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| **Policies and Procedures****Chaperone Policy** |

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| **Policy Title:** | **Chaperone Policy**  |
| **Executive Summary:** | This policy sets out guidance for the use of chaperones during clinical consultations.This policy has been written specifically for use in care home settings when a clinical consultation is being carried out, either by a member of care home staff or an external clinician.This policy is intended to offer safeguards to both patients and members of staff during clinical consultations.To be read in conjunction with:• Consent to Examination and Treatment Policy• Clinical Record Keeping Policy• Freedom to speak up: raising concerns (whistleblowing) Policy • Mental Capacity Act 2005• Safeguarding Adults Policy• Equality and Diversity Policy• Personal Safety & Lone Worker Policy• Incident Reporting Policy• Dignity and Respect Policy |
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| **Approved by:** | Care Home Manager |  |

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**The End of Life Partnership (EoLP) – Chaperone Policy**

# **1. POLICY STATEMENT**

* 1. This policy sets out guidance for the use of chaperones during clinical consultations, clinical examinations, investigations, and clinical interventions, particularly in relation to intimate procedures. These are referred to collectively as “clinical consultations” throughout this policy.
	2. This policy has been written specifically for use in care home settings when a clinical consultation is being carried out, either by a member of care home staff or an external clinician.
	3. This policy is intended to offer safeguards to patients, members of care home staff and external clinicians during clinical consultations.
	4. This policy should be read in conjunction with the organisation’s:

• Consent to Examination and Treatment Policy

• Clinical Record Keeping Policy

• Freedom to speak up: raising concerns (whistleblowing) Policy

• Mental Capacity Act 2005

• Safeguarding Adults Policy

• Equality and Diversity Policy

• Personal Safety & Lone Worker Policy

• Incident Reporting Policy

• Dignity and Respect Policy

1.3 This policy includes the use of formal chaperones in face to face clinical procedures and those carried out remotely e.g. via video link. Where a statement applies only to one type of situation, this is clearly indicated.

1.4 The term “patients” is used throughout, to reflect the context of this policy and the provision of clinical procedures.

# **2. ORGANISATIONAL RESPONSIBILITIES**

2.1 Manager Responsibilities:

To have overall accountability for ensuring that the care home meets its obligations in respect of delivering care to patients that is of a high quality with an emphasis on ensuring privacy, dignity and safety.

2.2 Employee Responsibilities:

To act as a formal chaperone, staff must be confident that their usual job role aligns with the requirements of this policy e.g. they are regularly involved in providing direct care including intimate care such as support with washing and dressing. Staff that do not carry out these tasks should not act as formal chaperones.

All staff should know how to report any incidents relating to the chaperoning of patients via the care home’s incident reporting process to ensure that the staff member’s line manager and the manager of the care home are informed of the incident.

# **3. PRINCIPLES**

## **3.1** **Policy Context and Background**

3.1.1 A number of inquiry reports have led to recommendations about the use of chaperones. The Committee of Inquiry Investigation report into the conduct of Dr Clifford Ayling, (Pauffley, 2004) made the following recommendations:

* Each organisation should have its own chaperone policy and this should be made explicit to patients and resourced accordingly
* An identified managerial lead (with appropriate training)
* The presence of a formal chaperone during clinical examination or treatment must be the clearly expressed choice of a patient and the patient has the right to decline a formal chaperone when offered
* Relevant policies should be followed where there are issues relevant to mental capacity
* Formal chaperones must receive appropriate training
* A family member or friend should not undertake a ­formal chaperone role

3.1.2 The subsequent investigation into governance arrangements within the paediatric and oncology service by Cambridge University Hospitals NHS Foundation Trust into the conduct of Myles Bradbury (Scott-Moncrieff & Morris, 2015), found that some recommendations from the 2004 investigation referenced above were either not implemented or enforced, were not applicable to children or were so restrictive that breaches were commonplace. The learning from the 2015 investigation includes:

* Chaperone policies should be workable in all situations – a too restrictive policy will inevitably lead to breaches
* A chaperone policy should offer guidance on maintaining professional boundaries with patients and families whilst at the same time fostering a relationship of trust and rapport
* The organisation must consider how best to enforce the policy
* The policy should be explicit to patients and their families
* The organisation should consider appointing an accredited managerial lead with responsibility for implementing the policy if not already in post

3.1.3 Whilst a chaperone may be used in any form of clinical consultations, examinations, investigations, or clinical intervention, the General Medical Council (GMC) has specific guidance for Intimate examinations (GMC, 2013) which recommends that:

‘When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the patient’.

