Chaperoning Policy

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
</tr>
<tr>
<td>Ratified by:</td>
</tr>
<tr>
<td>Date ratified:</td>
</tr>
<tr>
<td>Name of originator/author:</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
</tr>
<tr>
<td>Date issued:</td>
</tr>
<tr>
<td>Review date:</td>
</tr>
<tr>
<td>Target Audience</td>
</tr>
</tbody>
</table>
## CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>2. PURPOSE</td>
<td>3</td>
</tr>
<tr>
<td>3. SCOPE</td>
<td>3</td>
</tr>
<tr>
<td>4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>4</td>
</tr>
<tr>
<td>4.1 Board of Directors</td>
<td>4</td>
</tr>
<tr>
<td>4.2 Health Care Professionals</td>
<td>4</td>
</tr>
<tr>
<td>4.3 Matrons/Managers</td>
<td>4</td>
</tr>
<tr>
<td>4.4 Chaperones</td>
<td>4</td>
</tr>
<tr>
<td>5. PROCEDURE/IMPLEMENTATION</td>
<td>5</td>
</tr>
<tr>
<td>5.1 Mental Capacity</td>
<td>5</td>
</tr>
<tr>
<td>5.2 Using a Chaperone</td>
<td>5</td>
</tr>
<tr>
<td>5.3 Issues Specific to Religion, Ethnicity or Culture</td>
<td>6</td>
</tr>
<tr>
<td>5.4 Lone Working</td>
<td>6</td>
</tr>
<tr>
<td>5.5 Issues specific to patients who are lacking mental capacity</td>
<td>7</td>
</tr>
<tr>
<td>5.6 Examination of Children under 16 years of Age</td>
<td>7</td>
</tr>
<tr>
<td>6. TRAINING IMPLICATIONS</td>
<td>7</td>
</tr>
<tr>
<td>7. MONITORING ARRANGEMENTS</td>
<td>8</td>
</tr>
<tr>
<td>8. EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>8</td>
</tr>
<tr>
<td>8.1 Privacy, Dignity and Respect</td>
<td>8</td>
</tr>
<tr>
<td>8.2 Mental Capacity Act</td>
<td>9</td>
</tr>
<tr>
<td>9. LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>9</td>
</tr>
<tr>
<td>10. REFERENCES</td>
<td>10</td>
</tr>
<tr>
<td>11. APPENDICES (none)</td>
<td>10</td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

The relationship between a patient and their healthcare professional is based on trust. The healthcare professional may have no doubts about a patient they have known for a long period of time and feel it is not necessary to offer a formal chaperone. This should not detract from the fact that any patient is entitled to the right to request/be offered a chaperone, of the same sex, being present during any consultation, within the boundaries of each individual service or planned appointment made and especially when undergoing any procedure or examination.

The role of a chaperone can vary, depending on the needs of the patient, and can be classed as informal or formal.

**Informal Chaperone**

Many patients may feel reassured by the presence of a familiar person i.e. a family member of a friend and this in almost all cases should be accepted, the Chaperone will be there to provide emotional support and reassurance to the patient/service user. It is inappropriate to expect an informal chaperone to take an active part in the examination or to witness the procedure directly.

**Formal Chaperone**

A formal Chaperone implies a clinical health professional. This person will have a specific role to play in the consultation and this role should be made clear both to the patient and the person undertaking the chaperone role. This role may include assisting with undressing or assisting in the procedure. In this situation, the chaperone should have sufficient understanding to undertake the role expected of them.

The patient should be given the opportunity to state their preferences in relation to the sex of the chaperone. This must be documented in their health records.

The patient should have the opportunity to decline a particular person if that person is not acceptable to them for any reason. They must then decide if they wish the examination to proceed or be re-scheduled and this documented decision should be recorded in their health records.

2. **PURPOSE**

The purpose of this policy is to raise staff awareness for the use of chaperones and provides the procedure to follow for the protection of both patient and healthcare professional.

3. **SCOPE**

This policy applies to all healthcare professionals working within in-patient or community settings.
4. RESPONSIBILITIES, ACCOUNTABILITIES and DUTIES

4.1 Board of Directors

The Board of Directors have the responsibility that the Trust has policies and procedures in place to provide best practice. The Lead Director with responsibility for this policy is …

4.2 Health Care Professionals

The patient/service user should be offered a chaperone, to be present with them during the consultation/examinations/procedure.

