The Royal College of Emergency Medicine

Best Practice Guideline

Chaperones in Emergency Departments

March 2015

Summary of recommendations

1. The presence of a chaperone should be offered to all Emergency Department patients undergoing a "Sensitive Area Examination", regardless of patient-practitioner genders.
2. Chaperones need to be Emergency Department health care professionals or volunteers that have received appropriate training.
3. The presence or absence of a chaperone should be appropriately documented.
4. Vulnerable Emergency Department patients should be offered a chaperone for any examination or procedure.
5. If an Emergency Department patient declines a chaperone, the fact that one was offered and declined should be documented in the ED record.
6. A local hospital chaperone policy should be tailored to the specific requirements of patients within Emergency Department, and constraints within the Emergency Department

Scope

This policy applies to all healthcare professionals working within the Emergency Department of an NHS Hospital, with direct patient care.

The policy is equally applicable to both male and female practitioners dealing with either gender of patients.

The policy specifically applies to all **Sensitive Area examinations and procedures**, defined as any examination below the clavicles and above the mid-thigh. Note that other examinations may be considered sensitive by particular patients. Healthcare professionals should ensure that they are sensitive to this and tailor their service to the perceived needs of the patient.

Reason for development

The most up-to-date GMC guidance on intimate examinations states that patient's should be offered the use of chaperones wherever possible before conducting an intimate examination [(1)].

The Ayling report of September 2004 highlighted the risks that a patient might be subjected to by an unscrupulous medical professional. It promoted chaperone use as a means of preventing a similar situation from occurring in the future. It made the following recommendations:

- Each NHS Hospital should have its own chaperone policy and this should be made available to patients.
- An identified managerial lead (with appropriate training).
- Family members or friends should not undertake the chaperoning role.
- The presence of a chaperone must be the clear expressed choice of the patient; patients also have the right to decline a chaperone.
- Chaperones should receive training [(2)].

The Emergency Department is a specific microcosm of clinical practice, in which a fluid and flexible, whole body assessment is usually required. This reality combined with the time pressure and sense of urgency that pervades Emergency Departments, puts the practitioner in a position in which it is easy to take their patient's awareness of what is going on during the assessment for granted. For instance, migrating to the groin or axilla to assess the lymph nodes in the setting of a suspected limb infection or looking for hernias in the groin to assess abdominal pain may not be as logical a leap for the patient as it is for a medical practitioner. This can lead to patients feeling that doctors are behaving in a way that may be deemed inappropriate, as they may be unable to appreciate the medical reasoning behind their actions. In extreme cases, the patient may even be left feeling violated.

To tackle this issue specific to Emergency Department medicine, an NHS Hospital should devise guidelines that recommend the mandatory use of chaperones for all examinations that may occur over areas of the body that the patient may feel sensitive or embarrassed about. This goes beyond the "intimate examinations" referred to in GMC guidelines, for which the presence of a chaperone should by now be an absolute standard [(1)]. This new sub-group of examinations shall be referred to as "Sensitive Area examinations" and is defined as any examination below the level of the clavicles and above the mid-thigh level. Within the ED, this group of patients will constitute a significant number of patients; as it will likely include all non-ambulant patients, and proportion of ambulant patients. In

many departments, this could exceed half of all patients, which will represent a significant burden for the department to resource chaperones.

It has recently been shown that clinical practice regarding the use of chaperones during intimate examinations is not always consistent with GMC recommendations. Furthermore, there is a lack of consistency in how and when chaperones are used between Hospitals [3].

If the use of chaperones during intimate examinations in any clinical setting are neither sufficient nor standardised across the country it can be reasonably deduced that this deficiency is equally present, if not widespread, for Sensitive Area examinations.

In response to this, the guidelines proposed in this policy should serve to protect patient's interests, making them feel safe and re-assured when undergoing examinations they may find stressful or embarrassing. They should also serve to protect doctors from allegations of inappropriate behaviour that might lead to criminal, civil and GMC proceedings as well as adverse media publicity.

