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Chaperone Policy

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Summary

Patients can find some assessments or procedures distressing and may prefer to have a chaperone present to support them. It is good practice to offer all patients a chaperone for any intervention or where the patient feels one is required. Examples of intervention which may make the patient feel particularly vulnerable include the need to undress or any intimate examination. Throughout this policy the word intimate is used to describe any examination which may be considered personal and / or sensitive. Interpretation of an intimate examination will differ between patients, and this should be taken into consideration whenever any clinical examination is required. Staff should only ever carry out an examination of this nature if they are trained to do so and it is in their scope of practice. Any assessment should take place in line with the assessment, conveyance and referral of patient's policy.
The intimate nature of many health care interventions, if not practised in a sensitive and respectful manner, can lead to misinterpretation and the potential for allegations of sexual assault or inappropriate examinations. In these circumstances a chaperone will act as a safeguard for both patient and attending personnel.
For most patient's respect, explanation, consent, and privacy take precedence over the need for a chaperone (Webb and Odphel, 1996). The presence of a third party does not negate the need for adequate explanation and courtesy and cannot provide full assurance that the procedure or examination is conducted appropriately.
All patients have the right, if they wish, to have a chaperone present during an assessment. Having a chaperone present does not alleviate the requirement to have informed consent for any assessment/procedure.
The Trust is committed to providing a safe, comfortable environment where patients and the attending personnel can be confident that best practice is being followed. Chaperones should be considered for examination or treatment provided in a patient's home, public places and in Trust vehicles including emergency ambulances and Community Medical Units.
This policy should be used in conjunction with the Patient Consent to Examination or Treatment policy.

1.0 Introduction

1.1 This policy sets out guidance for the use of chaperones and highlights procedures that should be in place for clinical consultations, in particular when this involves intimate care. It is in place to safeguard patients and attending personnel of Yorkshire Ambulance Service (YAS) during episodes of intimate care provided by YAS.

1.2 Research shows many patients are not concerned whether a chaperone is present or not (Webb and Odphal, 1996). However, this should not detract from the fact that any patient is entitled to a chaperone if they feel one is required.

1.3 The Trust recognises the diversity of clinical situations which cannot be fully covered in this policy. Therefore, the accountability and responsibility for assessing and

seeking advice for each unique clinical situation lies with the respective attending personnel.

1.4 Applies to both adult and child patients.

This policy recognises the following principles which must always be considered:

1.5 That all medical consultations, examinations, and investigations are potentially distressing for individuals and those involving intimate procedures or the need to undress down to underwear, may make patients feel particularly vulnerable.

1.6 For some patients with mental health needs or learning disabilities a chaperone, particularly one trusted by the patient may help the patient through the process and minimise any distress or confusion the examination may cause the patient. This principle also applies to children and young people.

1.7 If the attending clinician is working alone and no chaperone is available, they should consider, where appropriate, asking for another resource to attend. If no other resource is available, the patient should be conveyed to hospital where the examination can be carried out.

2.0 Purpose/Scope

2.1 The policy applies to everyone who has direct patient contact and includes everyone directly employed on substantive or honorary contracts, volunteers and students who are on placement at YAS and those alternative providers working for YAS a contracted basis. Everyone will be referred to as ‘attending personnel.’ All attending personnel have a responsibility to ensure they work in line with their own professional code of conduct provided by the Health and Care Professions Council (HCPC), Nursing and Midwifery Council (NMC) and General Medical Council (GMC). For attending personnel that do not have a governing body they must practice within the scope of practice stipulated by YAS.

2.2 This policy applies to any necessary examinations where the patient may need to be exposed. There may be cultural variation as to what is deemed intimate; attending personnel should be aware of this when dealing with patients. When carrying out a 12-lead ECG, the back of the hand should be used to move breast tissue.

3.0 Definitions

3.1 **Chaperone** - There is no common definition of a chaperone since this role varies considerably depending on the needs of the patient, the attending personnel and the examination or procedure being carried out. It is acceptable for a friend, relative or carer to be present during a procedure if that is the wish of the patient.

3.2 **Formal Chaperone** - A health care professional, a health care support worker or a specifically trained non-clinical attending personnel member may be a chaperone. A formal chaperone acts as a witness for the patient and the attending personnel during an intimate examination or while the procedure is being undertaken and may also assist the attending personnel to undertake the relevant procedure. A formal chaperone should be sensitive and respectful of the person’s dignity; they also have a

responsibility to ensure their presence at the examination is documented and be prepared to raise concerns if misconduct is suspected.

