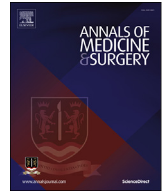
Annals of Medicine and Surgery 7 (2016) 58–60

Contents lists available at ScienceDirect

Annals of Medicine and Surgery

journal homepage: www.annalsjournal.com



An audit on the use of chaperones during intimate patient examinations

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HIGHLIGHTS

- Intimate patient examinations should be chaperoned and their identity documented.
- Providing medial legal protection to clinicians and ensuring patient safety.
- Using a chaperone sticker we have increased compliance to chaperone documentation.
- And urge other surgical units to do the same, protecting both clinician and patient.

ARTICLE INFO

Article history:
Received 7 January 2016
Received in revised form
6 March 2016
Accepted 7 March 2016

Keywords:
Chaperone
Intimate patient examination

ABSTRACT

Background: The general medical council stipulate all intimate examinations should be chaperoned, and their identity documented within patients' notes. We decided to audit our surgical unit for compliance to these guidelines.
Methods: A prospective audit before and after intervention was performed. Patients undergoing an intimate examination on the surgical assessment unit over five working days were recruited. Data was collected for the following: chaperone use, identity or decline by a patient. Statistical significance calculated using the unpaired *t*-test. Intervention following audit results included design of a chaperone sticker and posters to act as an aide memoir to clinicians.
Results: 61 patients recruited before intervention. Examination of notes revealed documentation of chaperone use in 10patients(16.4%), identity in 9patients(14.8%) and decline in 3patients(4.9%). Chaperone documentation was found in only 13 medical notes(21.3%). After two-months of intervention, 53patients were recruited. Analysis revealed documentation of chaperone use in 27patients(50.9%), identity in 20patients(37.7%) and decline in 5patients(9.4%). Following intervention chaperone documentation was found in 32 medical notes, an improvement to 60.3%($p = 0.0001$).
Conclusion: A chaperone should be offered to all patients who undergo an intimate examination. The identity of the chaperone or decline by a patient should be documented within their medical notes. Our team have demonstrated how effective an audit tool is to improve compliance to guidelines, patient safety and care. A further audit will be undertaken once our surgical proformas have been redesigned to incorporate an area for the chaperone to sign and we encourage other surgical units to do the same.
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1. Introduction

Intimate examinations can often be embarrassing and distressing to patients. The general medical council (GMC) have published guidelines, 'intimate examinations and chaperones 2013 [1], which recommend all patients irrespective of gender be offered a chaperone during an intimate examination. This should be documented within the medical notes at the time or immediately after

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http://dx.doi.org/10.1016/j.amsu.2016.03.005
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examination; either the chaperone details or decline of one by the patient. This recommendation has been supported by the medical defence union [2] (MDU) and been incorporated within the guidelines for The Royal College of Obstetricians and Gynaecologists [3].

Offering patients a chaperone is intended to support and protect them from harm, prevent inappropriate examinations from being conducted and provide medical legal protection to clinicians. Although as doctors we are judiciously taught to use chaperones, less emphasis has been placed on its meticulous record keeping within medical notes. We decided to evaluate our documentation in this regard within out surgical unit.

2. Materials and methods

A prospective audit before and after intervention (two months apart) was performed on the surgical assessment unit (SAU) at the Royal Stoke University Hospital, North Midlands NHS Trust. The GMC guideline 'intimate examinations and chaperones 2013', part of the good medical practice guideline 15 and 47 was used.

All patients who were assessed on SAU and underwent an intimate examination over five working days (Monday–Friday) were recruited and their medical notes examined. Data was collected for the following: age, gender, type of intimate examination, use of a chaperone, chaperone identity and decline of a chaperone by the patient. An intimate examination was defined by the GMC as an examination involving the breast, digital rectal (DRE), vaginal (PV) and genitalia. Specialities involved included general surgery, gynaecology, urology and vascular surgery. An unpaired *t*-test was used to determine statistical significance between the two audit groups.

3. Results

Audit before intervention included 61 patients, 25 male and 36 female patients with a mean age of 55y (22–90y). Of these the following were examined; Breast: 1, DRE: 38, PV: 7 and genitalia: 15. Chaperone documentation was present in 10 medical notes (16.4%) of which 9 (14.8%) had the chaperone identity recorded. 3 patients (4.9%) declined a chaperone. Chaperone documentation was found in only 13 patients' notes (21.3%).

