



Western Health
and Social Care Trust

Chaperoning Policy

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INTRODUCTION

This policy is intended to safeguard patients and staff of all ages, both genders and race, from misinterpretation of actions taken as part of consultation, examination, treatment and care.

Equality and Human Rights Statement

This Policy was fully equality and human rights screened. Some issues were identified and actions agreed to promote equality of opportunity. These are specified in sections 2.3 and 2.5 of the equality Screening document.

This Policy was not recommended for a full EQIA.

DEFINITION

A chaperone is someone in attendance who can offer reassurance and protection.¹

SCOPE OF POLICY

This policy applies to all NMC registered nurses, student nurses, health care assistants, allied health professionals, student allied health professionals, junior and senior medical staff, medical students and radiographers working with Individual patients in wards, departments, out-patient and clinic situations and patient home environments. The word 'nurse' is used to encompass registered Nurse, Midwife or Health Visitor.

The use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female. This policy covers patient consent and chaperone requirements in relation to all intimate examinations.

The following section (1.1- 1.22) of this policy gives important guidance that must be applied to the various situations where intimate examination is carried out.

Overarching Requirements

General issues

- 1.1 Patients must be prepared for examination by staff ensuring that adequate information and explanation is given as to why the examination or procedure is needed. Easily understood literature and diagrams where possible should be provided to support verbal information.

¹ Adapted from the Collins Shorter Dictionary and Thesaurus, Calendonian International Press Glasgow

- 1.2 Staff must be aware that intimate examinations may cause anxiety for both male and female patients whether the examiner is of the same gender as the patient or not. Intimate examinations include the examination of breasts external and internal female genitalia, penis scrotum and rectum. ² (Although other areas may also be classified as intimate by patients of diverse cultures e.g. chest or abdomen and could also include any examination where it is necessary to touch or even be close to the patient.) ³
- 1.3 A chaperone should be offered to all patients undergoing intimate examinations or procedures irrespective of gender of either the patient or the professional.
It is essential that the professional explains the nature of the examination to the patient and offers them a choice whether to proceed with that examination at that time.
If the patient prefers to be examined without a chaperone this request should be honoured.. Details of the examination and the absence of a chaperone should (if possible)⁴ be documented in the patients' medical records/notes indicating the patients reason for refusal, and the patient asked to sign a statement, if possible.

Consent

Consent is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it; and
- not be acting under duress.⁵

- 1.4 Valid Consent must be obtained relevant to the procedure being undertaken. The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. (see section 2.0 below)
- 1.5 For children under the legal age of consent (16 years), they and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and consent. There is a legal requirement to obtain consent from their legal guardian. However, in light of the Children Order (1995) and the Fraser principle, regard must be given to 'the ascertainable wishes and feelings of the child concerned considered in light of their age and understanding'.

² Good Practice in Consent – Student Health Professionals. (HSS/MD)28/2005

³ Staff must be sensitive to cultural diversities and respect what is classified as 'intimate' by the patient.

⁴ Some departments may not have access to patient records when carrying out examinations e.g medical imaging.

⁵ Good practice in Consent: Implementation guidance for health professionals. DHSS&PS (2003)

- 1.6 For patients with learning difficulties or mental illness, a familiar individual such as a family member or carer may be the best

chaperone. A careful simple and sensitive explanation of the technique is vital. Adult patients with learning difficulties or mental illness who cannot give consent and consequently resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. In life-saving situations further advice should be sought from a senior member of the Mental Health Care Team.

Environment

- 1.7 Attention must be given to the environment ensuring adequate privacy is afforded to maintain dignity.
- 1.8 Staff should be aware that darkened rooms for e.g. retinoscopy, ultrasound or other similar procedures, while not considered 'intimate examinations', may also lead some patients to feel vulnerable.