3.3 See paragraph 4.2 for guidance when a formal chaperone is advised.

3.4 **Informal Chaperone** – This is a person who would not be expected to take an active part in the examination or witness the procedure directly, it might be a family member or friend who can give reassurance and emotional comfort to the patient leading up to the intimate procedure and who may assist with undressing the patient. The informal chaperone should be someone acceptable to the patient and the patient should consent to their presence. Attending personnel should be mindful of the potential for victims of domestic violence to feel coerced into accepting the perpetrator as a chaperone.

3.4 A child should never be expected to be an informal chaperone for an adult including a parent, carer, or guardian.

4.0 The Role of the Chaperone

4.1 The chaperone's main responsibility is to provide a safeguard for the patient and for the attending personnel; they protect the patient by providing physical and emotional support and reassurance as well as identifying potential unusual or unacceptable behaviour on the part of the attending personnel. The presence of a chaperone protects the attending personnel against unfounded or malicious allegations by acting as a witness to continuing consent to the procedure or examination. To protect the patient from vulnerability and embarrassment, where possible the chaperone should be of the same sex as the patient, or the gender the patient identifies with (unless otherwise stated by the patient). It is acknowledged that some attending personnel work alone (See Appendix One and Two).

4.2 It is advised that a formal chaperone is always considered when intimate examinations or procedures are required; this may include but is not limited to:

- When examining or undressing the upper torso of a patient.
- Administration of rectal medication.
- An obstetrical/maternity situation when genitalia are exposed, especially considering whether the chaperone is aware of a possible pregnancy.
- Patients with a history of difficult or unpredictable behaviour, this may or may not be attributable to mental health illness.
- Adults who lack capacity, including those with a learning disability.
- Intimate nursing and clinical care interventions e.g., attending to very intimate personal hygiene, toileting requirements, changing an incontinence pad.
- Examination of patients who are unconscious or intoxicated due to drugs or alcohol.

4.3 Patients should be offered a chaperone or be invited to have a relative or friend present with them during any examination or procedure. Their personal preference should be documented in the patient record (Assessment, Conveyance and Referral of Patients, 2017). An opportunity should always be given to the patient to decline a particular person if that person is not acceptable to them for any reason. All decisions

about chaperoning, including the offer and decline by the patient should be clearly documented in the patient record.

4.4 Patients with learning difficulties, hidden disabilities such Autism or ADHD, suffering from mental health problems or physical disabilities including being hard of hearing, may react differently regarding a physical examination and find them more distressing due to sensory associated with some conditions. Informal and formal chaperones should be carefully considered and aware of any additional conditions which may need adjustment to make the examination bearable and less distressing.

4.5 Staff should consider whether the correct chaperone has been offered for example, if they are made aware of a patient's gender transition. It is understood that transitioning could be a complex issue within families and so an informal chaperone may not be aware of, or agree with, their transition – especially if the patients are under 18. Staff should make a decision as to the suitability of the chaperone with the facts provided and take extra care when examining a patient.

4.6 Healthcare professionals are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present and where possible staff should consider the benefits that a chaperone offers them as well as the patient.

4.7 There may be times when an intimate examination or procedure needs to be carried out in a situation which is life threatening, or where speed is essential in the care of the patient; this may be done without a chaperone. The reason and rationale for not having a chaperone should be clearly documented on the patient record.

5.0 Consent

5.1 Consent should always be obtained in line with the Mental Capacity Act 2005 and regard paid to the Mental Capacity Act Code of Practice for patients aged 16 and over. Consent should always be appropriate to the treatment or investigation being carried out. The patient's consent should be obtained before any examination and attending personnel should be prepared to discontinue the examination or procedure at any stage at the patient's request.

5.2 Staff should consider the patients relationship with an informal chaperone and whether consent needs to be obtained privately, so that the patient can speak openly.

5.3 Conditions such as dementia, Alzheimer's or Parkinson's are more prevalent in the older community and could affect the ability to give consent to an examination.

5.4 Staff should consider that older people may be affected by conditions that hinder the ability to consent which may or may not be diagnosed or known to the attending staff. Special care should be taken in making sure the patient fully understands what is being asked of them, and also their chaperone if this is an older family member.

6.0 Specific Patient Groups

6.1 Issues Specific to Children and Young People

6.1.1 For children and young people under the age of 16, where possible a parent, guardian or informal or formal chaperone should be present for any physical examination; the child should not be examined unaccompanied when this can be avoided. Parents or guardians must receive an appropriate explanation of the procedure to obtain their informed consent to examination.

