

# **Primary Care Services**

## **Chaperone Policy Version 1.0**

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#### Version Control Summary

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| 1.0     | February 2021 | ?      | Based on:<br>Trust Chaperone Policy,<br>Nigel's surgery 15:<br>Chaperones (Oct 2020),<br>The Medical Defence<br>Union - Chaperones (Nov<br>2017)<br><br>This policy makes<br>reference to the Online<br>and Video Consultation<br>Policy for Primary Care. |

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## Executive Summary

The Chaperone Policy highlights the requirements set out for Primary Care Services with regards to Chaperones.

The policy outlines that:

- Chaperones are there to support patients and staff.
- Chaperones should routinely be offered before intimate examinations.
- Patients can refuse a chaperone
- Documentation must be clear in the patient's clinical record of acceptance or refusal

The policy sets out the expectations for primary care services, the provision of information and training for staff, the role of staff, expectations of a chaperone and arrangements in place to monitor the process.

The COVID-19 pandemic has accelerated the use of online and video consultations as part of core clinical practice. An online, video or telephone consultation does not negate the need to offer a chaperone. The same principles would apply.

NHS England have produced some key principles for intimate clinical assessments undertaken remotely in response to COVID-19. They include how to conduct intimate examinations by video and the use of chaperones.

The GMC has published guidance on intimate examinations and chaperones. It provides a framework for all health care professionals. This sets out when and why a patient may need a chaperone and considerations that should be given. It is guidance only and not a mandate. If a GP wishes not to follow this guidance they should risk-assess the situation. They should record their logic or discussion clearly. Even by doing this rather than following the guidance, they will put themselves at risk.

## 1. Why is a chaperone needed?

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 called 'intimate examinations'. Cultural factors should be considered. This is important when examinations are performed by members of the opposite sex. Also, any consultations where patients may feel vulnerable.

For most patients and procedures, respect, explanation, consent and privacy are all they need. They take precedence over the need for a chaperone. A chaperone does not remove the need for adequate explanation and courtesy. Neither can it provide full assurance that the procedure or examination is conducted appropriately.

It is important that children and young people are provided with chaperones. The GMC guidance states that a relative or friend of the patient is not an impartial observer. They would not usually be a suitable chaperone. There may be circumstances when a young person does not wish to have a chaperone. The reasons for this should be clear and recorded.

All staff must be aware that chaperones are to protect both patients and staff. The following must be considered before any examination takes place:

- Explain the nature of the examination and obtain consent for the examination (refer to Primary Care Consent Policy). This may include:
  - Establishing that there is a genuine need for an intimate examination and discussing this with the patient
  - Explaining exactly what the purpose of the examination is and what it will entail
  - Stating that a chaperone will be offered, and if a suitable chaperone is not available that it may be necessary for the patient to return at another time. The patient may elect to specify which gender the chaperone should be and this wish should be respected.
- The issue of consent is all-important. Before any examination takes place, informed consent must be obtained from the patient and documented on their records. Clarification should be sought in the Primary Care Consent Policy.
- Young people of 16 years or over can give their own consent.
- Young people and children under 16 yrs can also give their own consent to examination or treatment if they are considered to be 'Gillick competent' (Gillick vs West Norfolk and Wisbech, 1986). 'If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared. (Department of Health, 2009). Services providing contraception and sexual health advice should also adhere to Fraser Guidelines (1985) see appendix.
- Children and Young people also have the same rights to confidentiality as adults (0–18 years, Guidance for all Doctors, GMC) and so should be seen without their family members in the first instance. This is essential to build trust between young people seeking healthcare and their doctor or other healthcare professional, without confidentiality young people may not seek healthcare or may not provide complete information.
- Where a patient has a learning disability, mental illness or who does not speak English, the clinician must accurately document how consent was given, and by whom.

## 2. Staff Responsibilities - Offering a chaperone

The chaperone policy should be clearly advertised through:

- patient information leaflets
- websites (where available) and
- notice boards.

All patients should routinely be offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted to ask if the patient wants a chaperone to be present. The offer of chaperone should be clear to the patient before any procedure. Ideally at the time of booking the appointment.

For children and young people, their parents, relatives and carers should be made aware of the policy and why this is important.

Where a patient is offered but does not want a chaperone, it is important the practice has records, and coded in the records:

- who the chaperone was
- their title and
- that the offer was made and declined.

If the patient has requested a chaperone and none is available, the patient must be able to reschedule within a reasonable timeframe. If the seriousness of the condition means a delay is inappropriate, this should be explained to the patient. It should be recorded in their notes. A decision to continue or not should be reached jointly. Special consideration needs to be given to examinations performed on home visits or during online, video or telephone consultations.

## 3. Chaperone Responsibilities and Training

All staff should have an understanding of the role of the chaperone. Staff should understand procedures for raising concerns.

Staff who undertake a formal chaperone role must have been trained so they develop the competencies required. Training can be delivered externally or provided in-house by an experienced member of staff. so that all formal chaperones understand the competencies required for the role.

Expectations – chaperones should:

- be sensitive and respect the patient's dignity and confidentiality
- reassure the patient if they show signs of distress or discomfort
- be familiar with the procedures involved in a routine intimate examination
- stay for the whole examination and be able to see what the clinician is doing, if practical
- be prepared to raise concerns if they are concerned about the clinician's behaviour or actions.

Training should include:

- what is meant by the term chaperone
- what is an 'intimate examination'
- why chaperones need to be present
- the rights of the patient
- their role and responsibilities. It is important chaperones should place themselves inside the screened-off area rather than outside of the curtains/screen (as they are then not technically chaperoning).
- policy and mechanism for raising concerns.

Clinical staff who undertake a chaperone role will already have a Disclosure and Barring Service (DBS) check. Non-clinical staff who carry out chaperone duties may need a DBS check. This is due to the nature of chaperoning duties and the level of patient contact. If a practice decides not to carry out a DBS check for any non-clinical staff, they need to provide a clear rationale for the decision. This should include an appropriate risk assessment.

#### **4. Use of chaperones during video consultations**

Many intimate examinations will not be suitable for a video consultation. Where online, video or telephone consultations take place, the Online and Video Consultation Policy for Primary Care explains how to protect patients when images are needed to support clinical decision making. This includes appropriate use of photographs and video consultations as part of patient care. Where intimate examinations are performed it is important that a chaperone is offered. Documentation should clearly reflect this. It is important to document who provided the chaperoning. It should also say what part of the consultation they were present for.

#### **5. Review**

This policy will be subject to review every three years, or, in light of any changes to the requirements of Chaperones in Primary Care Services or Trust Policy.