



Clinical Governance Support Team

**Guidance on the Role and Effective Use of
Chaperones in Primary and Community
Care settings**

MODEL CHAPERONE FRAMEWORK

June 2005

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1. INTRODUCTION

This paper sets out guidance for the use of chaperones and procedures that should be in place for consultations, examinations and investigations. This paper does not constitute national policy or guidelines and should not be seen to replace any other professional guidance or organisational policies. However, it does represent a distillation of current good practice across health care organisations.

This is also aimed at providing practical advice to healthcare professionals working in a variety of locations where availability of a chaperone may not always be possible.

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.

For most patients respect, explanation, consent and privacy take precedence over the need for a chaperone. 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.

Every primary care organisation that has direct contact with patients should have a chaperone policy in place for the benefit of both patients and staff. Primary care organisations that are responsible for primary care contractors should have model frameworks in place for local dissemination.

2. SCOPE OF GUIDANCE

This paper applies to all healthcare professionals working within an organisation, including medical staff, nurses, health care assistants, allied health professionals, medical students, radiographers and complementary therapists working with individual patients in surgeries, clinic situations, wards, departments, out-patient and in the patient’s home. This guidance also covers any non-medical personnel who may be involved in providing care. In this guidance all staff groups covered will be referred to as the “healthcare professional”. The use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

3. BACKGROUND

Recent public inquiries, such as the Clifford Ayling Inquiry, have made a number of recommendations into the use of chaperones in primary and community care settings, specifically around who should undertake the role of chaperone and the training for the role. These recommendations have been discussed in the light of practicality and suitability for primary and community care and with a wide range of stakeholders and this guidance reflects those discussions.

The majority of the research into the use of chaperones has been limited to general practice. A study looking at attitudes of patients towards the use of chaperones carried out in Tyneside found that 90% of female patients and 78% of male patients thought that a chaperone should be offered for 'intimate' examinations.

It is clear from available research that the use of chaperones is increasing with male doctors use of chaperones recorded at 68%, although use of chaperones by female doctors remains low at 5%. About one third of GP practices have a chaperone policy in place, although it is not clear what this entails. Practice nurses are the most commonly used chaperones (78%) with family member/friend (47%) and non-clinical staff (43%) listed as alternatives. In 60% of cases the chaperone is stationed beside the patient, whilst in 36% the chaperone remains outside the curtain. The offer of a chaperone and their presence is recorded in medical notes in less than a third of cases.

The most commonly identified issues that restrict the offer and use of chaperones were availability of chaperones and time constraints when one is required.

4. GENERAL ISSUES

Chaperones are most often required or requested where a male examiner is carrying out an intimate examination or procedure on a female patient. Complaints involving allegations of improper examination by a doctor are very rare. Where allegations of indecent assault during a clinical examination do occur almost all are against a male doctor and a small but significant minority of cases involve a male doctor and a male patient. However, it is good practice for a health organisation to offer all patients a chaperone for any consultation, examination or procedure where **the patient** feels one is required. This offer can be made through a number of routes including prominently placed posters, practice leaflets and verbal information prior to the actual consultation.

It is not always clear ahead of the consultation that an intimate examination or procedure is required. It may be wise, especially where a male clinician examines a female patient to repeat the offer of a chaperone at the time of the examination.

Adequate information and explanation as to why the examination or procedure is required should be provided and where necessary, easily understood literature and diagrams can support this verbal information. In addition, careful and sympathetic explanation of the examination technique to be used should be given throughout the procedure being carried out. It is unwise to assume that the patient understands why certain examinations are being conducted or why they are done in a certain manner. For example, patients need to be told why both breasts are examined when they may complain of a lump in only one, or why a vaginal examination may be necessary if a woman complains of abdominal pain or why the testes may be examined in a child with abdominal pain.

Attention must be given to the environment ensuring adequate privacy is afforded to maintain dignity.

Staff should be aware that intimate examinations might cause anxiety for both male and female patients and whether or not the examiner is of the same gender as the patient.

