Patient Chaperoning Policy

February 2012
**Validation Grid**

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Patient Chaperoning Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of originator/author</strong></td>
<td>– Operational Manager Equality &amp; Diversity</td>
</tr>
<tr>
<td></td>
<td>– Lead Nurse Practice Development</td>
</tr>
<tr>
<td><strong>Update author</strong></td>
<td>– Lead Nurse Practice Development</td>
</tr>
<tr>
<td><strong>Target audience</strong></td>
<td>This policy applies to ALL staff and students who may be present during patient examinations or diagnostic interventions</td>
</tr>
<tr>
<td><strong>Commissioning body</strong></td>
<td>TNMC</td>
</tr>
<tr>
<td><strong>Stakeholders consulted</strong></td>
<td>TNMC, Clinical divisions via DND’s: SS; TMN; TI; UC CPG, Learning disabilities lead</td>
</tr>
<tr>
<td><strong>Clinical practice/Advanced practice</strong></td>
<td>Clinical practice</td>
</tr>
<tr>
<td><strong>Associated policies and guidelines</strong></td>
<td>Single Equalities Scheme, Privacy and Dignity Policy, Consent Policy, Uniform Dress Code Policy, Interpreting service operational policy, Standards for Better Health, core standards C2, C7e, C13, C16,C18 and C20b, Human Rights Act</td>
</tr>
<tr>
<td><strong>Guideline replacement</strong></td>
<td>Patient Chaperoning Policy February 2008</td>
</tr>
<tr>
<td><strong>Significant changes to practice</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Implementation plan</strong></td>
<td>Availability of updated guideline on Freenet, Updated guideline link sent to all ward managers and matrons, Chaperoning is audited yearly as part of the existing privacy and dignity benchmark</td>
</tr>
<tr>
<td><strong>Date of submission</strong></td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>Date of ratification</strong></td>
<td>TNMC: February 2012, CAEC: March 2012</td>
</tr>
<tr>
<td><strong>Review date</strong></td>
<td>March 2015</td>
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<tr>
<td><strong>Key Words</strong></td>
<td>Chaperone, consent, privacy, safety, dignity</td>
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**Version Control Sheet**

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<tr>
<th><strong>Version</strong></th>
<th><strong>Date</strong></th>
<th><strong>Author</strong></th>
<th><strong>Status</strong></th>
<th><strong>Comment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>August 2011- Feb 2012</td>
<td>– Lead Nurse Practice Development, DND specialist services</td>
<td>Reviewed and updated</td>
<td></td>
</tr>
</tbody>
</table>
Royal Free Policy Statement

This policy is intended to safeguard the position of patients and staff throughout consultation, examination, treatment and in the delivery of care. This policy applies to all trust employees, including students, bank, locum and agency staff involved in the care of patients.

1. All patients and staff may feel vulnerable at some stage during examination, treatment or the delivery of care; the safety, privacy and dignity of patients is paramount.

2. Patients, with some exceptions, have the right to give or withhold their consent to any intervention; the patient can also withdraw any previously given consent.

3. All patients should be given the opportunity to have a trusted and appropriate adult present whilst any examination, care process or treatment takes place.

4. Patients should be informed that an appropriate member of staff can act as a chaperone if required, where possible requests for a chaperone of the same gender as the patient will be met; patients may decline a particular person if they find them unacceptable for any reason.

5. The practitioner has the right to refuse a patient’s nominated chaperone if they believe this to be in the best interests of the patient.

6. The chaperone for patients under the age of 16 will usually be an adult that has parental responsibility or alternatively someone known and trusted or chosen by the child.

7. The process of chaperoning allows healthcare professionals to safeguard themselves from any accusation by patients, of any improper conduct.

8. The presence of a third party does not negate the need for adequate explanation, courtesy, privacy and respect; Attention must be given to the environment ensuring adequate privacy is afforded to maintain dignity.

9. The relationship between a patient and their practitioner is based on trust. A practitioner may have no doubts about a patient they have known for sometime and feel it is not necessary to offer a chaperone; patients may also show no concern whether a chaperone is present; however this should not detract from the fact that a patient in your care is entitled to a chaperone if they require one.
Introduction
Recent public inquiries, such as the Clifford Ayling Inquiry (2004), have made a series of recommendations regarding the use of chaperones within the healthcare setting, specifically with regard to who should undertake this role and what training is required for this role. This policy is intended to safeguard the position of both patients and staff throughout consultation, examination, treatment and the delivery of care. The policy applies to all staff working for The Royal Free Hampstead NHS Trust, including students, bank, locum and agency staff that are involved in patient care. All staff should be made aware of this policy within their local induction.