6.1.2 If a child under 16, after consent is obtained by a parent or guardian, shows signs of not wanting to be examined, their emotions and distress should be taken into account by staff and if needed, the examination abandoned.

6.1.3 A parent, guardian or carer or someone already known and trusted by the child may also be present for reassurance.

6.1.4 For young people aged over 16, the principles of the Mental Capacity Act 2005 apply therefore, if there is no doubt about their capacity to consent to examination or treatment, the guidance that relates to adults is applicable.

6.1.5 If a child specifically requests an examination or treatment without a formal or informal chaperone, this must be discussed with the child and/or their parent, guardian or carer if safe to do so. If there are safeguarding concerns and it is deemed the child is suffering or likely to suffer significant harm a safeguarding referral should be considered as per YAS Safeguarding Policy. The attending personnel should consider whether the “intimate procedure” needs to take place as part of their care or whether this can be completed at hospital or other facility. All decisions should be clearly documented on the patient record.

6.1.6 In an emergency situation it is acceptable to provide care without a chaperone present (See Appendix One and Two).

6.2 Issues Specific to Patients with Learning Disabilities / Mental Health Problems

6.2.1 For patients who have learning disabilities, mental health problems or where there is doubt about a patient’s mental capacity to consent to the treatment or procedure, every effort should be made to ensure that the patient understands the relevant information. In cases such as these, a family member or carer may be the best placed to chaperone and may also be able to provide support in explaining the procedure to your patient. Consider any communication aids the patient may already have.

6.2.2 The attending personnel should be aware that these patient groups are more at risk of vulnerability and as such, may experience heightened levels of anxiety, distress, and misinterpretation.

6.2.3 Adult patients with learning disabilities 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.

6.2.4 In life threatening situations it may be appropriate to provide care without a chaperone present (See Appendix One and Two).

6.3 Issues Specific to Religion, Ethnicity or Culture

6.3.1 The ethnic, religious, and cultural background of some patients can make intimate examinations or procedures particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others.

6.3.2 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. Wherever possible, particularly in these circumstances, the patient should be able to choose the gender of the chaperone.

6.3.3 Patients should be given the privacy to undress and dress.

6.3.4 You should not proceed with any examination if the patient's ability to understand and consent may be compromised due to a language barrier. If an interpreter is required, the contact number is on pulse. (Please see appendix three)

6.3.5 In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination.

7.0 Recording and Documentation

7.1 Details of the examination including the presence and/or absence of a chaperone, who the chaperone is, and information given must be documented on the patient record. If a chaperone has been offered and declined, this should also be recorded.

8.0 Training Expectations

8.1 All attending personnel expected to act as a formal chaperone must understand:

- what is meant by a formal and informal chaperone?
- what is meant by an intimate examination?
- Why Chaperones Need to be present.
- the rights of the patient
- policy and mechanism for raising concerns.

9.0 Implementation Plan

9.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all attending personnel to view. New members of attending personnel will be signposted to how to find and access this guidance during Trust Induction.

9.2 This Policy will be circulated Trust Wide via Communications in Clinical Update and the weekly Community First Responder update.

9.3 Reference to this Policy will be made during Mandatory Safeguarding Training.

10.0 Monitoring compliance with this Policy

10.1 Through the Trust Annual Safeguarding and Clinical Audit plan.

11.0 References

GMC (2013) Intimate Examinations and Chaperones [online] [accessed 28 September 2018] https://www.gmc-uk.org/-/media/documents/maintaining-boundaries-intimate-examinations-and-chaperones_pdf-58835231.pdf

The Royal College of Emergency Medicine (2015) Best Practice Guideline, Chaperone in Emergency Department.

NHS Clinical Governance Support Team (2005) Guidance on the role and effective use of chaperones in primary and community settings.

Webb R, Odphal M. (1996) Breast and pelvic examinations: easing a women's discomfort. 'Can Fam Physician', 42:54-8.

NHS England (2015) Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework.

Roles & Responsibilities

Chief Executive

The Chief Executive is the executive member of the Trust Board with overall accountability in relation to safeguarding and patient experience.

Director of Quality Governance and Performance Assurance

The Director of Quality Governance and Performance Assurance is the nominated director responsible for coordinating the management of the safeguarding agenda and patient experience.

Medical Director

The Medical Director is the nominated director responsible for consent for treatment and ensuring that all attending personnel deliver care in accordance with best practice.