3.1.4 Chaperone policies should reflect changing practice, including of the increased use of remote consultations, particularly during the Covid-19 pandemic. ‘Remote Consultations Guidance under COVID -19 restrictions’ (RCN, 2020) states that:

* All patients should have the right, if they wish, to have a formal chaperone present during an examination or procedure, treatment or care irrespective of organisational constraints or settings in which they are carried out
* It is good practice to make sure that organisations, including general practice, have a chaperone policy in place and that this is clearly visible to the public, alongside information about why this is important

3.1.5 The GMC have also produced a ‘Remote Consultations’ guide for doctors who are being asked to triage and treat patients by remote consultations to protect staff and patients from infection of COVID-19 (GMC, 2020).

The guide includes a flow chart to help doctors:

* Apply ethical guidance
* Manage patient safety risks
* Decide when it is safe to treat patients remotely
* Decide when face to face treatment is preferable e.g. if there is a need to examine the patient

3.1.6 Where a healthcare professional is carrying out a clinical consultation, clinical responsibility for the patient rests with this professional, whether the consultation is carried out face to face or remotely.

3.1.7 These principles should be considered in conjunction with the Mental Capacity Act, Safeguarding, Equality Act and the Human Rights Act.

## **3.2 Definitions**

3.2.1 **Formal Chaperone**

A formal chaperone may be referred to as a person who acts as a witness for a patient and a practitioner during a clinical procedure.

A formal chaperone is a is a health care worker that is specifically trained for the role, for example a registered or unregistered member of the Nursing, Midwifery, Allied Health Professional or Medical team who has undertaken training in accordance with this policy.

The formal chaperone plays an active part in the delivery of a clinical procedure and will:

• Be sensitive and respect the patient’s dignity and confidentiality;

• Reassure the patient if they show signs of distress or discomfort;

• Observe and stay for the whole examination;

• Be able to identify any unusual or unacceptable behaviour on the part of the healthcare professional

• Raise concerns immediately if they are worried in any way about the behaviour and actions of the healthcare professional carrying out the consultation, procedure, intervention or examination;

• Complete a written incident report with regard to any concerns.

3.2.2 **Informal chaperone**

If it is the wish of the patient, it is acceptable for a friend, relative or carer to be present during a procedure in addition to a formal chaperone. The presence of an informal chaperone should be documented.

An informal chaperone is a person who is familiar with the patient and can include family members, friends, a legal guardian, or someone known, trusted or chosen by the patient.

An informal chaperone would not actively take part in any examination, procedure or investigation. Their role as person familiar to the patient is to provide comfort, reassurance and emotional support. It is permissible for an informal chaperone to assist with practicalities, for example undressing or dressing the patient, but they must not be used as a formal chaperone.

3.2.4 **Intimate Examination**

These are likely to include examinations of the breasts, genitalia and rectum but could also include any examination where it is necessary to touch or even be close to the patient. A patient’s perceptions of what constitutes an intimate examination may differ from staff perceptions; sensitivity must always be shown in respect of the patient’s prior life experiences, disability, age, social, ethnic and cultural perspectives.

In line with current GMC guidance, these types of examination should not be carried out remotely except under exceptional circumstances, and then only in line with professional guidance.

3.2.5 **Consent**

Consent is a patient’s agreement for a healthcare professional to provide care. Before healthcare professionals examine, treat or care for any person they must obtain their valid consent.

