

CLINICAL GUIDELINE

Chaperones

Printed or downloaded copies of this document are not controlled – In exceptional circumstances where hard copies or downloaded versions are required, these will only be valid on the day printed or downloaded – please always ensure that the most up-to-date version is accessed through the [Policy section of GHC Intranet](#). If any updates or changes to this document are required, please contact the Clinical Policy Group on: [REDACTED] prior to making any amendments. Documents are password protected to prevent any unauthorised changes.

Guideline Number	CLG013
Version:	V3
Purpose:	Contained in these guidelines is practical advice to healthcare professionals working in a variety of locations on implementation, when and how to offer a chaperone, record keeping and difficulties faced by community-based teams
Consultation:	Clinical Policy Consultation Group, with specific feedback provided by MCA Leads and Sexual Health Leads
Ratified by:	Clinical Policy Group
Date Ratified:	18/11/2025
Date of Issue:	03/12/2025
Review Date:	01/12/2028
Author / Reviewer:	Reviewed by: [REDACTED], Head of Safeguarding, [REDACTED] [REDACTED] Named Nurse for Safeguarding Children
Audience:	Registered and non-registered staff including Healthcare Assistants, Admin and Reception staff with competence
Dissemination:	This guideline is available on the Trust intranet under Clinical Guidelines
Impact Assessments:	This Guideline has been subjected to an Equality Impact Assessment. This concluded that this guideline will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date	Reason for Change
V1	March 2019	GCS policy review by 2G staff with comments and amendments offered – merged for GHC
V2	April 2022	Reviewed to reflect current guidance that family members, carers and friends should not usually be considered as a chaperone and to ensure that the latest guidance is reflected throughout the policy

V3	03/12/2025	Updates to links where appropriate. Added detail re MCA considerations to ensure compliance. Reference to learning disabilities (6.9) and safeguarding (9.1)
----	------------	--

SUMMARY

It is good practice to offer all patients a chaperone for any consultation, examination, or procedure, including the administration of medication, where the patient feels one is required.

TABLE OF CONTENTS

	Section	Page
1	Introduction	2-3
2	Purpose	3
3	Scope	3
4	Duties	3-4
5	Mental Capacity Act Compliance	4
6	Guideline Detail	4-9
7	Process for Monitoring Compliance	9-10
8	Incident, Near Miss Reporting and Duty of Candour	10
9	Training	10
10	References	10-11
11	Associated Documents	11
Appendix 1	Chaperone Guideline and Checklist	12
Appendix 2	Patient Notification	13
Appendix 3	Example Audit Tool from Sexual Health	14-15
Appendix 4	Assessment of Competency	16-18

ABBREVIATIONS

Abbreviation	Full Description
DBS	Disclosure and Barring Service
GHC	Gloucestershire Health and Care NHS Foundation Trust
GP	General Practitioner

1. INTRODUCTION

All clinical consultations, examinations and investigations are potentially distressing. Service users may find some examinations, collectively referred to as “intimate examinations” particularly intrusive. These can be examinations, investigations or photography involving the breasts, genitalia, anus (including vaginal and rectal examinations). Also, consultations involving dimmed lights, the need for service users to undress or for intensive periods of being touched, may make an individual feel vulnerable.

The 'Clifford Ayling Inquiry' in 2004, 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 these guidelines reflects those discussions.

2. PURPOSE

The purpose of this document is to ensure that the Trust meets statutory requirements and minimises risks to service users, professional staff and the organisation, by ensuring that a systematic and planned approach for the provision of chaperones is in place.

Contained in these guidelines is practical advice to clinical and non-clinical professionals who have received training, working in a variety of locations, when and how to offer a chaperone, record keeping and difficulties faced by community-based teams.

A chaperone, in this clinical instance, is a third-party present at a consultation that usually, but not exclusively, involves an intimate examination, as a safeguard for all parties and is a witness to continuing consent for the intervention.