5. ROLE OF THE CHAPERONE

There is no common definition of a chaperone and their role varies considerably depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out. Broadly speaking their role can be considered in any of the following areas:

- Providing emotional comfort and reassurance to patients
- To assist in the examination, for example handing instruments during IUCD insertion
- To assist with undressing patients
- To act as an interpreter
- To provide protection to healthcare professionals against unfounded allegations of improper behaviour
- In very rare circumstances to protect the clinician against an attack
- An experienced chaperone will identify unusual or unacceptable behaviour on the part of the health care professional

A chaperone is present as a safeguard for all parties (patient and practitioners) and is a witness to continuing consent of the procedure.

6. TYPE OF CHAPERONE

The designation of the chaperone will depend on the role expected of them and on the wishes of the patient. It is useful to consider whether the chaperone is required to carry out an active role – such as participation in the examination or procedure or have a passive role such as providing support to the patient during the procedure.

Informal chaperone

Many patients feel reassured by the presence of a familiar person and this request in almost all cases should be accepted. A situation where this may not be appropriate is where a child is asked to act as a chaperone for a parent undergoing an intimate examination. They may not necessarily be relied upon to act as a witness to the conduct or continuing consent of the procedure. However if the child is providing comfort to the parent and will not be exposed to unpleasant experiences it may be acceptable for them to be present. It is inappropriate to expect an informal chaperone to take an active part in the examination or to witness the procedure directly.

Formal chaperone

A formal chaperone implies a clinical health professional, such as a nurse, or a specifically trained non-clinical staff member, such as a receptionist. This individual will have a specific role to play in terms of the consultation and this role should be made clear to both the patient and the person undertaking the chaperone role. This may include assisting with undressing or assisting in the procedure being carried out. In these situations staff should have had sufficient training to understand the role expected of them. Common sense would dictate that, in most cases, it is not appropriate for a non-clinical member of staff to comment on the appropriateness of the procedure or examination, nor would they feel able to do so.

Protecting the patient from vulnerability and embarrassment means that the chaperone would usually be of the same sex as the patient. Therefore the use of a male chaperone for the examination of a female patient or of a female chaperone when a male patient was being examined could be considered inappropriate.

The patient should always have the opportunity to decline a particular person as chaperone if that person is not acceptable to them for any reason.

In all cases where the presence of a chaperone may intrude in a confiding clinician-patient relationship their presence should be confined to the physical examination. One-to-one communication should take place after the examination.

7. USE OF VIRTUAL CHAPERONES

Virtual chaperone technology enlists the support of electronic and digital recording techniques to provide a record of the consultation. There is possible merit in the use of this, although further investigation and trials would be helpful in determining to what extent. However it is unlikely that it provides a sole solution to the issue of chaperoning. Where a visual record is made the patients must be made aware of the nature and purpose of the recording and have the opportunity to decline to give consent.

Any primary care organisation wishing to offer virtual chaperone technology as a solution, either in part or in full, should ensure that they have explored all risks associated with such technology and put in place safeguards to address these.

For example, patients would need to be reminded that if recordings are to form part of their medical record and if they agree to their records being used for medical research or teaching, or if they give other people access to their records, that may include the recordings of their intimate examinations.

Storage of any digital records must be kept secure, and agreements made on lifespan for keeping recordings. Records could be subject to inappropriate use if mislaid or lost.

In situations where the lighting has to be dimmed for the examination, visual recording would presumably be of less use.

8. TRAINING FOR CHAPERONES

It is advisable that members of staff who undertake a formal chaperone role have undergone training such that they develop the competencies required for this role. These include an understanding of:

- 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 responsibility
- Policy and mechanism for raising concerns

Induction of new clinical staff should include training on the appropriate conduct of intimate examination. Trainees should be observed and given feedback on their technique and communication skills in this aspect of care.

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

9. OFFERING A CHAPERONE

All patients should be routinely offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted in order to ask if the patient wants a third party present. The offer of chaperone should be made clear to the patient prior to any procedure, ideally at the time of booking the appointment. Most patients will not take up the offer of a chaperone, especially where a relationship of trust has been built up or where the examiner is the same gender as them.

If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined. If a chaperone is refused a healthcare professional cannot usually insist that one is present and many will examine the patient without one.

Patients decline the offer of a chaperone for a number of reasons: because they trust the clinician, think it unnecessary, require privacy, or are too embarrassed.