Head of Safeguarding

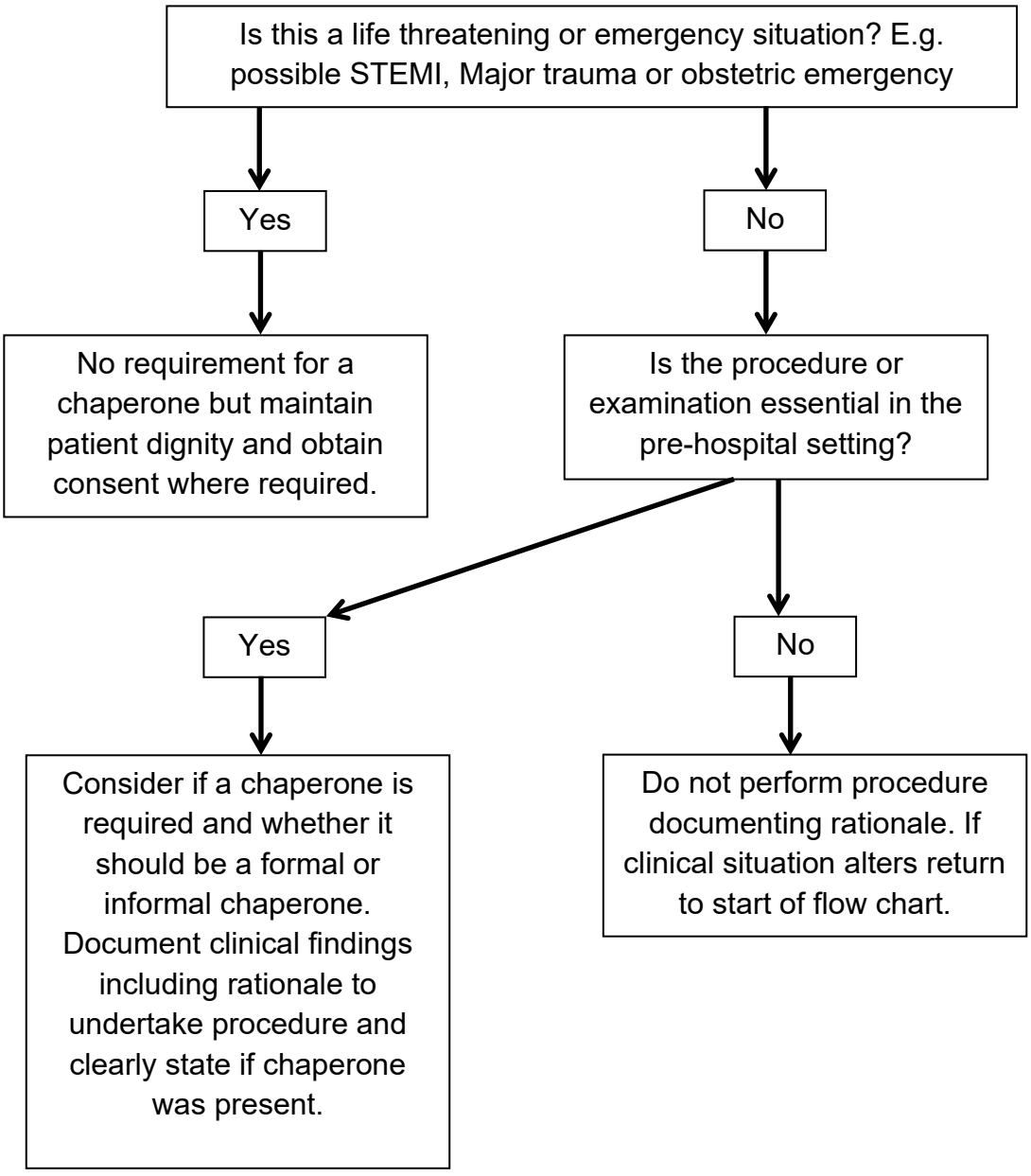
The Head of Safeguarding has a responsibility for the development and implementation of systems and processes for safeguarding, working with partner agencies in line with local and national standards and legislation. This includes overall responsibility for policy development, education content guidance, and safeguarding supervision. The Head of Safeguarding oversees the Named Professional for Safeguarding Vulnerable Groups.

YAS Attending Personnel

All YAS attending personnel are required to always act to safeguard the health and well-being of their patients. The attending personnel should be able to recognise when a chaperone may be required and when a medical emergency takes precedence over the need for a chaperone. The attending personnel should be familiar with and adhere to the Trust's policies and procedures.