3. SCOPE

This guideline is intended for staff working in clinical areas at Gloucestershire Health and Care NHS Foundation Trust.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aim to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.

- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on [MCA Compliance below](#) and the Mental Capacity Act Code of Practice 2007.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](#). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](#).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. GUIDELINE DETAIL

6.1 General Issues

Chaperones are most often required or requested where a male examiner is carrying out an intimate examination or procedure on a female service user. Complaints involving allegations of improper examination by a doctor are very rare, but 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 service user.

The College of Sexual Reproductive Healthcare; in their Service standards for consultations in sexual and reproductive health services (2020) states that, 'All patients should be given the option to have an impartial observer to act as a chaperone, wherever possible, for all intimate examinations. This is not dependent upon the gender of the healthcare professional and is recommended for all clinical examinations of an intimate nature'.

It is **good practice** for a health organisation to offer all patients a chaperone for any consultation, examination or procedure where **the service user** feels one is required.

Staff should be aware that intimate examinations might cause anxiety for both males and females regardless of whether or not the examiner is of the same gender as themselves.

Staff should remember when acting as chaperone they need to be in view and ear shot of the patient and clinician. It is not sufficient to be the other side of the curtain.

6.2 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 use of a chaperone should always be considered when a service user:

- Requires intimate examination, treatment or care and where a service user may not have capacity to consent to the proposed examination/treatment or care due to the following:
 - Is semi-conscious or unconscious.
 - Is intoxicated with alcohol or has taken any drug or substance known to have hallucinogenic effect.
 - Is confused and / or disorientated.
- Does not use English as their first language. Intimate examinations should never be carried out for non-English speaking patients without an independent interpreter (use telephone interpreter if necessary) except if not possible in an emergency or for emergency treatment e.g. sexual health.
- Has a hearing, visual or speech difficulty.
- Is an adult at risk e.g. a service user with learning disabilities, mental health difficulties or cognitive impairment?
- Vulnerable or anxious patients.
- Patients with whom there may have been a difficulty, misunderstanding or difference of recollection in the past.
- Has a history of abuse or where abuse is suspected.

The GMC guidance state that a chaperone should usually be a health professional. A relative or friend of the patient is not a trained impartial observer and so would not usually be a suitable chaperone. However, the presence of a chaperone does not override a patients wish to be

supported by a relative, friend or advocate. Therefore, a family member or carer cannot be a chaperone but could be present.

6.3 Type of Chaperone

The designation of the chaperone will depend on the role expected of them and on the wishes of the service user. 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 during the procedure. [Appendix 1](#) provides a Chaperone guideline and check list.

Informal Chaperone

Many individuals feel reassured by the presence of a familiar person, such as a family member or close friend, and this request in almost all cases should be accepted. However, the College of Sexual Reproductive Healthcare (2020) state that, 'A relative or friend of the patient is not an impartial observer and therefore would not usually be a suitable chaperone. The healthcare professional leading the consultation and examination, should comply with a patient's reasonable request to have such a person present as well as a chaperone.'

It is not appropriate for a child to act as a chaperone for a parent undergoing an intimate examination as 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 or a familiar person 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 registered nurse, non-registered 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 service user 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 undertaken the required training and assessment to understand the role expected of them.

All members of staff to act as a chaperone for a child or an adult must have an enhanced DBS check. 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 service user from vulnerability and embarrassment means that the chaperone would usually be of the same gender as the patient.

The service user should always have the opportunity to decline a particular person as a chaperone if that person is not acceptable to them for any reason. They should be made aware that in order to locate a replacement chaperone the procedure may be delayed or necessitate the appointment to be rescheduled.

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 separately.

6.4 Offering a Chaperone

Although it is good practice for all service users to be routinely offered a chaperone during any consultation or procedure, it does not mean that every consultation needs to be interrupted in order to ask if the service user wants a third-party present.