Introduction

The Emergency Department is an environment in which the entire range of physical examinations may be clinically necessary, and so a hospital should recognise the need for a clear chaperone policy **tailored** to the Emergency Department setting. This should involve increased use of chaperones for all examinations of Sensitive Areas to ensure compliance with defence organisations advice and GMC guidelines.

1. Outline

1.1 Any patient undergoing a Sensitive Area examination or procedure in the ED should be offered the opportunity to have a chaperone present, regardless of the patient's age or gender.

2. Chaperones

2.1 A chaperone should be a trained and impartial practitioner, health professional or volunteer, who will act to protect the patient from inappropriate conduct by the examining practitioner as well as protecting the examining clinician from allegation of inappropriate behaviour or action. An exemplary chaperone will:

- Be familiar with the examination or procedure being carried out.
- Be respectful to the patient and sensitive to their dignity and confidentiality.
- Be present throughout the entirety of the examination.
- Be positioned so that they have a clear view of what the doctor is doing, as well as being able to hear clearly everything the doctor is saying to the patient.
- Be prepared to raise concerns regarding a doctor's behaviour or actions, remembering that abuse can exist in both auditory and visual forms and it is not necessarily tactile.
- Reassure the patient if necessary.
- Pay attention to whether the examining clinician is spending an excessive amount of time on a particular examination of a sensitive area [1].

2.2 Ideally, the managerial lead should be responsible for making sure that all healthcare professionals, staff or volunteers who might act as chaperones in the ED are appropriately trained to act as chaperones, ensuring that they are capable of fulfilling the above criteria. It is a managerial responsibility to provide resource, and to ensure compliance.

2.3 Friends or family members of the patient are not regarded as impartial and therefore cannot act as formal chaperones, however efforts should be made to comply with reasonable requests to have these people present also.

2.4 Chaperones should have a low threshold for, and be empowered to, raising of concerns regarding:

- A less than professional manner.
- Over-exposure of a patient's body.
- Inappropriate comments or gestures.
- Inappropriate facial expressions [4].

2.5 In the scenario that a chaperone identifies a problem with a clinician's conduct, it is essential that a chaperone should inform the most senior member of the team as soon as possible. This should ensure that problems are dealt with efficiently and avoids confusion or muddled facts when attempting to recount the sequence of events subsequently.

2.6 The ED is a place of urgency and the relentless time pressures leave it vulnerable to practitioners not complying with their responsibility to offer and provide a chaperone to patients. Unpublished audit data and anecdotal experience show that this is particularly widespread in spite of advice and teaching to the contrary. To avoid this frequently encountered problem, the onus is on the hospital to ensure that there are sufficient numbers of trained staff or volunteers readily available at all times. It is appreciated that in some departments, resources could limit full compliance, however if this is the case, this should be identified as a departmental risk, and managerial responsibility clarified.

3. Sensitive Area Examinations

3.1 A Sensitive Area examination or procedure should be considered to be any examination or procedure that will occur below the level of the clavicles or above the level of the mid-thigh. This encompasses all of the intimate examinations (of breasts, anus, genitalia) as well as targeting body regions that are in close proximity to intimate areas, such as the axilla or the inner thigh and groin. It should be noted that a patients definition or appreciation of what constitutes a sensitive area examination may differ from this.

3.2 For vulnerable patients, (e.g. those that are known to have been victims of abuse in the past or those that a clinician perceives to be particularly anxious or sensitive to examination), any examination should be treated as a Sensitive Area examination [5]. Consideration should be given for chaperone presence for all patient interaction in some cases. If no history is available, clinical judgement and common sense must be used to

identify these patients by determining a perceived level of patient anxiety as well as considering any views expressed by the patient during the assessment.

3.3.1 For all examinations conducted in the presence of a chaperone, the clinician must converse in a language that is comfortably understood by both the patient and chaperone unless language barriers dictate otherwise.