The intimate nature of many medical, midwifery and nursing procedures, if not practiced in a sensitive and respectful manner, may lead to misinterpretation. It is therefore important that practitioners are sensitive to the needs of their patients and aware of the potential impact of their actions.

All clinical examinations are potentially distressing. Many patients find examinations, investigations or photography intrusive, particularly where this involves the rectum, genitalia or the breasts (which may be referred to as intimate examinations). The basic principles of respect, privacy, explanation and informed consent apply to all patients undergoing examinations, procedures or receiving care.

All patients, especially elderly patients, patients whose first language is not English and patients with visual or hearing impairments, should be given the opportunity to have a trusted adult present during any examination, or treatment, or the delivery of care. They must be informed that an appropriate staff member can act as a chaperone if required and where possible this will be a member of staff of the same gender as the patient. The patient has the right, at all times, to decline a particular person as chaperone if that person is not acceptable for any reason. The practitioner also has the right to request a chaperone or to refuse a patient's nominated chaperone if they believe this to be in the patient's or staff's best interests.

While this policy provides a role description for a chaperone, it also identifies elements of care and practice, which at ward level would be considered intimate care. In such instances, whilst one nurse might not be expected to act as chaperone to another, best practice would encourage all intimate care procedures to be delivered by two staff members. Examples of this in day to day ward level nursing care would include care of the incontinent patient, washing and dressing of dependent patients and dressing of certain wounds.

Role of the chaperone
The role of the chaperone is to ensure that the privacy, dignity and interests of the patients are supported and protected at all times during the consultation, examination, treatment or delivery of care. The specific role of a chaperone may include:
- Offering reassurance and emotional support to patients
- Assisting with an examination, for example handling instruments
To assist the patient with dressing and undressing
To act as an interpreter
To act as a witness for continuing consent
To provide protection to professionals against unfounded allegations of improper conduct
Ensure the privacy and dignity of the patient
A chaperone is a present as a safeguard for all parties and is witness to the continuing consent of the procedure

The chaperone will usually be any trusted adult who the patient requests is present during a consultation, examination or when care and treatment are being delivered. In the case of patients who are under the age of 16, this is usually an adult with parental responsibility. Staff who may be required to act as chaperones include medical staff and students, nurses, midwives, health care assistants as well as student nurses and midwives.

Key Policy Principles
All patients are entitled to have a chaperone present for any consultation, examination, procedure or treatment, where the patient feels that one is required. The chaperone is an important witness to continuing consent for a procedure.

Whilst exercising clinical judgement, staff are advised that they should always request a chaperone when the patient:
- Requires intimate examination or care (see guidance in next section)
- Is semi or unconscious
- Is under the influence of alcohol or drugs which may have an hallucinogenic effect

Additionally in the case of children:
- Undergoing examination for child protection procedures
- Requires perineal examination in the assessment of sexual, genito-urinary and elimination disorders
- When the patient is pubertal or post pubertal
- Who are not accompanied by an adult with parental responsibility, or where this individual is thought to be ineffectual or unreliable.

