Policy:

OPS 017 - Chaperone Policy

Executive Director Lead	Executive Director of Nursing and Professions
Policy Owner	Head of Nursing
Policy Author	Head of Nursing

Document Type	Policy
Document Version Number	Version 1 (New Policy)
Date of Approval By PGG	08/03/2021
Date of Ratification	29/03/2021
Ratified By	Quality Assurance Committee
Date of Issue	09/03/2021
Date for Review	31/07/2024 (extended from 31/03/2024 by PGG)

Summary of policy
This policy sets out the guidance for the use of chaperones during clinical procedures, particularly in relation to intimate procedures.

Target Audience	Clinical, Medical Staff, Allied Health Professionals

Keywords	Patient safety, privacy and dignity

Storage

Version 1 of this policy is stored and available through the SHSC intranet/internet.

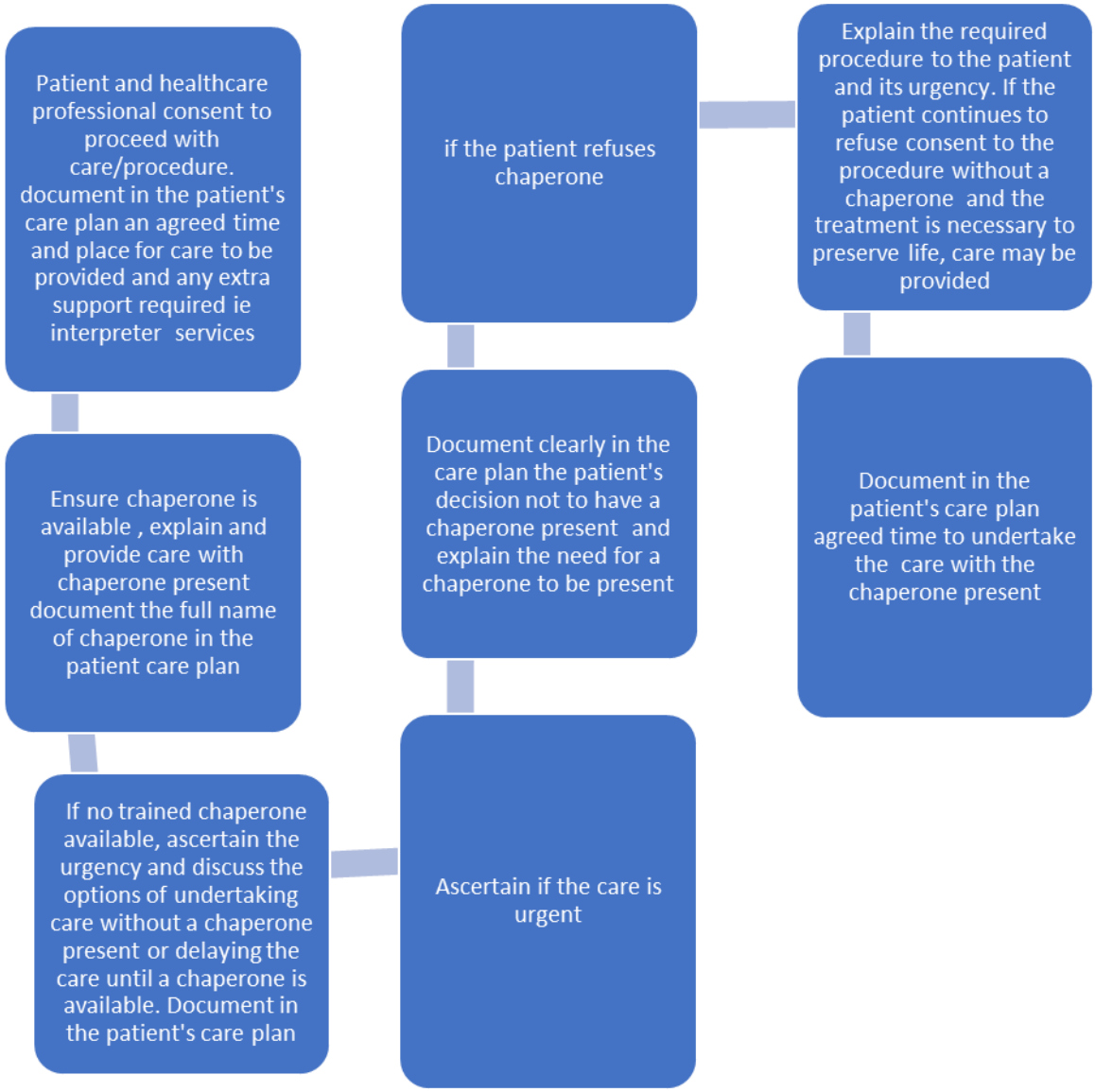
Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
Draft 0.1	New draft policy created	10/2020	New policy commissioned by EG on approval of a Case for Need.
Draft 1.0	Approval and issue	11/2020	Amendments made during consultation, prior to ratification.
Draft 2.0	Review / approve / issue	N/A	Early review undertaken to update the policy to to comply with new regulatory requirements.
Draft 2.1	Review on expiry of policy	N/A	Committee structure updated
1.0	Review / approval / issue	N/A	Full review completed as per schedule