4.3 Matrons/Managers

Matrons/managers are responsible for making staff aware of:-

- this policy and their responsibilities.
- that staff are competent and have the knowledge and skills to undertake the role of a chaperone as detailed below.

4.4 Chaperones

The Ayling Report (Department of Health 2004) found that there was no common definition of the role of a chaperone. The role can vary depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out. A chaperone acts as a safeguard for the patient and healthcare professional and is a witness to continuing consent of the procedure/examination. A chaperones role can include:-

- Always respect and maintain the privacy and dignity of the patient
- Provide emotional comfort and reassurance
- Be courteous
- Encourage questions
- Be alert for any signs of distress from the patient - verbal and non-verbal
- Be able to observe the examination/procedure
- Assist in the procedure if required to do so
- Act as the patients advocate/interpreter
- Identify unusual or unacceptable behaviour on the part of the healthcare professional and question or raise concerns at the time and /or with their line manager who may then make a referral under Safeguarding Adult Procedures. (Refer to the Trusts Safeguarding Adults Policy and Multi-Agency Procedures for detailed guidance)
- Assist with undressing/dressing, if requested
- Help the patient to understand what is being communicated to them
5. **PROCEDURE/IMPLEMENTATION**

5.1 **Mental Capacity**
There is a basic assumption that every adult has the capacity to decide whether to consent to or refuse a proposed intervention, before proceeding with an examination it is vital that the patient’s consent is gained.

This means that the patient must:

- Have capacity to make the decision
- Have received sufficient information and
- Not be acting under duress

5.2 **Using a Chaperone**

All patients have the right to have their privacy and dignity respected.

Any consultation, examination, procedure, treatment or care that is of an intimate nature, will be practised in a sensitive and respectful manner. Obvious examples of an intimate examination include examination of the breasts, genitalia and the rectum, but it also extends to any examination where it is necessary to touch or be close to the patient. This will take into account personal preferences, cultural, religious wishes of patients/service users, and ensuring wherever possible misinterpretation or misunderstandings do not occur.

If a chaperone is present to witness an examination/procedure being undertaken they must stand in a position whereby they can see the examination/procedure being carried out, to provide assurance that it has been conducted appropriately.

Therefore a chaperone in this situation will be a formal chaperone (another member of staff competent to fulfil this role).

If the patient prefers to undergo an examination/procedure without the presence of a chaperone, wherever possible this should be respected. This should be recorded in their health records as long as the following is satisfied:

- The patient is capable of making that decision and has the capacity to do so (this should be documented in the patient’s record and formally recorded on an MCA1 (Mental Capacity Assessment Form). Staff should refer to the Trust Mental Capacity Act 2005 Policy for guidance. See Section 5.5 for guidance regarding patients who lack capacity).
- It is in the interest of the patient
- The rights of the staff member and patient are considered and will not be compromised.
- If a decision is made to use a chaperone despite patient wishes, the patient must be given an explanation why.

If the situation is deemed an emergency, and the patient declines a chaperone,
it is acceptable to perform an intimate examination or procedure with or without a chaperone. This should be recorded in the patient's health electronic record. If a patient declines to have a chaperone present, but one is deemed to be necessary for safety reasons this will be explained to the patient/service user. If they continue to decline the presence of a chaperone the clinician will need to undertake an assessment of the level of risk should they proceed. It may be necessary to postpone the examination/procedure until advice can be sought, and to complete an IR1 form on the Trust’s Safeguard Reporting System. A culture of openness between patients/service users and health care professionals should be actively encouraged.

Details of any examinations/procedures should be recorded in the patient’s health record and the presence or absence of a chaperone recorded, including the name of the chaperone.

5.3 Issues Specific to Religion, Ethnicity or Culture

The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, so the background of patients must be taken into account, as some patients may have strong cultural or religious beliefs that restrict being touched by others.

If there is a language barrier it would be unwise for a procedure to take place if the healthcare professional is unsure that the patient understands what is going to happen. With the aid of an interpreter, staff should identify who the patient would like to act as a chaperone. Under normal circumstances family members/friends (and not a child) should not be asked to act as an interpreter or formal chaperone. However, a family member or friend may offer support as an informal chaperone.

5.4 Lone Working

Health care professionals are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present.

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 the use of chaperones should apply as previously identified in Section 1, where it is appropriate family members/friends may take on the role of informal chaperone. 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 or arrange for a colleague to attend the appointment alongside themself (double-up visit). Where this is not an option, for example due to the urgency of the situation, then good communication and record keeping are paramount.