Intimate examinations
Healthcare professionals should follow principles of good practice, given below, when involved with ‘intimate’ examinations. Intimate examinations are defined by the GMC (2001) as examinations of the breasts, genitalia or rectum:
- All patients should have the right to request a chaperone of their choice, irrespective of organisational constraints
- Establish whether there is a genuine need for an intimate examination and discuss this fully with the patient
• Explain to the patient why an examination is necessary and give the patient the opportunity to ask questions and ensure that the patient has a full understanding of the procedure and its rationale
• Offer a ‘professional’ chaperone, e.g. a nurse, midwife or healthcare assistant
• Where a chaperone is present this should be documented in the patient notes, recording the identity of the chaperone
• The practitioner has the right to refuse a patients nominated chaperone if they believe this to be in the best interests of the patient or staff
• If, for any justifiable reason, you are unable to offer a chaperone, this should be explained to the patient and where possible an alternative time/date for the examination should be offered; a record of this discussion and its outcome should be documented in the patient notes
• The patient should have the opportunity to decline a particular person as chaperone if that person is not acceptable to them for any reason
• A clear explanation of the procedure should be given in order for the patient to understand what to expect, including any pain or discomfort they may experience
• The patients consent should be obtained and documented before the examination and the practitioner should be prepared to discontinue the examination if requested by the patient
• Discussion during the examination should be relevant and should avoid unnecessary personal comments
• The patient should be given privacy to dress and undress and drapes should be used during the examination to maintain the patients dignity
• Assistance for dressing and undressing patients should only be given where the patient has requested this, patients should be encouraged to self-care as far as is practicable
• The presence of a chaperone should be confined to the physical examination if it interferes with the confidentiality of the doctor-patient relationship
• Staff need to be aware and respect the ethnic, religious and cultural background of some patients, which make intimate examinations particularly difficult
• The privacy, dignity and confidentiality of the patient should be respected at all times

**Anaesthetised/sedated patients**
Whenever possible, e.g. for elective surgery patients, consent for examination, procedures or investigation should be obtained prior to anaesthetic/sedation in writing following the trust procedure for obtaining consent. Where this is not possible, e.g. as a result of unplanned or emergency surgery, every effort should be made to ensure that a chaperone is present during examination.

Where students are being supervised it is important to ensure that valid consent has been obtained before any intimate examination is carried out under anaesthesia/sedation.
Children (under the legal age of consent – 16 years)
All children should have a chaperone present during any examination. Chaperones will usually be the child’s parent or carer, alternatively they may be an adult that is known and trusted or chosen by the child. Both the child and their parents/guardians should receive an appropriate explanation of the procedure in order to obtain their consent and co-operation.

Where a young person has the capacity to consent (Fraser competence) they may decline the use of a chaperone. This decision should be recorded in the nursing and medical notes. The practitioner should consider the impact a chaperone has on deterring the young person from being frank and asking for help (GMC, 2007).

Patients with learning disabilities difficulties/mental illness /communication needs

A familiar individual such as a family member or carer may be the best chaperone. Adult patients with learning disability /mental illness /communication needs who cannot give consent, capacity should be assessed and treatment delivered under the principle of best interests. Under English law, no one is able to give consent to the examination or treatment of an adult unable to give consent for him or herself (an “incapable” adult). Therefore, unless a lasting power of attorney exists, a relative or family member cannot consent on behalf of such an adult. Decisions are made by the healthcare team under the guiding principle of what is considered to be in the best interests of the patient. If time allows a familiar individual such as a family member, carer or advocate should be present with the patient to assist with communication, to provide reassurance and ensure that the individual understands what is happening during the procedure. If there are doubts about the individual’s capacity and they subsequently resist any examination or procedure this must be interpreted as refusing to give consent and the procedure must be abandoned and a full capacity assessment carried out.

However, in certain circumstances such as an emergency, it will be lawful to carry out such examinations or treatment, if it is deemed to be in the patient’s best interests, on the provision that the specific examination or procedure has not been the subject of an advanced refusal in a valid and signed advance directive. In certain cases, patients may have taken steps in advance to document what interventions they will and will not consent to at a time in the future where they may lack capacity to consent for themselves. In these circumstances all practicable steps are to be taken to ensure that there is a familiar person with the individual (For further guidance see Department of Health’s Reference guide to consent for examination or treatment) Trust Mental Capacity Act 2005 policy on Freenet

Patients whose first language is not English
The trust is committed to providing accessible and appropriate care to all patients. Staff should ensure that patients whose first language is not English
receive the information they need and that they are able to communicate effectively with healthcare staff. It is not appropriate to use children for the purpose of interpreting and family members are not always appropriate to act in the role of chaperone. Where the practitioner has any difficulty or concerns with regard to effective communication and the ability to obtain informed consent for a procedure an interpreter should be called, the practitioner should refer to the trust interpreting services operational policy for guidance.

Additional considerations
Staff should be aware that the environment in which examinations or procedures are carried out may contribute to a patient feeling vulnerable e.g. darkened rooms or that the number of staff present during an examination may be intimidating. For some patients, the level of embarrassment increases in proportion to the number of individuals present. Staff should be aware that intimate examinations might cause anxiety for both male and female patients and whether or not the examiner is of the same gender as the patient.