There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way. Staff must refer to the relevant consent and mental capacity policy in relation to this.

Staff must be mindful that by attending a consultation it may be assumed that a patient is seeking treatment. However, before proceeding with an examination it is vital that the patient’s valid consent is obtained. This means that the patient must have:

* Capacity to make the decision
* Received sufficient information
* Not be acting under duress

When the patient does not have the capacity to give consent for a consultation, healthcare professionals must undertake an assessment of mental capacity and make the decision in the patient’s best interests in line with the Mental Capacity Act 2005 and local policies.

This must be clearly documented in the patient’s notes and should be applied to all situations relating to an adult who does not have capacity for a consultation. If in doubt, advice should be sought from the local safeguarding team.

3.2.6 **Healthcare Professional**

This is a person who holds a current registration with a relevant professional body e.g. the Nursing and Midwifery Council for nurses, the General Medical Council for doctors, including GPs.

# **4. PROCEDURES**

## **4.1 Prior to a clinical consultation (including intimate procedures)**

4.1.1 The care home should establish that there is a genuine need for a consultation and discuss this with the patient. Explain to the patient why the consultation is necessary giving opportunity for questions.

4.1.2 Establish whether there is a genuine need for a formal chaperone and discuss this with the patient prior to the consultation taking place.

4.1.3 Offer the use of a formal chaperone. Where possible, they should be the same sex as the patient.

4.1.4 If a formal chaperone is used, they must be introduced to the patient and the healthcare professional prior to the consultation and roles and responsibilities should be clarified to ensure that formal chaperones are not asked to undertake tasks that are outside of the scope of their job role.

4.1.5 If the offer of a formal chaperone is declined then this must be documented in the patient’s notes. If a formal chaperone has been refused a healthcare professional must decide whether to continue with the consultation without, or to abandon the examination or procedure. If it is decided to continue without a formal chaperone this should be discussed and documented.

4.1.6 Where there are safeguarding concerns, and where it would not be appropriate for a family member to act as the informal chaperone , this should be explained to the family (and patient if appropriate) and a formal chaperone should always be present.

4.1.7 Obtain and document consent prior to the consultation and be aware that consent may be withdrawn during the consultation. In the case of the withdrawal of consent the consultation will be discontinued.

4.1.8 Relevant policies should be followed where there are issues relevant to mental capacity.

4.1.9 Offer the opportunity for the patient to talk in private with the formal chaperone prior to the consultation.

## **4.2 During a clinical consultation**

4.2.1 Attention must be given to the environment ensuring adequacy is afforded to maintain dignity. Intimate examination should ideally take place in a closed room or a well screened area that cannot be entered while the examination is in progress, with no interruptions for example phone calls or messages. If this is not possible all efforts must be made to prevent any interruption or breach of the patient’s privacy and dignity throughout the consultation and a “do not enter” sign must be attached to the door.

4.2.2 The formal chaperone should be present for the entirety of a consultation.

4.2.3 There should be adequate facilities provided to enable the patient to get undressed in private. The formal chaperone should not help the patient to remove clothing unless they have asked for or indicated that they require help. Once the patient has undressed there should be no delay in commencing the consultation.

4.2.4 Maximise privacy and dignity at all times with the use of gowns/drapes. Only the part of the patient’s body that is being examined should be exposed and for the shortest time possible.

4.2.5 If an examination or procedure involves contact with blood or body fluids then the appropriate personal protective equipment (PPE) should be used. Additional PPE may be required during the Covid-19 pandemic (refer to current guidance). Ensure hand hygiene is performed before and after any contact with the patient/resident.

4.2.6 The healthcare professional must give clear information to the patient throughout the consultation, explaining what they are going to do before they do it. If this differs from what the patient has been told beforehand, the healthcare professional must explain why and seek the patient’s permission. The healthcare professional must stop the consultation if the patient requests this.

4.2.7 During the consultation, the formal chaperone should be able to offer reassurance. They should be respectful of the patient’s privacy and dignity and avoid any irrelevant discussion or personal comments.