For further guidance, see Lone Working Policy.
5.5 Issues specific to Patients who are lacking mental capacity

A familiar individual such as a family member or carer may be the best chaperone and be able to act as an advocate for patients with health problems that may affect capacity. Should the family member or carer wish to have a chaperone present, this should be provided for support also.

Adults 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 must be abandoned and an assessment should be made of whether the patient can be considered as having capacity or not.

If a patient lacks capacity, they should be treated according to his or her own best interests. The process of assessing best interests follows the format identified in section 4 of the Mental Capacity Act.

5.6 Examination of Children Under 16 years of Age

Before carrying out a procedure/examination on a child less than 16 years of age, verbal consent must be obtained from the child and from the parent/person with parental responsibility.

However if a child is assessed as being Gillick Competent and therefore has ‘sufficient understanding and intelligence to enable him or her to understand fully what is being proposed’ they can consent to an examination or procedure without parental involvement/consent.

For a child assessed as competent the same guidance relating to adults is applicable, including the option to decline a chaperone.

For a child assessed as not competent the practitioner will need consent to examine from the child’s legal guardian and it would be appropriate for both an informal and formal chaperone to be present.

In situations where abuse has been identified or is suspected, practitioners should follow child protection procedures in line with the Trusts Safeguarding Policy.

It is imperative that the child’s records evidence that this process has been followed, good record keeping is paramount.

6. TRAINING IMPLICATIONS

There is no specific training for staff who act as a chaperone. However, their knowledge and skills should be appropriate to support the procedure or examination being undertaken. These include having an understanding of:

- Why a chaperone needs to be present
- Their role as a chaperone
- Mechanism for raising any concerns
It is the responsibility of each clinical service to be satisfied that staff have a good level of understanding in relation to the above. Staff have a personal responsibility to identify that they have enough understanding and support to undertake this role.

7. **MONITORING ARRANGEMENTS**

<table>
<thead>
<tr>
<th>Area for Monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any feedback, complaints or Your Opinion Counts which relate to non-compliance with the standards in this policy</td>
<td>Investigation Feedback review</td>
<td>Matrons/Managers</td>
<td>Care Group Leadership and Quality Groups</td>
<td>Ongoing as the need arises</td>
</tr>
<tr>
<td>IR 1 Analysis</td>
<td>Any IR1 information relating to Chaperoning to be analysed in line with this policy</td>
<td>Matrons/Managers</td>
<td>Care Group Leadership and Quality Groups</td>
<td>As they occur</td>
</tr>
</tbody>
</table>

8. **EQUALITY IMPACT ASSESSMENT SCREENING**

The completed Equality Impact Assessment for this Policy has been published on this Policy’s Trust web page.

8.1 **Privacy, Dignity and Respect**

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).
8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

<table>
<thead>
<tr>
<th>Indicate how this will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)</td>
</tr>
<tr>
<td>The policy refers staff to mental capacity issues at section 5.1, 5.2 and 5.5</td>
</tr>
</tbody>
</table>

9. LINKS TO ANY ASSOCIATED DOCUMENTS

Policy for Consent to Examination or Treatment, Clinical Policies, RDaSH Intranet

Safeguarding Adults Policy, Clinical Policies, RDaSH Intranet

Safeguarding Children Policy, Clinical Policies, RDaSH Intranet

Mental Capacity Act 2005 Policy, Clinical Policies, Mental Capacity Act, RDaSH Intranet

Policy for the provision of, access to and use of interpreters for patients/service users and carers, Clinical Policies, General, RDaSH Intranet

Lone Working Policy, Security Policies, RDaSH Intranet

Safeguarding Adults, South Yorkshire’s ADULT Protection Procedures (Doncaster and Rotherham)

North East Lincolnshire Multiagency policy, Procedures and Practice Guidelines for the Protection of Vulnerable Adults

The Protection of Vulnerable Adults, Multiagency Policy, Procedures and practice guidelines for the Protection of Vulnerable Adults in North Lincolnshire

Multiagency Policy for Safeguarding Adults (Manchester)
10. REFERENCES


Tameside Hospital NHS Foundation Trust Chaperone Policy January 2012

Ashford and St Peter’s Hospital NHS Foundation Trust Chaperone Policy January 2012

Department of Health, September 2004 Committee of Inquiry – Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling

General Medical Council (GMC) (2013) Intimate examinations and chaperones.

11. APPENDICES

None