Contents

CHAPERONE FLOW CHART

When intimate and personal care is required, assessment must take place as to who is the most appropriate person to undertake this care and patient involvement



1 Introduction

Sheffield Health and Social Care NHS Foundation Trust (SHSC) are committed to providing a, safe and comfortable environments where service users and staff can be confident that best practice is being followed at all times. The safety of all service users and staff is paramount, whilst recognising that clinical consultations and investigations have the potential to cause unintentional stress.

A chaperone is a person who has a role to witness both a service user and clinician/practitioner and to safeguard both parties during an examination or procedure. It is recognised that not all chaperones are registered nurses and will undertake appropriate training.

This policy sets out the guidance for the use of chaperones during clinical procedures, particularly in relation to intimate procedures. Under Standard 6.2 of the NMC code, nurses are required to maintain the knowledge and skills they "need for safe and effective practice" (NMC, 2018b). Therefore, if they are not properly trained to act as chaperones, they may be putting themselves at risk professionally

All service users have the right to refuse to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out.
Please note that service users are not entitled to choose the colour of skin of the chaperone. Kline (2020) acknowledges that some service users might not be able to give reasoned requests and might be an expression of an underlying disorder and healthcare professionals will need to deal with this in a sensitive way.

2 Scope

This policy applies to all healthcare professionals working within SHSC including medical staff, Nurses, Healthcare Support Workers and Allied Health Professionals.

All healthcare professional responsibilities are outlined in their respective professional code of conduct.

3 Purpose

This policy sets out the guidance for the use of chaperones during clinical procedures, particularly in relation to intimate procedures. It is recognised that if intimate procedures are not carried in a sensitive, respectful and dignified manner, it can lead to misinterpretation and the potential for allegations of sexual assault or inappropriate examinations. Some service users may find some, clinical consultations, examinations, investigations or procedures particularly distressing and may require support. It is good practice to offer support that is acceptable to the service users, the role of the chaperone may help the service user through the process and help to minimise the level of distress.

When chaperoning staff should be sensitive to our service users protected characteristics and support in a culturally appropriate, recognising equality, diversity and inclusivity. Wherever possible the chaperone should be the same gender as the service user.

All service users have the right to refuse to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out.

4 Definitions

Chaperone: To acknowledge a service user's vulnerability and to ensure their dignity is preserved at all times. They may assist the health profession with examination, investigation or procedure and provide emotional support and reassurance throughout process.
It is acceptable for a friend, relative or carer to be present during a procedure to support the service user in addition to a chaperone if that is their wish and should be documented accordingly.

Consent: Service user agreement for a health professional to provide care or share information. Prior to any examination, investigation or procedure takes place, health care professionals must obtain informed consent and documented.

Mental Capacity Assessment: To be undertaken if the health professional feels the service user lacks capacity to consent to examination, investigation or procedure.

Intimate Examinations: Examinations, investigations or photography relating to the breasts, genitalia or rectum. Examination of the chest or heart in women, which can involve touching the breasts, (e.g. lifting them up to hear the mitral valve), would fall into this category. It can include any examination where it is necessary to touch or even be close to the service user. Health professionals need to be aware that intimate may have different implications to service users from culturally diverse backgrounds.

5 Detail of the policy

This policy sets out the guidance for the use of chaperones during clinical procedures, particularly in relation to intimate procedures. It is recognised that if intimate procedures are not carried in a sensitive, respectful and dignified manner, it can lead to misinterpretation and the potential for allegations of abuse by a professional carer including sexual abuse or inappropriate examination. Some service users may find some, clinical consultations, examinations, investigations or procedures particularly distressing and may require support. It is good practice to offer support that is acceptable to the service users, the role of the chaperone may help the service user through the process and help to minimise the level of distress.

6 Duties

Chief Executive: is responsible for ensuring effective corporate governance within SHSC and supports the implementation of this policy

Executive Directors: Director of Nursing, Medical Director and Chief Operating Officer are responsible for endorsing the full implementation of this policy and its relevance to practice within safeguarding, patient dignity and delivery of quality care.

Healthcare Professionals: are responsible for the undertaking of the and ensure that any care/examination is completed in a suitable environment. Healthcare Professionals must demonstrate an understanding of the role of the chaperone and the procedures for reporting concerns.
Healthcare professionals have a responsibility to ensure accurate information about the process is documented on Insight (EPR)

Chaperone: Members of staff who act as a chaperone must understand the role and the requirements of this policy. Administrative and Clerical staff cannot be used as a chaperone.