4.2.8 The formal chaperone should always remain alert to verbal and non-verbal signs of distress from the patient.

4.2.9 The healthcare professional should be prepared to discontinue the consultation at any stage should the patient request this and record the reason.

4.2.10 Where there are concerns about the possible inappropriate conduct of a healthcare professional the Whistleblowing Policy and local multi-agency procedures in relation to raising concerns about staff working with vulnerable groups must be followed.

## **4.3 After a clinical consultation**

4.3.1 If a formal chaperone was present, their name, designation and contact details should be documented in the patient’s records.

4.3.2 Record any other relevant issues and escalate concerns immediately following the examination, this may include the completion of an incident form.

## **4.4 Additional Procedures for Remote Consultations**

4.4.1 The Royal College of General Practitioners has developed the following guidance for supporting high quality consultations by video in general practice during COVID-19 (RCGP, 2020). This should be read in conjunction with section 4.4 above.

4.4.2 Prior to the clinical consultation

* Ensure that internet access is secure (e.g. use a virtual private network (VPN) and/or if possible, avoid public Wi-Fi), and make sure any security features are in use
* Ensure that the formal chaperone has access to a computer, tablet or smartphone with a built-in camera and microphone
* The formal chaperone should test the audio and video connection and adjust the settings so that all involved can see and hear well. Use a well-lit room, that will allow clear visibility for the clinician.
* There is the potential to lose connection and not reconnect. This will need to be discussed between the healthcare professional and formal chaperone and an agreement made at the beginning of the consultation as to what steps are needed if this were to occur.

4.4.3 At the time of the clinical consultation

* The formal chaperone should advise the patient that video communication works the same as face to face, but it may feel less fluent and there may be glitches (e.g. blurry picture).The patient should be advised that they don't need to look at the camera to demonstrate that they are engaged. Looking at the screen is fine.
* The formal chaperone should initially focus on the camera position in order that the patient can see the clinician’s full face and they are in focus.
* Check that the patient can hear the clinician, adjust the volume if required.
* The formal chaperone should use the screen camera to show things (e.g. a rash).

4.4.4 At the end of the clinical consultation

* The healthcare professional should summarise and check that the patient has understood key points and knows next steps
* The healthcare professional should close the call

## **4.5 Documentation**

4.5.1 All healthcare professionals have a duty to keep clear and accurate records relevant to their practice. Guidelines in regard to record keeping are provided by each relevant professional or regulatory body. It is the responsibility of each healthcare professional to keep up to date with, and adhere to relevant legislation, case law and national and local policies relating to record keeping.

4.5.2 Record-keeping specific to chaperoning must include:

* Details of the consultation and informed consent
* The offer of a formal chaperone and whether accepted or declined
* Reason for refusal of any formal chaperone
* The presence or absence of a formal chaperone – this must include their details i.e. name, designation and contact details
* The presence of an informal chaperone including name and relationship to the patient/resident

## **4.6 What to Do When A Formal Chaperone Is Not Available or Declined**

4.6.1 The presence of a formal chaperone must be the clearly expressed wish of the patient. Patients must have the right to decline any formal chaperone offered (Pauffley 2004).

4.6.2 All patients must routinely be offered a formal chaperone prior to any consultation. It is not always clear ahead of a healthcare interaction that a formal chaperone may be required, especially in community or domiciliary settings.

If this becomes apparent, or where a patient requests a formal chaperone and none is immediately available, the patient must be offered the choice of:

* Waiting until a formal chaperone is available
* Re-scheduling the appointment for another day (and within a reasonable timeframe) so that arrangements for a formal chaperone can be put in place

4.6.3 If the seriousness of the situation would dictate that a delay is inappropriate, then this must be explained to the patient and recorded in the clinical record. A decision to continue or otherwise must be reached jointly.

4.6.4 Patients have a right to refuse a formal chaperone. The healthcare professional will clearly explain the reasons why the presence of a formal chaperone is advisable. If the patient refuses to have a formal chaperone present, the healthcare professional needs to consider if it would be safe and appropriate to continue.

