Chapelgreen Practice

Chaperone Policy

Version No	Type of Change	Date	Description of Change
V1.2	Edit	01/03/2024	Insertion of reference to DBS checks for formal chaperones.
Review Date: March 2026			

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1. Introduction

Chapelgreen Practice is committed to providing a safe, comfortable environment where the safety of patients and staff is of paramount importance. A key issue to be addressed is the need for patients experiencing consultations, examinations and investigations to be safe and to experience as little discomfort and distress as possible. Equally health professionals are at an increased risk of their actions being misconstrued or misrepresented if they conduct examinations where no other person is present and must minimise the risk of false accusations of inappropriate behaviour.

2. Principles of Good Practice

Patients may find any examination distressing, particularly if these involve the breasts, genitalia or rectum (known as “intimate examinations”). Also consultations involving dimmed lights, close proximity to patients, the need for patients to undress and being touched may make a patient feel vulnerable.
Chaperoning may help reduce distress but must be used in conjunction with respectful behaviour which includes explanation, informed consent and privacy.

3. Consent

In attending a consultation it is assumed that a patient is seeking treatment and therefore is 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 for it to take place.

4. What is a chaperone?

A chaperone is present as a safeguard for both parties (patient and healthcare professionals) and is a witness to the conduct and the continuing consent of the procedure.
The precise role of the chaperone varies depending on the circumstances. It may include providing a degree of emotional support and reassurance to patients but more commonly incorporates:

- Providing protection to healthcare professionals against unfounded allegations of improper behaviour.
- Assisting in the examination or procedure, for example handing instruments during IUCD insertion

- Assisting with undressing, dressing and positioning patients

Under no circumstances should a chaperone be used to reduce the risk of attack on a health professional.

5. Who may Chaperone?

5.1. Informal Chaperones

Many patients feel reassured by the presence of a familiar person and this request in almost all cases should be accepted. This informal chaperone may not necessarily 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. It is inappropriate to expect an informal chaperone to take part in the examination or to witness the procedure directly.

5.2. Formal chaperones

A ‘formal’ chaperone implies a clinical health care professional, such as a nurse or a healthcare assistant. 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 chaperone. It is important that chaperones have had sufficient training to understand the role expected of them and that they are not expected to undertake a role for which they have not been trained for. The formal chaperone will have undertaken a formal DBS check.

Protecting the patient from vulnerability and embarrassment means that the chaperone would usually be of the same sex as the patient. There will be occasions when this is difficult to achieve. If the patient is requesting a male chaperone then a male GP can be called upon to act as the chaperone or the patient can be offered to rebook their appointment with a male GP.
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 justifiable reason.

6. Training for chaperones

Members of staff who undertake a formal chaperone role should undergo training. This should include an understanding of:

- What is meant by the term chaperone
- The specific details of different types of intimate examinations

- The rights of the patient
- Their role and responsibility
- Policy and mechanism for raising concerns

Introduction of new clinical staff should include the above training.

7. Offering a chaperone

The relationship between a patient and healthcare professionals is based on trust. A practitioner may have no doubts about a patient they have known for a long time and feel it is not necessary to offer a formal chaperone. However this should not detract from the fact that any patient is entitled to a chaperone if they feel one is required.
It is good practice to offer all patients a chaperone of the same sex for any examination or procedure. If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined.
Staff should be aware that intimate examinations might cause anxiety for both male and female patients whether or not the examiner is of the same gender.
If a chaperone is refused, a healthcare professional cannot usually insist that one is present. However, there may be cases where the practitioner may feel unhappy to proceed, for example where there is a significant risk of the patient displaying unpredictable behaviour, or making false accusations. In this case, the practitioner must make his/her own decision and carefully document this with the details of any procedure undertaken.

8. 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 timeframe (this may include simple waiting in the practice until a member of staff is available). 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 must 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 be documented in the patient's notes.
It is acceptable for a healthcare professional 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 also be recorded in the patient's notes.

9. Issues specific to children

Children and their parents or guardians must receive an explanation of the procedure in order to obtain their co-operation and understanding. 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 an examination.
In these cases it is advisable for a formal chaperone to be present for any intimate examinations.
In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse. In these situations healthcare professionals should refer to the local child protection policies and seek advice from the Child Protection Lead/Team as necessary.

10. Issues specific to religion, ethnicity, culture and sexual orientation

All 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. Some patient's ethnic, religious, cultural background and sexual orientation can make intimate examinations particularly difficult. For example, Muslim and Hindu women may have a strong cultural aversion to being touched by men other than their husbands, or a lesbian woman or likewise a gay man may possibly have an aversion to intimate examinations being performed by the opposite gender. These considerations should be taken into account and discussed, not presumed. We must recognise that each individual has very different needs and before the procedure these should be mutually agreed with the healthcare professional.

11. Issues specific to people with learning difficulties and 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 simple and sensitive explanation of the technique is vital. This patient group is a vulnerable one and issues may arise with physical examination.
Adult patients with learning difficulties or mental health problems who resist an examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. In life-saving situations the healthcare professional should use their clinical judgement. Where possible the matter should be discussed with a member of the Mental Health Care Team.

12. Non English speaking patients

In the situation of a non English speaking patient being examined the use of an independent interpreter should be enlisted. The use of a formal chaperone may still be appropriate with the interpreter in the room. A family member or interpreter should not be used as a formal chaperone.

13. Lone working

Where a healthcare professional is working in a situation away from other colleagues, for example during a home visit, the same principles for offering and use of chaperones should apply. 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. In all instances the outcome must be documented.

14. Patient confidentiality

In all cases where the presence of a chaperone may intrude in a confiding clinician-patient relationship their presence should be confined to the physical examination. Communication between the healthcare professional and the patient should take place before and after the examination or procedure.

15. Communication and record keeping

The key principles of communication and record keeping will ensure that the healthcare professional and 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 the failure in communication between both parties, either in the practitioner's explanation or the patients understanding in the process of examination or treatment. It is essential that the healthcare professional explains the nature of the examination and offers them a choice whether to continue. Chaperoning in no way removes or reduces this responsibility. Details of the examination including the presence or absence of a chaperone and the information given must be documented in the patient's clinical record. The records should make

clear from the history that the examination was necessary. In any situation where concerns are raised or an incident has occurred this should be dealt with immediately in accordance with the Incident Reporting Procedure.