Professionals working at the Trust employed by other organisations for example other health care professionals, staff with honorary contracts and locum or agency staff will be required to adhere to the policy.

Clinical area(s)

- This policy applies to patients being cared for in all in-patient /out-patient settings including adult and paediatric areas, Community/ Newark hospitals; maternity areas; assessment areas; emergency department

Patient group(s)

- The policy is applicable to all adult, maternity and paediatric patients

Exclusions

- There are no exclusions within the policy

3.0 DEFINITIONS/ ABBREVIATIONS

SFHT:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
Registered Health Professionals:	All employees of the Trust holding a professional qualification, which is registered with a national body agreed by law
Clinician:	The health professional responsible for the current episode of care or intervention
Chaperone:	An individual able to support patient in an informed but impartial way
HCP:	Health Care Professional
ISHS:	Integrated Sexual Health Services

4.0 ROLES AND RESPONSIBILITIES

4.1 Clinician

The clinician responsible for the care of the patient at that time should make an assessment of the need for a chaperone and offer this to the patient. The chaperone should record in the patient's notes their name and designation (or additional member of the team) present during an examination or clinical interaction, in whatever role but also acting as a chaperone.

The clinician is responsible for explaining the procedure to be undertaken and obtaining verbal or non-verbal consent to proceed (see Consent Policy). The clinician should, as in every situation, be prepared to discontinue the procedure if requested to by the patient.

If the offer of a chaperone is declined by the patient this should be documented in the patient's notes. If the clinician does not want to proceed with the examination in the absence of a chaperone the patient should be advised of this and asked to reconsider or accept an appointment with another clinician, if appropriate, or reach another compromise.

The clinician should consider the need for verbal consent as part of this process (refer to Consent Policy for guidance, if the patient's mental capacity is in question you must follow the Mental Capacity Act.)

4.2 Chaperone

Ideally the chaperone will be a member of the clinical team. They should introduce themselves to the patient and inform them of their position within the clinical team.

The chaperone will assess the level of physical and emotional support needed by the patient and remain with them throughout the procedure.

The chaperone should record in the patient notes any specific care or observations they have made during the procedure and sign their name and designation.

5.0 APPROVAL

This policy has been approved by the Maternity & Gynaecology Clinical Governance Group

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Overview

See Appendix A – Chaperone policy -Quick reference guide which highlights the salient points of the guidance.

All patients are vulnerable at some stage during consultation, examination, treatment or care. The protection, safety, privacy and dignity of both patients and staff within the organisation are of paramount importance.

Patients have the right to request a trusted adult (i.e. partner, family member, friend or health care worker) to be present whilst any consultation, examination, care or treatment takes place. The clinician (health care professional) also has the right to request a chaperone where they consider they may be placed in a vulnerable or compromised position. Chaperones should be used primarily for the protection and comfort of patients.

Whilst only the patient can judge if they would feel more comfortable with a chaperone present, it is the clinician's responsibility to assess whether a chaperone needs to be included in an episode of care and to make the necessary arrangements in consultation with the patient.

Effective communication is essential in avoiding misunderstandings and putting patients at their ease in situations where they may feel embarrassed or vulnerable.
When the chaperone is a nurse or another member of the health care team, they can act as an advocate and assist patients with their understanding of the examination or procedure and the reasons why certain treatments or interventions are required.
They can assess the patients understanding of the situation and act as a reassuring presence.

Health professionals should always consider the presence of a chaperone when undertaking intimate examinations and procedures to avoid misunderstanding and, in rare cases, false accusations of abuse.

The use of a chaperone is a matter of patient choice and clinical judgement, it brings both advantages and disadvantages which should be considered when assessing the need for their use.

6.2 Advantages

A chaperone:

- may provide comfort to the patient enabling them to relax more during the procedure this may be achieved by e.g. hand holding (if the patient explicitly agrees to this), eye contact, distraction,
- is a safeguard for the patient against abuse during examination,
- can act as a safeguard against a clinician causing unnecessary discomfort, pain, humiliation or intimidation during an examination,
- can communicate and maintain eye contact with a patient whilst the clinician performs a procedure,
- can assist with dressing and undressing and positioning a patient when required,
- protects clinician against false allegation by patient,
- may be present in a clinical role as well as a chaperoning one to facilitate the procedure etc. being undertaken by the clinician.

6.3 Disadvantages

The presence of a chaperone may:

- inhibit the patient confiding deeply sensitive information such as sexual abuse, particular lifestyle choices, previous terminations, patients undergoing sexual health interviews [within ISHS] or domestic violence - the patient should normally be interviewed without a health care chaperone present unless they or the clinician specifically request one, to allow for a confidential discussion to occur.
- Intrude in a confiding clinician – patient relationship,
- Lower clinicians acuity in detecting non-verbal signs of distress,
- Increase the sense of embarrassment the patient feels.