Case Study 1

"I regularly offer chaperones to patients when planning an intimate examination. The majority don't take me up on the offer, but when one does I phone through a request to reception. If no one is available immediately the patient goes back to the waiting room and I continue to see my patients until someone is available. This means that I can stick to time and carry on seeing my list of patients and the first patient is seen as soon as someone is available."

However, there are some cases where the (usually male) doctor may feel unhappy to proceed. This may be where a male doctor is carrying out an intimate examination, such as cervical smear or breast examination. Other situations are where there is a history of violent or unpredictable behaviour on behalf of the patient or their family member/friend.

In these situations it may be possible to arrange for the patient to see another doctor or health professional.

For some patients, the level of embarrassment increases in proportion to the number of individuals present.

10. WHERE A CHAPERONE IS NEEDED BUT NOT AVAILABLE

If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe. If the seriousness of the condition would dictate that a delay is inappropriate then this should be explained to the patient and recorded in their notes. A decision to continue or otherwise should be jointly reached. In cases where the patient is not competent to make an informed decision then the healthcare professional must use their own clinical judgement and record and be able to justify this course of action.

Case Study 2

"If a patient of mine takes me up on the offer of a chaperone and no one is available I give them two options, either to wait until the end of surgery when a chaperone can be found or to rebook for another day when we can plan for someone to be available. Patients seem happy to wait as it is their choice to have the chaperone and understand the limitations in the middle of a busy day"

It is acceptable for a doctor (or other appropriate member of the health care team) to perform an intimate examination without a chaperone if the situation is life threatening or speed is essential in the care or treatment of the patient. This should be recorded in the patients' medical records.

11. CONSENT

Implicit in attending a consultation it is assumed that that a 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.

11.1 Special circumstances

There may be special situations where more explicit consent is required prior to intimate examinations or procedures, such as where the individual concerned is a minor or has special educational needs. In these circumstances individuals should refer to their local policy on Consent for specific details relevant to their working environment. For example, in the case of a woman who is a victim of an alleged sexual attack valid written consent must be obtained for the examination and collection of forensic evidence.

12. 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.

<p>Healthcare professionals should refer to their local Child Protection policies for any specific issues.</p>

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 presents 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).

13. ISSUES SPECIFIC TO RELIGION/ETHNICITY OR CULTURE

The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult, for example, Muslim and Hindu women have a strong cultural aversion to being touched by men other than their husbands. 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.

14. 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 should be abandoned and an assessment should be made of whether the patient can be considered competent or not. If the patient is competent, despite learning difficulties or mental health problems, the investigation or treatment cannot proceed, If on the other hand, the patient is incompetent, the patient should be treated according to his or her own best interests. Assessing best interests must take into account the potential for

physical and psychological harm but in some situations it may be necessary (to secure the patients best interests) to proceed in an appropriate manner which, in some cases, may mean examination under anaesthetic. In life-saving situations the healthcare professional should use professional judgement and wherever possible discuss with a member of the Mental Health Care Team.

The series Books Beyond Words (Gaskell Publications), especially “Looking After My Breasts” and “Keeping Healthy Down Below” may be helpful.

15. LONE WORKING

Where a health care professional is working in a situation away from other colleagues e.g. home visit, out-of-hours centre, the same principles for offering and use of chaperones should apply. Where it is appropriate family members/friends may take on the role of informal chaperone. In cases where a formal chaperone would be appropriate, i.e. intimate examinations, the healthcare professional would be advised to reschedule the examination to a more convenient location. However in cases where this is not an option, for example due to the urgency of the situation or because the practitioner is community based, then procedures should be in place to ensure that communication and record keeping are treated as paramount.

Case Study 3

“I work on my own in my premises, but on Tuesday and Thursday afternoons another therapist works in the room opposite. I let any of my patients know that if they prefer to be treated with a chaperone present then these are the times when I can arrange it for them. This works well and I can also provide the same service to my colleague.”

Health care professionals should note that they are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present.

16. DURING THE EXAMINATION/PROCEDURE

Facilities should be available for patients to undress in a private, undisturbed area. 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. Examination should not be interrupted by phone calls or messages.

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. If appropriate this can be used as an educational opportunity for the patient. The professional must consider (asking the patient as necessary) if it is appropriate for the chaperone to remain at this stage.

Any requests that the examination be discontinued should be respected.