Role of the Chaperone

- 1.9 A chaperone should provide reassurance to the patient and may assist an infirm or disabled patient with dressing and undressing. The doctor or nurse undertaking the examination should offer assistance with undressing only if absolutely necessary.
- 1.10 The chaperone maintains communication and eye contact with the patient while the doctor's attention is focused on the examination. Some patients' level of embarrassment may increase in proportion to the number of individuals present.
- 1.11 Where the presence of a chaperone may intrude in a confiding doctor-patient relationship it should be confined to the physical examination. One-to-one communication should take place after the examination.
- 1.12 It is acceptable for a doctor (or other appropriate member of the health care team) 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 be recorded in the patients' medical records.
- 1.13 In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse. Staff should also acknowledge that some patients may perceive intimate examination as a repeat of the abuse.(in circumstances where sexual abuse is suspected, joint

medical examinations are usually carried out by the Trust Named Doctor for Child Protection and the Forensic Medical Examiner under Joint Protocol mechanisms).

Recommended chaperones

- 1.14 It is preferable to have a professional chaperone (eg. Nurse) but discussion with the patient about other appropriate chaperones may include consideration of advocates, relatives, friends or appropriately trained administration staff in certain circumstances.
- 1.15 In the case of children a chaperone would normally be a parent or carer with parental responsibility, alternatively once consent has been obtained it could be someone known and trusted or chosen by the child.
(Parental Responsibility is necessary in order to give consent on behalf of a child)

Examinations

- 1.16 There should be no undue delay prior to examination once the patient has removed any clothing.
- 1.17 During the examination/procedure:
- a) Explain to the patient what you are going to do before you do it and, if this differs from what you have already outlined to the patient, explain why and seek the patients permission;
 - b) Be courteous
 - c) Offer reassurance
 - d) Keep discussion relevant
 - e) Avoid unnecessary personal comments
 - f) Encourage questions and discussion
 - g) Remain alert to verbal and non-verbal indications of distress from the patient⁶
- 1.18 Any requests that the examination be discontinued should be respected.
- 1.19 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

⁶ Chaperone Policy: Isle of Wight Healthcare NHS Trust 2008.

investigation or imaging. Wherever possible, particularly in these circumstances, a trained female healthcare practitioner should perform the procedure.

- 1.20 Patient's should be given a choice whether they would like their relatives to be present during procedures.

Governance Issues

- 1.21 Induction of all new registered nurses, student nurses, health care support staff, allied health professionals, student allied health professionals, junior and senior medical staff, medical students and radiographers should include training on the appropriate conduct of intimate examination.
Trainees should be observed and given feedback on their technique and communication skills in this aspect of care.
- 1.22 Where a concern is raised regarding intimate examination this should be reported on the Trust's adverse incident form.

Best Practice Guidance for Intimate Examinations

- 2.1 Most patients will accept intimate examinations if the necessity for the procedure is explained and the examination is performed by a member of staff who is skilled, sympathetic and gentle.
- 2.2 Consent for intimate examination – verbal. This must be obtained prior to all examinations and following explanation, discussion and information giving. Consent for intimate examination – written. In the case of a woman who is a victim of an alleged sexual attack valid written consent must be obtained for the examination and collection of forensic evidence.
- 2.3 Intimate examination should never be carried out for non-English speaking patients without an interpreter/advocate (taking account of gender) being present (except in an emergency).
- 2.4 Intimate examination should take place in a closed room or well-screened bay that cannot be entered while the examination is in progress. Examination should not be interrupted by phone calls or messages.
- 2.5 Where appropriate a choice of position for the examination should be offered for example left lateral, dorsal, recumbent and semi-recumbent positions for speculum and bimanual examinations. This may reduce the sense of vulnerability and powerlessness complained of by some patients.

- 2.6 Once the patient is dressed following an examination the findings must be communicated to the patient. If appropriate this can be used as an educational opportunity for the patient. The professional must consider (asking the patient as necessary) if it is appropriate for the chaperone/advocate to remain at this stage.
- 2.7 Details of the examination including the absence of a chaperone and information given must be documented in the patient's medical records.