6.4 Further considerations

The following is to be taken into consideration by all health care professionals:

- Does the procedure involve an intimate examination, especially genital, rectal or breast examination?
- Do not assume you do not need a chaperone if you are the same sex as the patient
- There are no upper or lower age limits
- Take cultural sensitivities into account
- Do not make assumptions about the preferences of different groups of patients e.g. age, sex, race etc.?
- Trust your instincts if you feel uncomfortable yourself or your patient seems unduly reluctant to be examined; arrange for a chaperone or suggest they see another clinician.
- Within the trust the patient may undergo examination for instance within a department where the patient notes are not available to make an entry regarding the presence of a chaperone, for example in X-Ray or scan. In this instance the information should be recorded as part of the examination report.

6.5 Choice of chaperone

Ideally the chaperone will be selected from the clinical team and be sufficiently familiar with the procedure to be undertaken to be able to adequately support the patient and anticipate where and when additional intervention or explanation needs to be given.

Patients may request to be accompanied by a family member or trusted friend. Whilst these individuals may fulfil the role of chaperone the following issues should be considered:

- Could the presence of another family member or friend result in a breach of patient confidentiality?
- Might the patient be being coerced into having the person present?
- Could the individual impact adversely on the patient's experience by bringing their own agenda, fears and prejudices to the fore?
- Does the presence of another family member reduce the likelihood of disclosure of sensitive information?
- Does the presence of a parent delay the development of self confidence in young people?
- Would the presence of a dominant male inhibit communication particularly related to gynaecological or obstetric history, marital or sexual problems or domestic violence?
- If no other member of the team is present the clinician may be "doubly" vulnerable to accusations of abuse or inappropriate behaviour or physical intimidation, they should have the right to request the presence of a fourth party in the room.
- Health & safety considerations should be taken into account at all times for example radiological procedures.

6.6 Good Practice

All clinicians should follow principles of good practice.

- All patients regardless of age, gender, ethnic background, culture, sexual orientation or mental status have the right to have their privacy and dignity respected.
- Patients should be offered a chaperone or invited to have a relative or friend present with them during any examination or procedure. Their personal preference should be recorded in the clinical notes.
- A full explanation of the examination, procedure or treatment to be carried out should be given to the patient allowing them to exercise their rights to request the presence of a chaperone. Always check to ensure the patient has understood the information; this can be achieved by asking a question testing the patients understanding (refer to Consent Policy for further information).
- If the patient prefers to undergo the examination/procedure without the presence of a chaperone, the decision must be respected unless the clinician does not feel able to concur with this request (see above) or a further member of the team is required to assist with the procedure. The patient's request not to have a chaperone present should be clearly documented in the patient's records, by the responsible clinician. If the clinician feels that he/she needs a chaperone to be present, then one should be

made available and this should be discussed with the patient. If the patient declines to proceed, the patient should be offered another appointment with another clinician, if possible, or a resolution negotiated by the line manager.

- Patients should be informed if a chaperone is unavailable (either due to unforeseen circumstances or emergency situations) they should be asked if they consent to the examination/procedure going ahead without a chaperone or they would prefer to postpone until one is available. This should also be clearly documented in the patients' notes, by the responsible clinician.
- Patients should be encouraged to maintain their independence as far as is practical, for example undressing themselves, however assistance should be offered.
- A culture of openness between patients and health care professionals should actively be encouraged.
- Details of the examination, date, name and grade/status of the examiner, including signature and also the name of the chaperone must be clearly written in the medical notes.
- Written notices should be clearly displayed within the organisation informing patients of the availability of chaperones.

6.7 Additional guidance in the case of children

Most children and young people will be accompanied by a parent or carer who can chaperone the clinician. If not present, consider delaying the examination / procedure until they are able to be present.

It is considered best practice for a suitably experienced staff member to undertake the role of chaperone in the following circumstances:

- Examination for child protection procedures,
- Perineal examination in the assessment of patients with sexual, genitourinary and elimination disorders,
- During or post puberty,
- Where children are not accompanied by an individual with parental responsibility but are deemed to be competent or where the individual with parental responsibility is thought to be ineffectual or unreliable. (Consideration must be given to safe guarding/child protection issues

6.8 Religion, Ethnicity or Culture

The ethnic, religious and cultural background of patients may be particularly challenging, as 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 the anatomy that requires investigation or imaging. Wherever possible, particularly in these circumstances, a same sex healthcare practitioner should perform the procedure.

Health professionals should seek to reassure patients, and limit the degree of nudity and uncover only the part of the anatomy that is to be examined.

It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a communication barrier. If an interpreter is available they may be able to double as an informal chaperone. (This can also be either an informal or formal chaperone that has the skills to translate accurately) In life saving situations, every effort should be made to communicate with the patient by whatever means available before proceeding with the examination.

Language barriers may also be an issue if the healthcare professional is unsure of the patient's understanding. The Trust would advocate use of the interpreter service wherever possible.

Caution should be exercised in the case of intimate examinations.