17. COMMUNICATION AND RECORD KEEPING

The most common cause of patient complaints is a failure on the patient's part to understand what the practitioner was doing in the process of treating them. It is essential that the healthcare professional explains the nature of the examination to the patient and offers them a choice whether to proceed with that examination at that time. The patient will then be able to give an informed consent to continue with the consultation.

A case where a female patient complained against her male doctor for conducting an inappropriate breast examination. She complained that she was asked to strip off and display her naked torso and that the doctor spent some time looking at her breasts. He then asked her to raise her arms and examined the 'normal' breast. The case was dismissed from the GMC but illustrates how a simple explanation of what the examination entails could prevent problems.

Recording in Patients' notes

Details of the examination including presence/absence of chaperone and information given must be documented in the patient's medical records. This could include formal GP records, nursing notes, Patient Medication Records for pharmacists or therapists record cards.

For GP records appropriate READ coding is available, either in 4 or 5 byte mode:

4byte		5 byte (include full stop)
9NP0	Chaperone Offered	9NP0.
9NP1	Chaperone Present	9NP1.
9NP2	Chaperone Refused	9NP2.
9NP3	Nurse Chaperone	9NP3.

E.g. for EMIS practices:

<i>Select patient</i>	
MR	
A =	Add
C =	Common entry
A=	Medical Records Entry
Enter:	Chaperone (or type code 9NP1)
Select:	Chaperone Present
Enter free text	(e.g. Jane Bloggs, Chaperone, no problems
Or	
Enter:	Chaperone (or type code 9NP2)
Select:	Chaperone Declined

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.

In any situation where concerns are raised or an incident has occurred and a report is required this should be completed immediately after the consultation. Please refer to local policy on Raising Concerns.

There is currently no formal requirement to monitor the offer and use of chaperones. However some organisations may find it helpful as a measure of good practice. It would be simple to carry out an audit of chaperone use, looked at in conjunction with the policy of the organisation.

18. WEARING OF GLOVES

During an intimate internal examination it is strongly recommended that surgical gloves be worn. The glove acts as a physical barrier, keeping the examination on a clinical basis, limiting the possibility of sexual connotations. Situations where a healthcare professional may reasonably not wear gloves would be in a life-saving situation where gloves are not available. Healthcare professionals should always seek to carry gloves when on call.

19. SUMMARY

The relationship between a patient and their practitioner is based on trust. A practitioner may have no doubts about a patient they have known for a long time and feel it is not necessary to offer a formal chaperone. Similarly studies have shown that many patients are not concerned whether a chaperone is present or not. However this should not detract from the fact that any patient is entitled to a chaperone if they feel one is required.

Chaperone guidance is for the protection of both patients and staff and this guidance should always be followed. The key principles of communication and record keeping will ensure that the practitioner/patient relationship is maintained and act as a safeguard against formal complaints, or in extreme cases, legal action.

A sample chaperoning policy is attached at Appendix A and a sample patient information notice is attached at Appendix B. These are generic and could be adjusted for individual use. All primary care organisations should have a chaperoning policy in place, which covers all staff undertaking patient consultations, examinations or procedures.

20. FURTHER INFORMATION

1. **Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling.**
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4088996&chk=mlRN1X
2. **Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale**
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4088995&chk=pkjiaG
3. www.the-shipman-inquiry.org.uk
4. **Reference Guide to Consent for Examination or Treatment, Dept of Health**
<http://www.dh.gov.uk/assetRoot/04/01/90/79/04019079.pdf>
5. **GMC: Intimate examinations** <http://www.gmc-uk.org/standards/intimate.htm>
6. **Royal College of Nursing: The role of the nurse and the rights of patients, Guidance for nursing staff, July 2002** Publication code 001 446 www.rcn.org.uk
7. **Chaperones for intimate examinations: cross sectional survey of attitudes and practices of general practitioners, 3/12/04**
<http://bmj.bmjournals.com/cgi/content/full/330/7485/234>
8. **Use and offering of chaperones by general practitioners: postal survey in Norfolk, 16/12/04** <http://bmj.bmjournals.com/cgi/content/full/330/7485/235?ehom>
9. **Attitudes of patients towards the use of chaperones in Primary care – Whitford DL, Karin M, Thompson G. British Journal of General Practice 2001; 51:381-3**
10. **Guidelines in Practice, July 2002 Vol 5 (7), 52-53** www.eguidelines.co.uk
11. **Virtual chaperone enhances patient records 18 July 2003**
http://www.bupa.co.uk/about/html/pr/180703_virtual_chaperone.html
12. **Big Sister is watching you, The Economist 18 Nov 2004**
http://www.economist.com/science/displayStory.cfm?story_id=3398801
13. **Black Box – Lachlan Clark** <http://www.studentbmj.com/search/pdf/03/03/sbmj57.pdf>
14. **Primary Care Training Centre, Bradford Tel: 01274 617617 Chaperone study day**
<http://www.primarycaretraining.co.uk>