Ideally the offer of a chaperone should be made prior to the actual consultation via prominently placed posters, practice leaflets and verbal information when booking appointments, although it is recognised that it is not always clear ahead of the consultation that an intimate examination or procedure is required. An example of a patient notification poster can be found in [appendix 2](#).

People will decline the offer of a chaperone for a number of reasons: because they trust the clinician, therefore think one is unnecessary, require privacy or would find the situation too embarrassing with a third-party present. For some, the level of embarrassment increases in proportion to the number of individuals present.

However, there are some cases where the clinician may feel unhappy to proceed unless a chaperone is present e.g. where there is a history of violent or unpredictable behaviour on behalf of the service user or their family member/friend.

If a chaperone is refused by the service user, a healthcare professional cannot usually insist that one is present, but where reasonably practicable in these situations it may be necessary to reschedule the appointment to enable the health professional to seek advice.

Depending upon the circumstances of the service user and the intervention, if the service user is offered and declines a chaperone, it is important that this is recorded.

6.5 Where a Chaperone is Needed but not Available

If the service user has requested a chaperone and none is available at that time, the service user must be given the opportunity to reschedule their appointment within a reasonable timeframe. If the appointment is to be rescheduled, and/or treatment has been delayed, a DATIX must be completed.

If the seriousness of the condition would dictate that a delay is inappropriate, then this should be explained and recorded in the clinical record. A decision to continue or otherwise should be jointly reached. If there are concerns that the service user may not have capacity to consent, a formal capacity assessment should be undertaken. If they are assessed as lacking capacity a formal best interests' decision should be recorded using the Trust MCA forms.

It is acceptable for a doctor (or another 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 service user. This should be recorded in the service users' clinical records.

6.6 Consent

It is assumed that in attending a consultation a service user is seeking treatment. However, before proceeding with an examination/treatment, healthcare professionals should always provide

sufficient information for the individual to be able to make an informed decision to give consent or not (Consent to for Examination or Treatment, Department of Health, 2009 [Consent to Examination or Treatment Policy - CLP213](#))

This may be by word or gesture, or some explicit indication that the patient understands the proposal for examination/treatment and can make a decision whether to agree or not to it being carried out in line with the capacity assessment test within the Mental Capacity Act (2005).

Consent should always be appropriate to the treatment or investigation being carried out, and in some cases written consent should be sought. Consent cannot be given if the person lacks capacity to give their consent. If a person is assessed formally as lacking consent to examination or treatment, then a formal best interest decision must be made following a formal best interest process, recorded on the Trust MCA best interest form, In cases where intervention is urgent, the MCA paperwork can be completed retrospectively, after the clinician has completed the examination/treatment in the patient's best interests.

6.7 Issues Specific to Children

If an examination is to be carried out on a child for a non-intimate procedure, a parent, carer, or someone trusted, known and chosen by the child can be an informal chaperone.

During an intimate examination, a child aged 16 or 17 years can give their own consent to an examination or treatment if the health care professional considers them to have capacity and the guidance relating to adults is applied. A formal chaperone must be offered, and an informal chaperone can also be present to comfort if required.

A child under 16 years can consent to their treatment or examination if the practitioner feels that they are 'Gillick competent'. Additional, if the child is seeking support with contraception and sexual health they must meet the Fraser Guidelines. In these cases, a formal chaperone must be present, and no child should be seen unaccompanied. An informal chaperone can also be present to comfort if required.

In cases where abuse is suspected, there must always be a formal chaperone. The General Medical Council guidance states that, 'a relative or friend of the patient is not an impartial observer. They would not usually be a suitable chaperone.'

Healthcare professionals should refer to the Safeguarding Children's Policy on the intranet for further guidance or contact the GHC Safeguarding team. Additional information about confidentiality, data protection and consent can be found at: [Working together to safeguard children - GOV.UK](#)

6.8 Issues Specific to Religion / Ethnicity or Culture

The ethnic, religious and cultural background of some women can make intimate examinations particularly difficult. Some women have a strong cultural aversion to being touched by men other than their husbands, so in these cases 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.