3.3.2 In the U.K. this will almost entirely refer to English, however if the patient cannot easily understand English and the practitioner is able to speak a language more familiar to them, then this acceptable, provided:

- There is no chaperone present that can also understand the preferred language.
- The practitioner diligently relates, exactly what is being communicated between patient and practitioner so that the chaperone can hear and understand.

3.4 All Sensitive Area examinations must be performed with the area of the body being examined completely exposed, to ensure that clothing does not obscure the chaperone's view of the practitioner's hand.

3.5 The presence or absence of a chaperone should be documented clearly in the notes. A sample format is given in Appendix 2.

4. Declined Chaperone

4.1 It is the patient's right to decline a chaperone if offered. If this is the case it must be documented that a chaperone was offered and declined before physical examination.

4.2.1 A practitioner may feel uncomfortable performing the examination without a chaperone. This might occur because the patient is behaving in a sexualised way[1], or because the patient is known to file complaints against practitioners. If a doctor feels uncomfortable to proceed without a chaperone the care of the patient should be handed to the most senior member of the team.

4.2.2 The patient's clinical needs should always take precedence. If delaying the examination or procedure could adversely affect the patient's well-being then the practitioner should continue without a chaperone, taking special care to document that one was offered and declined. This situation is unlikely to occur in the Emergency Department; in the acute setting presence of other staff is often required for the unwell patient.

5. Documentation

5.1.1 The Emergency Department record could contain a section specific to chaperoning that should be completed alongside the assessment of every patient (an example is given in Appendix 2).

5.1.2 Such a section could include the following details: presence of chaperone, name, full job title, date and whether any issues or concerns were raised. Exemplary documentation would be completed by chaperone and include both the time that the chaperone arrived to witness the examination as well as the time the chaperone left. This not only provides a valuable time stamp denoting the period in which a chaperone is able to comment upon, but also creates a record of the duration of the examination.

5.2.3 If a chaperone has been declined by a patient, this should also be documented in the aforementioned chaperone section.

Authors

Christian Kleanthous, University College London

Manolis Gavalas, ED Consultant, University College Hospital, London

First published in March 2015

Acknowledgements

Review

Usually within three years or sooner if important information becomes available.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None

Audit standards

There should be a documentation and audit system in place within a system of clinical governance.

Key words for search

Chaperone; Intimate Examinations; Sensitive Area Examinations; Emergency Department; guidelines.

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Appendix 2

Below is a suggested form to be included in all ED notes to ensure that the requirement for a chaperone is not overlooked, while also serving as a tangible record of key information in the unfortunate event of court proceedings against a doctor or hospital.

Emergency Department Chaperoning

To be completed by examining practitioner

Name:

Date:

Grade:

Chaperone offered: Y ☐

N ☐

If no state reason:.....

.....

To be completed by Chaperone

Name:

Title/Grade:

Date:

Time of arrival:

Time of departure:

Concerns: Y ☐

N ☐

Further comments:

Signature:.....

References

1. General Medical Council. Intimate Examinations and Chaperones (2013). Good medical practise.

2. Ayling report, 2004. http://www.dh.gov.uk/assetRoot/04/08/90/65/04089065.pdf

3. Loizides, S., Kallis, A., Oswal, A., Georgiou, P., Kallis, G., Gavalas, M. Chaperone policy in accident and emergency departments: a national survey. *Journal of Evaluation in Clinical Practise,* 2010: 16:107-110.

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

5. Old, S. Best Practise in the use of chaperones. *MDU Journal,* April 2014. Issue 1, Volume 30: 11-13.

The Royal College of Emergency Medicine
7-9 Breams Buildings
London
EC4A 1DT
Tel: +44 (0)20 7400 1999
Fax: +44 (0)20 7067 1267
www.collemergencymed.ac.uk
Incorporated by Royal Charter, 2008
Registered Charity number 1122689

Excellence in Emergency Care