

PLAINS VIEW SURGERY

CHAPERONES POLICY

INTRODUCTION

This policy sets out guidance for the use of chaperones and procedures that should be in place for consultations, examinations and investigations.

PURPOSE OF CHAPERONE

All medical consultations, examinations and investigations are potentially distressing. Patients can find examinations, investigations or photography involving the breasts, genitalia or rectum particularly intrusive (these examinations are collectively referred to as “intimate examinations”). Also, consultations involving dimmed lights, the need for patients to undress or for intensive periods of being touched may make a patient feel vulnerable.

Chaperoning is the process of having a third person present during such consultations to:

- provide support, both emotional and sometimes physical to the patient.
- to protect the doctor against allegations of improper behaviour during such consultations, and sometimes to provide practical support.

WHEN, AND HOW, SHOULD A CHAPERONE BE OFFERED?

Information concerning the availability of chaperones is made to patient by:

- Signs in each consulting and treatment room
- Signs in the waiting room
- Chaperoning information on practice website, patient information leaflet and registration pack

It will only be apparent that a chaperone will be necessary once the consultation is started. The triggers that make the offer of a chaperone necessary include:

- when an intimate examination is deemed necessary. This offer should be accompanied by an explanation as to why the examination is required.
- when an examination which is not intimate, but involves close proximity, physical contact or dim lighting is necessary and the clinician is concerned that a chaperone is necessary; this may be to protect him/herself, or if the patient is particularly vulnerable or at risk.

- whether the patient and clinician are the same sex or not is not relevant; an offer of a chaperone should be made regardless. However, if the sex of both parties is the same it is likely that the clinician will less frequently consider themselves to need a chaperone present to proceed as the risk of allegation is reduced, though they must be aware it is by no means absent.

DURING THE CONSULTATION IN WHICH A CHAPERONE IS REQUIRED

It is important to provide an environment in which the patient feels relaxed, and is given privacy to undress in preparation for the examination.

Prior to examination, the patient must be given a full explanation of the reason for the examination and what will be done and if possible how it will feel.

There should be no undue delay prior to examination once the patient has removed any clothing.

- During an intimate examination
- Offer reassurance
- Be courteous
- Keep discussion relevant
- Avoid unnecessary personal comments
- Encourage questions and discussion
- Remain alert to verbal and non-verbal indications of distress from the patient

Intimate examination should take place in a closed room or well-screened bay that cannot be entered while the examination is in progress.

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.

Once the patient is dressed following an examination or investigation the findings must be communicated to the patient.

Any requests that the examination be discontinued should be respected.

WHO CAN BE A CHAPERONE?

A friend or relative of the patient is an inadequate chaperone – they are neither trained nor independent; however, in reality the clinician may well appropriately feel that their presence will reduce the risk of allegations, and may therefore allow an examination to proceed even if a chaperone is offered and declined; but a chaperone should still be 'offered'.

An appropriate chaperone is otherwise any member of the nursing team; all are trained appropriately and have a DBS check – both are requirements for them to be a chaperone.

The chaperone should be the same sex as the patient; otherwise the patient's anxiety and risk of allegation will increase.

ROLE OF THE CHAPERONE

Their role can be considered in any of the following areas:

1. Providing emotional comfort and reassurance to patients
2. To act as an observer of the examination to protect the clinician from false allegation.
3. Empowered to alert their line manager should they feel any improper behaviour has occurred.

If the clinician requires practice assistance during the examination, for example during a coil insertion, they should request an HCA or nurse to support them, and that person would then provide both practical and physical support as well as implicitly acting as a chaperone. In this case, they may be a differing sex from the client, but as they are providing a clinical function this is acceptable – a full explanation needs to be given to the patient and their agreement obtained.

The chaperone should introduce herself/himself to the patient giving her name. The two parties should have a short conversation between themselves to ensure there is clear understanding of the role and expectations.

RECORDING OF CHAPERONE OFFERS

Whenever the clinician feels a chaperone may be necessary, it should be offered. Whenever the offer is made, that fact should be recorded on TPP System One, together with either the fact that it was declined, or the name of the person performing the role of chaperone entered in the associated free text box.

If the offer is declined, but the clinician feels they are at risk without a chaperone being present, it is appropriate and correct them to:

- further explain why a chaperone is necessary and re-offer one
- refuse to proceed with the examination and ask the patient to rebook with a clinician of the same sex; this is the best possible scenario for the examination to be safely performed, but even then, it may be that a same sex clinician will also feel a chaperone is necessary and again decline to proceed; these cases must be dealt with individually, but the clinician has no obligation to proceed with an action which he is uncomfortable in doing. The patient insisting it is done is not a sufficient justification to put clinicians at risk. All these decision processes and explanations must be recorded on System One

The only exception to this is if there is an urgent medical need for the examination to proceed – in this scenario patient safety may and should override clinician's assessment of their own risk.