In every case the health professional should be able to demonstrate, if challenged, that they have taken all reasonable steps to protect themselves and the patient from allegations of improper behaviour.

6.9 Consent and 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 to enable them to make the decision and
- not be acting under duress

If the patients capacity is in question when explaining to the patient about the proposed medical intervention then you must follow the Mental Capacity Act- by assessing the patient's capacity using the 2 stage test, then following the Best Interests Framework. Your MCA assessment and best interest plan must be documented. Please refer to the Trust's Mental Capacity Act policy.

6.10 Issues Specific to Vulnerable patients (Learning Disabilities / Mental Health)

The majority of vulnerable adults will be able to consent to the procedure and need for a chaperone. For some vulnerable patients such as those with learning disabilities or mental health problems that may affect their capacity, a familiar individual such as a named family member or professional Carer / HCP may be the best formal chaperone. This must be agreed and documented with the individual and the family member /Carer as part of the overall best interest decision making process (See section 5.9)

These patient groups may be more at risk of vulnerability and as such, may experience heightened levels of anxiety, distress and misinterpretation. Due to these additional vulnerabilities there may be concerns about how the patient will tolerate:

- The initial physical examination
- Intimate “touch”
- Verbal and other “boundary-breaking” circumstances.

A careful, simple and sensitive explanation of the technique is vital in these circumstances, using whatever means possible at an appropriate level for the person i.e. easier read information, pictorial information, showing equipment to be used. If the patient is having an elective examination a person familiar to the patient should be involved in the best way to plan (best interests meeting). If the patient is known to the mental health team or learning disability nurse they could be contacted in advance to provide advice and specialist input regarding the planning of intimate procedures and the support individuals will require.

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.

Adult patients with learning disabilities 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. If the patient lacks capacity another best interests meeting may be needed to plan next steps.

6.11 Guidance for lone workers

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.

In cases where this is not an option, for example due to the urgency of the situation or because the practitioner 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.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS – monitoring against this policy will be through line managers /clinical leads and divisional governance forums.

Monitoring will be in place in relation to the numbers of clinical incidents, complaints and safeguarding issues relating to the policy which will be reported through the Quality & Governance Unit.

Divisions will be required to monitor compliance against the policy at an operational level and report through their respective divisional governance systems. Actions as a result of incidents/complaints will be documented and acted upon.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used)**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Availability of Chaperones	Line managers /Clinical leads	Encourage Datix reporting in lack of chaperone availability. Action log at Divisional governance forums/Service line meetings.	Monthly	Divisional governance/Service line meetings.
The Identity and presence of chaperone in documentation	Individual undertaking examination	Audit of medical records/patient notes by data quality	Quarterly	Divisional governance.

8.0 TRAINING AND IMPLEMENTATION

All New staff will be made aware of requirements of this policy at departmental induction.

Any changes to the policy will require briefing through line management arrangements and update via the trust intranet.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix B
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Reference Guide to Consent, Examination or Treatment ,Department of Health 2009
- Maintaining boundaries, General Medical Council, November 2006
- RCN - Chaperoning -The Role of The Nurse and The Rights of The Patient - Guidance for nursing staff ,2003 [reprint 2006]. Publication number 001 446
- NMC -The Code: Standards of conduct, performance and ethics for nurses and midwives 2015
- Gynaecological examinations –guidelines for specialist practice RCOG July 2002
- GMC intimate examinations 2013
- Requirement for use of chaperones policy Version 4; Cambridge University Hospitals NHS Foundation Trust 2016

Related SFHFT Documents:

- Policy for consent to examination, treatment and care
- Safeguarding children and young people policy
- Safeguarding adults policy
- Mental Capacity Act Policy
- Deprivation of Liberty Safeguards Policy

11.0 KEYWORDS

Chaperoning, dignity, accompany patient, intimate examination, examinations, procedure, procedures, treatment and care, cultural differences

12.0 APPENDICES

Appendix A – Chaperone Policy: Quick Reference Guide
Appendix B – Equality Impact Assessment Form

Appendix A – Chaperone Policy: Quick Reference Guide

CHAPERONE POLICY : QUICK REFERENCE GUIDE FOR CONSULTATION INVOLVING INTIMATE INVESTIGATION OR 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 prior to commencement.
• 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 medical 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 times.

APPENDIX B – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Chaperone Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: October 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	N/A	N/A
Gender	None	N/A	N/A
Age	None	N/A	N/A
Religion	None	N/A	N/A
Disability	None	N/A	N/A
Sexuality	None	N/A	N/A
Pregnancy and Maternity	None	N/A	N/A
Gender Reassignment	None	N/A	N/A
Marriage and Civil Partnership	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? • None			
What data or information did you use in support of this EqIA? • None			
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • None			
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: **Low Level of Impact** For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.			
Name of Responsible Person undertaking this assessment:			
Signature: Louise Morgan			
Date: October 2021			