Student Health Professionals

- 3.1 Students from some healthcare professions will at times see, and may be expected to examine, intimate parts of patients' bodies. This includes breasts, external and internal female genitalia, penis scrotum and rectum.⁷
- 3.2 There are some situations where intimate examination by students is inappropriate, for example:
 - Where the patient is known to the student or vice versa.
 - Intimate examinations of adults who are incapable of giving or withholding consent.
 - Examination of the rectum of conscious children.
- 3.3 Where students carry out a physical examination of intimate parts of patients' bodies this should be carried out in appropriately structured, supervised and consented way.⁸
- 3.4 No patient should have an examination of his or her genitalia or rectum performed by more than one student at any one consultation without expressed consent in exceptional circumstances.
- 3.5 Irrespective of the gender of the supervising professional, examining student and the patient, a chaperone is necessary during all intimate examinations. A chaperone should be a member of staff.
- 3.6 The date, time and location of the examination, the names of the student, the supervising chaperone, and the consent obtained should be recorded in the patient's records.⁹

Chaperoning children

⁷ Good Practice in Consent – Student Health Professionals. (HSS/MD)28/2005

⁸ If you are supervising a student you should ensure valid consent has been obtained before they carry out any intimate examination.

⁹ Recording the name of the student, supervising chaperone and consent in the patient record is best practice but may not be applicable for all examinations.

Children and young people are a vulnerable client group due to their physical, emotional and psychological stage of development in relation to their age. *Reference should also be made to the Trust's Intimate Care Policy and Guidelines Regarding Children.*¹⁰

- 4.1 All children and young people have the right to have their privacy and dignity respected, regardless of their age. The use of a chaperone should be considered in the following circumstances
- undergoing examination for child protection procedures
 - when the patient is pubertal or post-pubertal
 - who are not accompanied by an individual with parental responsibility, or where this individual is thought to be ineffectual or unreliable
 - Details of the examination including the absence of a chaperone and information given must be documented in the patient's medical records.
- 4.2 Informed consent is required prior to carrying out any procedure, including routine care, on a child or young person as with any other client group. Guidance on what constitutes informed consent is available in the main body of the protocol.

This may be obtained from either the child or young person, or according to their age and level of understanding, from the person with parental responsibility for them.

In order to reflect the ethos of "Partnership in care" it is good practice to obtain consent from both the child or young person and the person with parental responsibility wherever possible.

- 4.3 As part of gaining informed consent, a child or young person should have the option explained to them of having another person present whilst they undergo the care or procedure. This may be a nurse, doctor, allied health professional, person with parental responsibility, relative or friend depending on the child's wishes. It is acknowledged that there may be situations where a family member or friend may not be the ideal chaperone. The Health Professional should be sensitive to this and offer the child or young person alternatives.

If they do not wish another person to be present during an episode of care or procedure the Health Professional must be sure that the child or young person is competent to make that decision. Wherever possible this should be discussed with the person with parental responsibility.

¹⁰ Western Health & Social Care Trust, Intimate Care Guidelines regarding Children (2009).

The Health Professional concerned must also ensure that they are happy with the child or young person's decision, and that considerations of advocacy are paramount in relation to the child or young person's well-being.

References

Adaptations from Isle of Wight NHS Trust Chaperoning Policy (2006)

Good Practice in Consent, Consent for examination, treatment or care. DHSS&PS, Handbook for the HPSS, (2003).

Good Practice in Consent: Implementation Guide for Health Professionals. DHSS&PS (2003).

Good Practice in Consent – Student Health Professionals. (HSS/MD) 28/2005

GMC – Maintaining Boundaries – Guidance for Doctors. (2011).

Regional ACPC Child Protection Policy & Procedures (2005).

Safeguarding Children – a Protocol for Health Professionals, Allied health Professionals and Health Care Staff in Child Protection, WH&SCT, (2009).

Western Health & Social Care Trust, Intimate Care Guidelines regarding Children (2009).