WHERE A CHAPERONE IS NEEDED BUT NOT AVAILABLE

If the patient requests a chaperone, but an appropriate one is not available, the appointment should be re-booked at a time when one is available. The only exception is when there is urgent clinical need – this should be explained to the patient.

If the doctor wants for whatever reason a chaperone to be present, but one is not available, then again, the appointment should be re-scheduled unless there is overriding medical need when each case should be taken individually, or the clinician may consider the clinical need overrides his own risk to exposure.

Careful recording of all decision-making processes must be made.

ISSUES OF CONSENT

Consent may be implicit in attending a consultation – for example, a patient attending with a breast lump may reasonably be assumed to expect a breast examination. However, it is always prudent to obtain consent after explanation before all intimate examinations. Verbal consent is sufficient.

The clinician may assume that the patient is seeking treatment and therefore 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 to it being carried out. Consent should always be appropriate to the treatment or investigation being carried out.

The clinician must however be aware that:

- an assessment of capacity may occasionally be necessary to ensure consent is valid.
- that if consent is given, either actual or implied, this is nothing to do with the offer of a chaperone. A patient may consent to an intimate examination, but still request, assume or prefer a chaperone to be present so a chaperone offer should still, always, be made.

SPECIAL CIRCUMSTANCES

If there are medico-legal reasons for the examination, for example after alleged assault, or perhaps because of abuse, the clinician should be aware that written consent may be necessary for the examination to be valid. The clinician should make

appropriate enquiries first. This will be an unusual and rare occurrence.

ISSUES SPECIFIC TO CHILDREN

In the case of children, a chaperone would normally be a parent or carer or alternatively someone known and trusted or chosen by the child. Patients may be accompanied by another minor of the same age. For competent young adults, the guidance relating to adults is applicable.

The age of Consent is 16 years, but young people have the right to confidential advice on contraception, pregnancy and abortion and it has been made clear that the law is not intended to prosecute mutually agreed sexual activity between young people of a similar age, unless it involves abuse or exploitation. However, the younger the person, the greater the concern about abuse or exploitation. Children under 13 years old are considered of insufficient age to consent to sexual activity, and the Sexual Offences Act 2003 makes clear that sexual activity with a child under 13 is always an offence.

In situations where abuse is suspected great care and sensitivity must be used to allay fears of repeat abuse.

Healthcare professionals should refer to their local Child Protection policies for any specific issues.

Children and their parents or guardians must receive an appropriate explanation of the procedure in order to obtain their co-operation and understanding. If a minor present in the absence of a parent or guardian the healthcare professional must ascertain if they are capable of understanding the need for examination. In these cases, it would be advisable for consent to be secured and a formal chaperone to be present for any intimate examinations.

Further information about confidentiality, data protection and consent can be found at www.doh.gov.uk/safeguardingchildren/index.htm and Working Together to Safeguard Children (Department of Health 1999).

ISSUES SPECIFIC TO RELIGION, ETHNICITY OR CULTURE

The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others. 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 or imaging. Wherever possible, particularly in these circumstances, a female healthcare practitioner should perform the procedure.

It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a language barrier. If an interpreter is available, they may be able to double as an informal chaperone. In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination.

ISSUES SPECIFIC TO LEARNING DIFFICULTIES/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 careful simple and sensitive explanation of the technique is vital. This patient group is a vulnerable one and issues may arise in initial physical examination, “touch” as part of therapy, verbal and other “boundary-breaking” in one to one “confidential” settings and indeed home visits.

Adult patients 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, unless the patient has been sectioned. In life-saving situations the healthcare professional should use professional judgement and where possible discuss with a member of the Mental Health Care Team.

LONE WORKING

Where a health care professional is working in a situation away from other colleagues e.g. home visit, the same principles for offering and use of chaperones should apply.

In reality it is more likely here that a relative or friend will be available – this person may well be acceptable as a chaperone to both patient and clinician.

Where it is not appropriate or available, or the clinician feels unable to proceed with a formal chaperone, the clinician may need to rebook the visit and return accompanied by, for example, a district nurse or HCA to provide chaperone role, or request the patient attend the surgery at a later date.

If there is an overriding medical need and urgency, then this should take priority, or may cause the clinician to consider an alternative route of disposal such as referral to A & E Dept. or NEMS

Health care professionals should note that they are at an significantly increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present, especially in the patient’s home. The clinician has every right, except in cases of dire emergency, to protect themselves from such risk.

COMMUNICATION & RECORD KEEPING

Details of the examination including presence/absence of chaperone and information given must be documented in the patient’s medical records.

If the patient expresses any doubts or reservations about the procedure and the healthcare professional feels the need to reassure them before continuing then it would be good practice to record this in the patient’s notes. The records should make clear from the history that an examination was necessary.