It would be unwise to proceed with any examination if the healthcare professional is unsure that the service user 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 service user by whatever means available before proceeding with the examination.

6.9 Issues Specific to Learning Difficulties/ Learning Disabilities / Mental Health Problems

For service users with learning difficulties, learning disabilities, mental health problems or verbal communication limitations there may be a need for the service user’s capacity to consent, or not, to be recorded in relation to the treatment and the proposed chaperone for that examination/ treatment. Where the service user does not have capacity in this area, a formal chaperone should be identified. A family member or carer should not act as a formal chaperone but may be additional support for the person being examined. A careful, simple and sensitive explanation of what is happening and who will be staying with the service user is vital.

6.10 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. In cases where a chaperone would be appropriate, i.e. intimate examinations, the healthcare professional would be advised to reschedule the examination to a more convenient location or at a time when another health care professional may be able to attend as a formal chaperone. 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. The GHC Lone Working Policy should be read in conjunction with this section of the guidelines.

Healthcare 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.

6.11 During the Examination/Procedure

Chaperones will stay within their described role and restrict their participation in the procedure as agreed in advance with the healthcare professional. On completion of the procedure and once the service user is dressed and is in a position to resume the consultation it may be appropriate for the chaperone to leave the service user to continue the consultation and discuss findings in private.

6.12 Communication and Record Keeping

Details of the examination including presence/absence of chaperone and information given must be documented in the service user’s clinical records. This must include name of the chaperone and their relationship to the service user if appropriate.

It is best practice that the chaperone logs into the patients IT clinical records in their name to document that they acted as a chaperone to the patient.

7. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line	YES
---	-----

with national, regional, trust or local requirements?	
---	--

Monitoring Requirements and Methodology	Frequency	Further Actions
Any Service User feedback, complaint or information from Patient and Carer Experience which relates to non-compliance with the standards in this guideline will be subject to DATIX and further investigation.	On going	Reported to the Trust Board
Individual services may wish to audit their own use of chaperones – see appendix 3 for a suggested template.	Annual	Reported to the Trust Board

8. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust’s Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources. Professional Duty of Candour and the overarching principle of ‘being open’ should apply to all incidents. For any possible Safeguarding concerns, please contact the Safeguarding Advice line on 0300 421 6969 for guidance.

9. TRAINING

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

All unregistered staff who are to undertake a formal chaperone role must have been trained so they develop the competencies required.

It is highly recommended that registered staff also undertake the training.

The Chaperone training can be accessed via Care to Learn and an Assessment of Competence (see [appendix 4.](#)) must be completed and signed by an assessor or senior member of staff.

10. REFERENCES

GHC Consent to Examination or Treatment Policy (CLP213) [Consent to Examination or Treatment Policy - CLP213 - Interact \(ghc.nhs.uk\)](#)

Committee of Inquiry – Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling. [Search - UK Government Web Archive](#)

Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [Search - UK Government Web Archive](#)

Reference Guide to Consent for Examination or Treatment, Dept of Health
<https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

GMC (2013) Intimate examinations and chaperones
<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations->

[and-chaperones](#)

Genital Examination in Women A resource for skills development and assessment (2002)

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>

RCOG (2001) Why Mother s Die. 1997-1999. RCOG: London
New References

RCN (2020) Genital examination in women. A resource for skills development and assessment

The Royal College of Radiologists (2015). Intimate examinations and the use of chaperones. London: The Royal college of Radiologists, August 2015.