Where a number of staff are required to be present, e.g. in an endoscopy suite, as far as is possible there should be a balance between male and female staff in order to avoid the situation where there is an all male workforce present with a female patient and vice-versa. Staff should also consider the number of people that are required to be present and not compromise the privacy and dignity of the patient.

To ensure privacy and dignity is maintained in the environment at all times, the following should be considered:

- There should be sufficient space for the consultation/examination
- Conversations should not be overheard i.e. doors and windows are shut properly
- Staff and patients do not feel isolated or vulnerable
- Patients are not left unnecessarily exposed
- Consider, should the need arise can help be summoned quickly

This policy provides guidance for the protection of both staff and patients and should always be followed. The key principles of communication and record keeping will ensure that the practitioner/patient relationship is maintained and safeguard against formal complaints with regard to improper conduct.

Dissemination
RFH NHS Trust ensures that all staff involved in the consultation, examination and delivery of treatment or patient care have the appropriate knowledge and skills to do so. Dissemination and raising awareness of this policy in order to safeguard the interests of both patients and staff will be achieved by:

- The policy being taught on relevant training and education programmes
- Local induction for staff new to the trust
- Policy available on Freenet
Roles and responsibilities

Managers
- Must ensure that the policy is disseminated and implemented, including identifying any training needs
- Ensure reviews on chaperoning are undertaken
- Ensure Privacy and dignity audits are undertaken every year

Clinical staff
- Staff to be involved in the development and implementation of policies
- All staff should maintain their awareness of the need to offer patients a chaperone during an examination/consultation
- Identify the need for any training in respect of policies and procedures
- Attend training/awareness sessions where appropriate

Audit
Each area should undertake a regular audit of privacy and dignity, of which chaperoning is an integral feature, using the trust benchmarking tool. Audit and evaluation should focus not just on the percentage scores for the tool, but also the accuracy and reliability of the information. Additional information can be gathered from patient satisfaction surveys, data from patient affairs and PALS and observation of practice within the clinical areas.

Review
The guidance for the use and role of chaperones will be reviewed at intervals of two years as a minimum, by the author and sponsoring body, if amended it will be resubmitted to the appropriate committee for approval. The guidance will be reviewed earlier if:
- There are significant changes to practice which require a change in policy
- It is deemed appropriate by the author, sponsoring body or authorising body
- A significant incident or a series of incidents, concerning the operation of the policy occurs.

References
- Department of Health, 2004, Independent investigation into how the NHS handled Allegations about the conduct of Clifford Ayling
- Royal College of Nursing, 2002, Chaperoning: the role of the nurse and the rights of the patient
- General Medical Council, 2007, 0 – 18 Years, Guidance for all Doctors
- Gillick vs. Norfolk and Wisbech AHA & DHSS, 1985, Fraser competence

Acknowledgements
Barnet and Chase Farm Hospital NHS Trust - Chaperoning policy 2006
Whittington NHS Trust – Chaperoning policy 2003
Homerton Hospitals NHS Trust – Protocol for the chaperone of patients during physical examination, 1999
Appendix A - Equality impact assessment tool

Equality and Health inequalities Impact Assessment Screening Checklist

<table>
<thead>
<tr>
<th>Name of policy/service</th>
<th>Patient chaperoning policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this a new or existing policy/service</td>
<td>Review and update of 2008 policy</td>
</tr>
<tr>
<td>Purpose of the policy/service</td>
<td>This policy provides a framework for best practice for patient chaperoning. The needs and the interests of patients are the driving principle, placing the patient/client at the centre of their care.</td>
</tr>
<tr>
<td>Stakeholders in policy/service development</td>
<td>See validation grid</td>
</tr>
<tr>
<td>Person responsible for policy/service impact assessment</td>
<td></td>
</tr>
<tr>
<td>Proposed date for implementation of policy/service</td>
<td>February 2012</td>
</tr>
</tbody>
</table>

Do you think the policy/service will impact upon any group within the population based upon:

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Yes</th>
<th>Lower socio-economic groups</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Yes</td>
<td>Involvement in the criminal justice system</td>
<td>No</td>
</tr>
<tr>
<td>Religion/belief</td>
<td>Yes</td>
<td>Homelessness</td>
<td>No</td>
</tr>
<tr>
<td>Disability (including long term conditions and mental health)</td>
<td>Yes</td>
<td>Looked after children</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>Yes</td>
<td>Population groups more at risk of developing certain conditions (based on community health profile data)</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation or gender identity</td>
<td>No</td>
<td>Any other groups</td>
<td>No</td>
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Equality impact assessment screening checklist summary sheet

1. Positive impacts (Note groups affected)
The aim of this policy is to safeguard patients and staff during episodes of intimate care provided within the hospital environment and to provide a guide to best practice in conjunction with trust policies such as privacy and dignity, safeguarding adults policies.

The policy promotes safety, privacy, dignity, choice and respect for all patients.

The policy promotes principles of good care and safety for all groups.

2. Negative impacts (note groups affected)
- Race/ethnicity (language/communication needs)
- Disability
- Gender
- Religion/belief
- Age

3. Additional information/evidence required
The role of the chaperone is to ensure that the privacy, dignity and interests of the patients are supported and protected at all times during the consultation, examination, treatment or delivery of care. The specific role of a chaperone may include:
- Offering reassurance and emotional support to patients
- Assisting with an examination, for example handling instruments
- To assist the patient with dressing and undressing
- To act as an interpreter
- To act as a witness for continuing consent
- To provide protection to professionals against unfounded allegations of improper conduct
To enable implementation of this policy there needs to be effective communication. Communication needs of patients and relatives are recorded routinely in the nursing notes. Training is provided for staff on communication on commencement at the trust; supportive literature/local policies are available on the trusts intranet.

All staff who are required to provide clinical care of an intimate nature are personally responsible for ensuring that their actions comply with this policy.

4. Recommendations
Implementation of the policy will be monitored through the Essence of Care food and respect and dignity benchmark audits, and painter feedback through patient experience feedback.

5. As a result of completing the impact checklist, have any negative impacts been identified, and if so is a full impact assessment recommended?
Yes
Some groups of people may be particularly vulnerable to a loss of dignity including people with visual or hearing impairments, people with major physical disability people, for whom English is a second language, people with mental health issues, including dementia, delirium. Steps are in place to minimise loss of dignity as set out in this policy and other guidance documents for staff in direct and indirect contact with patients.

We recognise that staff need to be sensitive to differing expectations associated with race, ethnicity, culture, age and gender; and wherever possible staff of the same gender should be available to chaperone.

When intimate personal care has been required and a member of staff of the same gender has been requested and is not available, this must be brought to the attention of the Nurse/Midwife in charge.

Communication:
It is essential that patients understand their care so they are able to make informed decisions and express their needs, preferences and concerns. Therefore patients/relatives who do not speak English as a first language or who have specific communication needs may require the support of an interpreter or communication aide to explain the process and facilitate understanding, cooperation and consent.

The Trust has a robust interpreting service enabling patients and carers to access information in different languages. This is detailed in the bedside handbook, which also states how information can be obtained in different languages and formats.

Staff are made aware of the need for good communication around this issue. This is covered as part of the corporate and local induction processes.

Behaviours and attitudes:
Not understanding the cultural background of a patient can lead to confusion and misunderstanding.

Equality and diversity training is mandatory for all staff. The purpose is to help staff recognise and prevent any barriers to access and support because of stereotyping, or prejudice associated with age, ethnicity, disability, religion or belief, sexual orientation and gender.

Psychological, emotional and spiritual needs:
These needs are reviewed as part of overall patient care. Supportive literature/local policies are available on the trust’s intranet.

Physical handling:
There may be sensitivities in relation to personal contact/touch and personal boundaries. In particular, these issues might arise as a result of gender, culture and ethnicity.
Intimate examinations include the examination of breasts, genitalia or rectum, (although other areas may also be classified as intimate by patients relating to their cultural beliefs).

| 6. If impact assessment has not been recommended please state the reasons why. | Arrangements are in place to address any actual or potential negative impact see section 5 therefore a full impact assessment is not required. |
| Date for completion of screening checklist review / completion of full impact assessment: | August 2013 |

| Managers name and signature: | Date: |
| Approved by Operational manager for Equality and Diversity (name and signature) | August 2011 |

| | Date: |
| | August 2011 & February 2012 |