4.6.5 If a patient refuses to have a formal chaperone where the situation warrants one, this must be documented in their notes along with the reason for their refusal. The patient should be informed of the consequences or possible alternatives as well as the effects on, or delays to, treatment or diagnosis.

4.6.6 If an examination is to take place without a formal chaperone this must be discussed with a fellow healthcare professional and the reason for carrying out the examination without a formal chaperone clearly documented in the clinical record. The documentation should include the details of the healthcare professional with whom the discussion took place.

## **4.7** **Emergency Situations**

In an emergency or life-threatening situation, where the patient can give consent, the guiding principles should be followed. However, where the patient is unable to give consent and speed is essential in the care and treatment of the patient it is acceptable for healthcare professional to perform intimate examinations without a formal chaperone. This must always be recorded in the patient’s records.

## **4.8 Issues Specific to Religion, Ethnicity or Culture**

healthcare professionals must always be sensitive to cultural differences and treat every patient in a way that respects their views and wishes and preserves their dignity. Cultural differences can affect people’s perceptions of what is intimate or appropriate. The ethnic, religious and cultural background of patients may also have particular significance to intimate examinations. For example, some patients may have strong cultural or religious beliefs that restrict being touched by others. Wherever possible, particularly in these circumstances, a same sex healthcare professional should perform the consultation.

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, but it should be noted that this individual will most likely not be trained as a formal chaperone. healthcare professionals should assess in each circumstance if this would be appropriate.

## **4.9 Roles and Responsibilities**

4.9.1 The role of staff acting as a formal chaperone is:

* To protect the interests of the patient and the healthcare professional by providing impartial observation of clinical procedures, examinations, investigations, or care, including intimate procedures

* To ensure that the nature and extent of a clinical consultation is appropriate and to protect the patient and practitioner from any suggestion the examination was inappropriate
* To report incidents relating to the chaperoning of patients in line with the local incident reporting system and policy. The staff member’s line manager and the manager of the home must be informed of the incident.

4.9.3 The responsibilities of the formal chaperone are to:

* Maintain the patient’s privacy and dignity
* Provide comfort and reassurance to the patient
* Assist the patient with dressing and undressing in accordance with the patient’s requests
* Ensure that there is no undue delay prior to examination once the patient has removed any clothing
* Help vulnerable patients from being abused
* Help protect healthcare professionals against false allegations of misconduct or sexual abuse
* Help position the patient for the consultation, using appropriate moving and handling techniques
* Have the ability to take appropriate action and highlight concern, either during or immediately after the event
* Understand cultural, ethical, and religious diversity
* Ensure that the healthcare professional undertaking the consultation documents the name, designation and contact details of the formal chaperone in the patient‘s notes

4.9.4 For remote consultations, the additional responsibilities of the formal chaperone are to help the healthcare professional to see the patient. They will do this by using a video camera and by exposing the relevant part(s) of the patient’s body, if required albeit exposure should be kept to a minimum to maintain the patient’s dignity.

## **4.10 Suggested additional training**

* What is meant by the term formal chaperone: purpose, function, role and responsibility
* What is an “intimate examination”/an understanding of the consultation which they are chaperoning
* Appropriate conduct during intimate examinations
* The rights of the patient
* How to respond in the event of a concern; taking appropriate action and highlighting concerns (this may include stopping an examination or procedure)
* Understanding cultural, ethical and religious diversity
* Disability awareness
* Knowledge of this policy
* Access to support from professionally registered staff
* A basic awareness of the Safeguarding Adults at Risk policy for the organisation

# **5. SUGGESTED APPENDICES**

* Consent to Examination and Treatment Policy

• Clinical Record Keeping Policy

• Freedom to speak up: raising concerns (whistleblowing) Policy

• Mental Capacity Act 2005

• Safeguarding Adults Policy

• Equality and Diversity Policy

• Personal Safety & Lone Worker Policy

• Incident Reporting Policy

• Dignity and Respect Policy