Care Quality Commission (2021) GP mythbuster 15: Chaperones

<https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-15-chaperones> [accessed 17.02.22]

Bibliography:

1. CEG National Guidelines – consultations requiring sexual history taking
2. *Chaperone Policy, Gloucestershire LMC, Dec 2001 (Sexual Health Services, Clinical Governance Forum, March 2004*
3. *GMP in action: GMC guidance brought to life (gmc-uk.org)*
4. [Intimate examinations and chaperones - summary - GMC \(gmc-uk.org\)](#)
5. [MDU-Guide to chaperones-20220321227.pdf \(themdu.com\)](#)

11. ASSOCIATED DOCUMENTS

GHC Health Records and Clinical Record Keeping Policy (CLP005)

GHC Consent to Examination or Treatment Policy (CLP213)

Lone Working Policy (GHC/SY_POL/02)

GHC Managing Allegations against Professionals who work with Children and Adults (CLP152)

Appendix 1

Chaperone Guideline and Checklist

Gloucestershire Health and Care NHS Foundation Trust 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 guideline 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 guideline 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 guideline.

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

Checklist for Consultations that may involve the need for a chaperone in 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.

Appendix 2

PATIENT NOTIFICATION CHAPERONE GUIDELINE

Gloucestershire Health and Care NHS Foundation Trust is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being always followed and the dignity and 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 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 guideline.

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

Example Audit Tool

Chaperone Guideline for Intimate Examinations (Guidelines for staff)



OBJECTIVE: All patients undergoing intimate examination of the breasts, genitalia, or rectum are offered a chaperone.

*Audit tool key: A = Documentary evidence. B = Ask patient C = Ask staff

Aspect	Standard	Exception	Definition and Instructions	*Audit Method
1. Patients will be offered a chaperone for all occasions when they are to be examined by a health care professional. This is irrespective of the sex of the patient or their doctor.	100%	None	a) Display a notice in reception outlining that patients will be offered a chaperone. It is recommended that this notice reads: <i>You will be offered the option of a third party with you when you are examined in the clinic today.</i>	B C
	100%	None	b) All members of staff will be aware of the Chaperone Guideline	C
	100%	None	c) All health professionals will understand the sensitive issues of intimate examinations and the importance of maintaining dignity, privacy and confidentiality of the patient.	C
	100%	Staffing levels, staff safety, patient choice	d) The chaperone will usually be a health care professional or a relevantly trained member of staff whom the patient agrees to be present, but a family member would be appropriate depending on the clinical examination planned.	B C
	100%	Patient choice	e) There may be circumstances when family members, friends or partners would not be appropriate chaperones for reasons of confidentiality, possible coercion, and personal preference ¹ .	B

2. Details of chaperone use will be recorded in the patient's notes	100%	Declined by patient.	a) If a chaperone is declined this is recorded in the notes.	A
	100%	Patient choice and health care professional in agreement	b) A chaperone should always be offered when a male member of staff examines a female patient.	B C
	100%		c) A chaperone should be offered when a female health care professional examines a male patient.	B C
	100%		d) If for any reason a chaperone is not available this is explained to the patient and offered an alternative date for the examination.	A B C

Appendix 4: GHC Assessment of Competence for Registered and Non-Registered Staff including Healthcare Assistants, Admin and Reception Staff Clinical Skill: Use of Chaperones – Click [here](#) to download an editable document