Appendix One

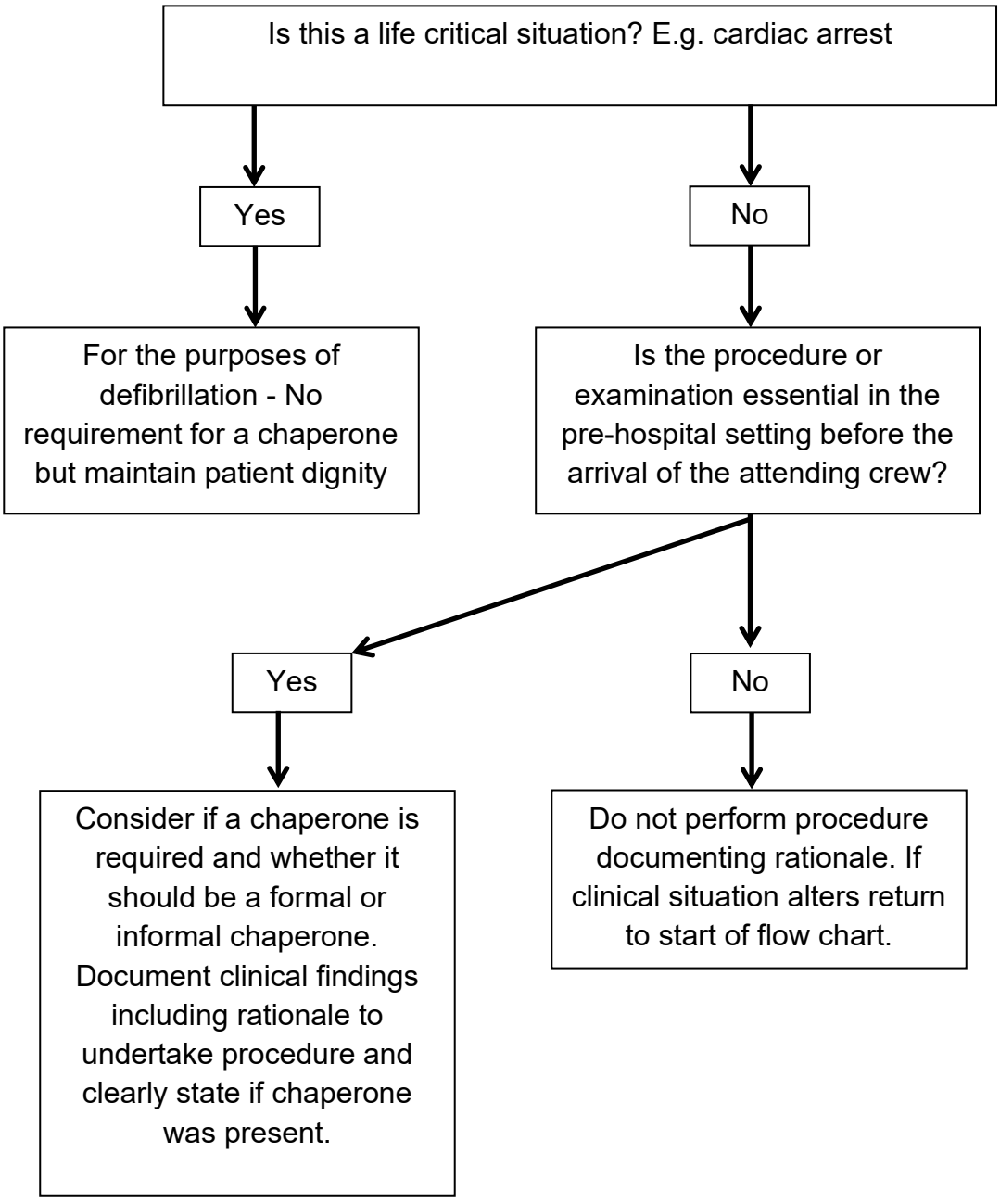
Operations Chaperone Decision Making Flowchart



Author: Mark Millins Associate Director Paramedic Practice January 2019
Reviewed by Mark Millins. October 2023.

Appendix Two

Community First Responder Chaperone Decision Making Flowchart



Authors: Emma Scott Community Resilience Manager, Paul Stevens Head of Community Resilience. February 2019
Reviewed by Ben Rushworth, Community Defibrillation Officer. October 2023.