Members of Staff: Have a responsibility to provide full assurance that the procedure or examination is conducted appropriately. All members of staff are expected to conduct themselves that promotes the human rights to fairness, respect, equality, dignity and autonomy.

7 Procedure

Within SHSC it is mandatory that a chaperone is present for all intimate examinations on children and young people less than 16 years of age if the service user is unconscious or under the influence of drugs or alcohol or where there are concerns.

7.1 Role of Chaperone and Intimate Examination Process

- Attention must be given to the environment ensuring dignity is maintained
- Intimate examination should ideally take place in a closed room that cannot be entered while the examination is in progress. If this is not possible, all attempts must be made to prevent any interruption or breach of the service user's privacy and dignity throughout the procedure/examination and signage must be attached to the closed curtain. Staff should be aware that darkened rooms for radiological, retinoscopy or other similar procedures whilst not considered "intimate examinations" may lead the service user to feel more vulnerable.
- The service user must be given complete privacy without the risk of interruption, to undress and dress before and after the examination/procedure. Assistance should be provided by the chaperone as requested by the service user. If a chaperone is not present, the healthcare professional should only assist the service user if requested to do so by service user.
- There should be no delay prior to examination/procedure once the service user has removed clothing/ The process should not be interrupted by phone calls or messages.
- Establish whether there is a need for a chaperone and discuss this with the service user prior to the examination/procedure taking place. It is not always clear prior to a consultation that an intimate examination /procedure is required.
- If an intimate examination is required, explain to the service user why it is necessary and give them the opportunity to ask questions and a full explanation what this involves.
- Offer service user a chaperone to support them through this, the service user may have a family member/friend present at their request and this is separate to the role of the chaperone
- Where possible the service user should be offered a chaperone of the same gender and cultural background during intimate examinations/procedures
- If a student is present permission is always sought from the service user prior to an intimate examination
- The service user can decline a person as chaperone if that person is not acceptable to them for any reason, requires discussion and documentation as may have cultural implications.
- If a chaperone is refused for intimidate examination/procedure and the healthcare professional have concerns they should decide whether it is appropriate to continue, the service user should be informed of the

consequences or possible alternatives and effects on delays to treatment or diagnosis.

- If a service user has requested a chaperone and none is available at the time, the intimate examination/procedure must not be undertaken until a chaperone is available. It may be necessary to refer the service user to another service, in these circumstances the service user must be given the opportunity to reschedule their appointment within a reasonable timeframe. All discussions, actions and decisions must be documented in the service user's notes.
- Obtain the service user's consent before the examination and record where appropriate that permission has been obtained in the service user's notes. Please refer to the consent policy for definitions of consent.
- Follow relevant policies where there are issues regarding mental capacity.
- Be prepared to discontinue the examination at any stage should the service user request this and document reason.
- It is mandatory for all children under 16yrs to have a chaperone present when undergoing intimate examinations/procedures
- Children should have the opportunity to have parents present if they wish to support them during the whole examination/procedure. If a child does not wish a chaperone to be present the healthcare professional must explain that it is Trust policy for all intimate examinations/procedures for children under 16yrs and they will be unable to proceed.
- Explanation needs to be given throughout each stage of the examination/procedure, the outcome when it is complete and next steps. The discussion needs to be relevant and avoid personal commentary.
- In all cases, where the presence of a chaperone may intrude in the healthcare professional/service user confiding relationship, their presence should be confined to the examination/procedure. Any other communication must take place after the examination/procedure.
- If a chaperone is appropriate and present throughout the process, the identity of the chaperone must be documented in the service user's notes.
- Ensure the service user is supported to dress fully after the examination/procedure, maintaining dignity and privacy at all times.

8 Development, Consultation and Approval

- The following groups and individuals consulted
  Care Networks, Safety Service User Group, Associate Director of Patient Safety, Sunrise Service User Group, Ward Managers, Senior Operational Managers, Heads of Nursing, Education, Training and Development Lead, Clinical Director and Clinical Commissioning Group. NICE guidance, NMC code and GMC guidance followed.

- This is a new policy and the need for specific chaperone training identified during the consultation phase

- Sent to Physical Health Group and Safety Service User Group

- Consultation and review took place 02/11/2020 to 20/11/2020

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Chaperone policy implemented and embedded into ward/team areas	e.g. Review, audit	Physical Health Reference Group or Service User Safety Group	Annual Annual	Safeguarding Assurance Committee	Physical Health Reference Group Or Service User Safety Group	Safeguarding Assurance Committee
B) Chaperone role activity and effectiveness	Dip sampling of EPR	Physical Health Reference Group	Annual	Safeguarding Assurance Committee	Physical Health Reference Group	Safeguarding Assurance Committee

This policy will be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is 31 March 2024.