		 Gloucestershire Health and Care NHS Foundation Trust																															
Assessment of Competence for Registered and Non-Registered Staff including Healthcare Assistants, Admin and Reception staff. Clinical Skill: Use of Chaperones																																	
Name:		Area of Work:																															
AIM:	To be confident and competent to act as a chaperone when requested and to have a clear understanding of the expectations and role.																																
OBJECTIVES:	The staff member will be able to: <ul style="list-style-type: none"> - Discuss understanding of the Chaperone Policy to include: - An understanding about why a chaperone may be required, and the barriers. - Demonstrate knowledge of the role, and types of chaperones. - Demonstrate an understanding of consent and confidentiality. - Demonstrate appropriate behaviour. - Follow instruction from the clinician. - Understand the importance of documenting in clinical records. 																																
TRAINING:	Training on Care2Learn, includes reading the Chaperone policy, eLearning and assessment.																																
ASSESSMENT:	Assessors must be: <ul style="list-style-type: none"> • A registered health care professional. • Be a clinically competent experienced practitioner. • Achieved competency in being a chaperone. • Undertaking this clinical skill regularly. <p>If <u>any</u> concerns for practice are found, competency sign off must not be completed (see performance criteria below).</p>																																
RISK ASSESSMENT:	Moderate risk C = 4 L = 1 RISK total score – 4) <table border="1" data-bbox="1099 1585 1321 1753" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="6">Consequence</th> </tr> </thead> <tbody> <tr> <td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>10</td> </tr> <tr> <td>3</td><td>6</td><td>9</td><td>12</td><td>15</td><td></td> </tr> <tr> <td>4</td><td>8</td><td>12</td><td>16</td><td>20</td><td></td> </tr> <tr> <td>5</td><td>10</td><td>15</td><td>20</td><td>25</td><td></td> </tr> </tbody> </table>			Consequence						2	3	4	5	6	10	3	6	9	12	15		4	8	12	16	20		5	10	15	20	25	
Consequence																																	
2	3	4	5	6	10																												
3	6	9	12	15																													
4	8	12	16	20																													
5	10	15	20	25																													
UPDATE:	<ul style="list-style-type: none"> • Competence to be reviewed annually at appraisal. • Record of competency to be kept on Care2Learn 																																

UNDERPINNING KNOWLEDGE

It is expected that the staff member will be able to:

- Explain the role of the chaperone and when one is be required.
- Discuss when a chaperone should be offered to a service user.
- Describe what types of chaperones there are and who can act as one.
- Fully discuss the importance of consent and the barriers to gaining consent.
- Demonstrate an understanding about consent for children under 18.
- Describe the process of acting as a chaperone and the expectations.
- Discuss how to report any safeguarding concerns identified.
- Accurately document in the electronic patient records that a chaperone was used in accordance with trust policy.

I certify that the above-named staff member has successfully completed the eLearning and assessment on Care2Learn.

Signed:		Date:	
Print Name:		Position:	

CLINICAL SKILL

PERFORMANCE CRITERIA - The Healthcare practitioner will:		Performed Safely (✓)
1.	Introduce yourself to the service user and state that you are going to chaperone and gain verbal consent that they are comfortable with you being present.	
2.	Prepare and position the individual adequately giving appropriate reassurance, ensuring privacy and dignity are maintained	
3.	Clarify where the clinician would like you to stand.	
4.	Maintain good communication with the individual and offer reassurance throughout the procedure as required.	
5.	Continue to observe for nonverbal cues of pain and discomfort being experienced and inform the clinician without delay.	
6.	Ensure the patient is comfortable before leaving.	
7.	Accurately record your presence as chaperone within the electronic patient record system.	

I confirm that the above-named staff member has completed the assessment competently.

Signed:		Date:	
---------	--	-------	--



Print Name:		Position:	
-------------	--	-----------	--

ASSESSOR COMMENTS

--

CANDIDATE COMMENTS

--

DECLARATION

I confirm that I have had theoretical and practical instruction on how to safely and competently act as a chaperone and agree to comply with the policy and procedures of the Trust. I acknowledge that it is my responsibility to maintain and update my knowledge and skills relating to this competency.

Signed:		Date:	
---------	--	-------	--

SPONSOR/PEER REVIEW

To ensure the content is accurate, current and evidenced based, competencies are required to be peer reviewed by subject matter experts within the specialty. It is your responsibility, as the author, to ensure this is undertaken and the peer review section is signed by the appropriate person.

Author's Name:	██████████	Position:	Named Nurse for Safeguarding Children
Peer Review Name:		Position:	
Signed:		Date:	