Written by:

Dr Clare Gerada, NHS Clinical Governance Support Team

Lucy Warner, Primary Care, NHS Clinical Governance Support Team

With thanks to:

Dr Maurice Conlon, NHS Clinical Governance Support Team

Philip Leech, Consultant Advisor in Primary Care

Elaine Edgar, Department of Health

Elaine Fletcher, Department of Health

Dr Orest Mulka, Royal College of General Practitioners

Lynn Young, Royal College of Nursing

Dr Paul Lambden, Small Practices Association

Dr Hamish Meldrum, British Medical Association

Gail Norcliffe, British Medical Association

Joan Russell, National Patient Safety Agency

Dr Peter Old, National Clinical Assessment Service

Martin McLeish, Royal College of Physicians

Dr Fiona Subotsky, Royal College of Psychiatry

Dr Sherry Williams, Medical Protection Society

Peter Schutte, Medical Defence Union

Mary Shepherd, National Institute for Mental Health in England

Helen Woodhead, Primary Care Training Centre

Mavis Bates, Primary Care Training Centre

Heidi Wright, Royal Pharmaceutical Society of Great Britain

Julia Ashford, North Hampshire Primary Care Trust

SAMPLE CHAPERONE POLICY

Primary Care Organisation

This organisation is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

This chaperone policy adheres to local and national guidance and policy – e.g. **“NCGST Guidance on the Role and Effective Use of chaperones in Primary and Community Care settings”**.

The chaperone policy is clearly advertised through patient information leaflets, websites (where available) and on notice boards,

Patients are encouraged to ask for a chaperone if required at the time of booking appointment wherever possible.

All staff are aware of, and have received appropriate information in relation to, this chaperoning policy.

All formal chaperones understand their role and responsibilities and are competent to perform that role.

Checklist for Consultations involving intimate examinations

1. **Establish there is a genuine need for an intimate examination and discuss this with the patient.**
2. **Explain to the patient why an examination is necessary and give the patient an opportunity to ask questions**
3. **Offer a chaperone or invite the patient to have a family member/friend present. If the patient does not want a chaperone, record that the offer was made and declined in the patients notes.**
4. **Obtain the patients consent before the examination and be prepared to discontinue the examination at any stage at the patient’s request.**
5. **Record that permission has been obtained in the patients notes.**
6. **Once chaperone has entered the room give the patient privacy to undress and dress. Use drapes where possible to maintain dignity.**
7. **Explain what you are doing at each stage of the examination, the outcome when it is complete and what you propose to do next. Keep discussion relevant and avoid personal comments.**
8. **If a chaperone has been present record that fact and the identity of the chaperone in the patients notes.**
9. **Record any other relevant issues or concerns immediately following the consultation.**

This policy is agreed on behalf of the above organisation.

Signed _____

Name _____

POLICY AGREED – (Date)

POLICY REVIEW DUE – (Date)

SAMPLE PATIENT NOTIFICATION

CHAPERONE POLICY

This organisation is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

All patients are entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. This chaperone may be a family member or friend. On occasions you may prefer a formal chaperone to be present, i.e. a trained member of staff.

Wherever possible we would ask you to make this request at the time of booking appointment so that arrangements can be made and your appointment is not delayed in any way. Where this is not possible we will endeavour to provide a formal chaperone at the time of request. However occasionally it may be necessary to reschedule your appointment.

Your healthcare professional may also require a chaperone to be present for certain consultations in accordance with our chaperone policy.

If you would like to see a copy of our Chaperone Policy or have any questions or comments regarding this please contact the manager.