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Chief Nurse/Corporate Governance	March 2021	TBC
Make team aware of new policy	Ward/Team Manager	TBC	TBC

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	March 2021	March 2021	March 2021	TBC

12 Training and other resource implications

There is currently no specific chaperone training within SHSC and this needs to be developed with the Education, Development and Training Department.

Any staff who are required to chaperone within their role will be required to undertake the relevant training and be compliant with:

- Safeguarding Children, Adults and Prevent
- Mental Capacity Act
- Data Security and Information Governance

13 Links to Other Policies, Standards (Associated Documents)

- Capacity to Consent to Care Support and Treatment Policy
- Record Management Policy
- Freedom to Speak Up
- Mental Capacity Act 2005
- Safeguarding Children, Adults and Prevent Policy
- Equality and Diversity Policy
- Lone Worker Policy
- Incident Reporting Policy
- Dignity and Respect Policy
- Kline, R. (2020) What happens if a patient wants to choose the ethnicity of their Doctor. The BMJ Opinion.
- Mersey Care NHS Foundation Trust (2018) Chaperone Policy
- Care Quality Commission (2020) Nigel's Surgery 15: Chaperones.
- General Medical Council (2013) Intimate Examinations and Chaperones
- Nursing and Midwifery Council (2018b) the Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates.

14 Contact Details

Title	***Name***	***Phone***	***Email***
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Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Brenda Rhule 31st December 2020	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Disability	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Gender Reassignment	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Pregnancy and Maternity	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**

Race	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Religion or Belief	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Sex	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Sexual Orientation	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - no changes made.

Impact Assessment Completed by: Brenda Rhule 31st December 2020

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Yes/No	Evidence
	Executive Lead		
1.	Is the Executive Lead sighted on the development or review of the policy?	Yes	
2.	Is the team/Directorate PGG member sighted on the development of the review of the policy?	Yes	
	Development and Management of Policies		
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process, *insert hyperlink to Case for Need process*?	No	Case of need to be completed once policy agreed
4.	State the reasons for development of the document	yes	Patient safety, dignity and respect
5.	Please confirm the individuals involved in the development of the policy?	Yes	Sent to Care Networks, Service User Safety group, Safeguarding, Physical Health Group, Sunrise Service user group, Education Training and development and Clinical Commissioning Group.
6.	Is the policy title clear and unambiguous and meets the requirements of the Policy on Policies, *insert hyperlink to policy,*	Yes	
7.	Does the style and format of the policy meet with the requirements of the Development, Management and Review of Policies?	Yes	
8.	Has it been completed in line with the template?	Yes	
9.	Is the policy in Arial font 12?	Yes	
10.	Have page numbers been inserted? Please make sure that there is no page number	Yes	

	showing on the front cover, version control or contents pages		
11.	Does the policy contain a list of definitions of terms used?	Yes	
12.	Has the policy been quality checked for typographical errors, links, accuracy etc.	Yes	
13.	Does the policy include any references to other associated policies and key documents	Yes	
14.	Is there evidence of consultation with all relevant teams and directorates e.g. HR, Finance, Procurement?	Yes	
15.	Has the policy been discussed and agreed by the local governance groups e.g. Medicines Optimisation Committee, or Trustwide specialist groups e.g. Resuscitation and Physical Health Group	Yes	
	Policy Content		
16.	Is the document linked to a strategy?	Yes	Patient Safety
17.	Is the purpose of the policy clear?	Yes	
18.	Are the intended outcomes of the policy described?	Yes	
19.	Does the policy reference requirements of the CQC or other relevant bodies e.g. NHSLA RMSAT, if applicable?	Yes	
20.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.		
21.	Are supporting references cited in full?	Yes	
22.	Are Trust supporting documents referenced?	Yes	
	Approval		
23.	Have Staff Side (or equivalent) approved the document (HR policies only)?	N/A	
	Dissemination and Implementation		
24.	Does the dissemination plan identify how dissemination will be implemented, see 11 of Policy on Policies.	Yes	

25.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes	
	Document Control		
26.	Have you included version control on the document?	Yes	
27.	Does the document identify where it will be held? See Storage on policy cover sheet.	Yes	
	Process for Monitoring Compliance		
28.	Is there a plan to: i. Review ii. Audit compliance with the document	Yes	
	Review Date		
29.	Is the review date identified?	Yes	
	Overall Responsibility for the Document		
30.	Who will be responsible for co-ordinating the: i. Dissemination ii. Implementation iii. Evidencing iv. Monitoring	Head of Nursing	