Recommendations from our audit included the design of a 'chaperone sticker' [see Fig. 1], which can be easily placed within the clerking documentation. Dissemination of results was conducted via several methods including presentations to respective surgical directorates; SAU teams (doctors, nurses and health-care assistants) and posters [see Fig. 2] were placed on SAU to act as an aide memoir within the department.

Audit after intervention included 53 patients, 25 male and 28 female with a mean age of 49y (19y–86y). The following were performed; Breast: 1, DRE: 29, PV: 15 and genitalia: 8. Chaperone documentation was present in 27 (50.9%) medical notes of which 20 (37.7%) had the chaperone identity recorded. 5 patients (9.4%) declined a chaperone. Chaperone sticker was used in 16 patients (30.2%). Chaperone documentation was found in 32 patients' notes (60.3%).

Intimate examination performed? Y N

Consent obtained ? Y N

Chaperone used? Y N Patient declined

If N, reason...

Chaperone to PRINT NAME.............................. Sign.............

UHNM, Surgical directorate

Fig. 1. Chaperone sticker placed in surgical clerking pro-formas'.

Are

Documenting Chaperones Identity

During ***intimate patient examinations***, in accordance to **GMC guidelines?**

USE THE STICKERS

Re-AUDIT

Fig. 2. Posters placed within the surgical assessment unit.

4. Discussion

The Clifford-Ayling and Nafees-Hamid inquiries have illustrated the paramount importance that intimate examinations are chaperoned and recorded within the medical notes at the time of examination. The GMC guidelines were developed to protect both patient and clinician.

Findings of our audit before intervention demonstrate only 13 patients' notes (21.3%) had documentation that either a chaperone was used or the patient declined one. This is not in keeping with the GMC a guideline where doctors 'should record any discussion about chaperones and its outcome'. By producing a chaperone sticker, which can be easily placed within the surgical proforma, and educating the importance of meticulous documentation we have improved compliance to the GMC guidelines. Following intervention 32 patients' notes (60.3%) had documentation of chaperone use or decline by the patient with a statistical significance of $p = 0.0001$.

Similar studies by Rosenthal [4] (2005) and Khoo et al. [5] (2009) demonstrated 71% and 74% of doctors did not document chaperone use respectively. Further studies have reviewed patient perception of chaperone use. Sinha et al. [6] (2009) investigated patient attitudes to chaperones during breast examinations and

	Audit before intervention (61 patients)	Audit after intervention (53 patients)	Improvement (%)	Unpaired *t*-test (p values)
Documentation of chaperone use	10	27	34.3%	p = 0.0001
Chaperone details	9	20	22.9%	p = 0.0055
Chaperone declined by patient	3	5	–	–
Chaperone documentation within patient notes	13	32	39%	p = 0.0001

found 52% wanted a chaperone regardless of the sex of the examining doctor. With a chaperone patients felt eased in 68%, supported in 28%, less embarrassed in 23% and safer in 10%. Of 200 patients offered a chaperone, 68% thought it as a sign of respect and 75% did not feel this negatively affected the doctor patient relationship. Most patients preferred family members to act as chaperones, and although this is acceptable by the GMC, the care quality commission state that those acting as chaperones need a valid DBS check and receive appropriate training [7].

Gender differences exist between patients with the preference for a chaperone. Teague et al., 2007 [8] found that men rarely wanted a chaperone during genital examinations irrespective of the examining clinician's gender. In contrast, women were more likely to accept a chaperone if the examining clinician was male citing prevention of awkwardness during the examination rather than the worry of professional misconduct.

The MDU advocate each trust have a chaperone policy, which is made available to patients in a written format. All patients for intimate examinations should be offered a chaperone. If a patient declines the need for a chaperone and the doctor would prefer one then an explanation should be given to the patient why a chaperone is necessary, but one must maintain and respect the dignity and religious belief of the patient. The length of time the chaperone is present in these circumstances should be kept to a minimum.

A chaperone's main responsibility is to safeguard patients, but they can be very helpful to reassure or comfort patients during embarrassing examinations. Other roles include supporting patients with undressing, interpreting, setting up equipment or creating a friendlier environment for the examination to take place. Furthermore they can bear witness to the continuing consent for the examination and protect doctors from false allegations of abuse [9].

Currently our surgical clerking proforma makes no specific accommodation for chaperone identity to be recorded and furthermore there is no local policy for chaperone use.

Chaperone use is not without its limitations; the availability of one can be problematic and lead to added waiting times. However all patients should be offered a chaperone regardless of organizational issues and be invited to have a friend or relative present and the patient preference documented within the notes [10].

5. Conclusion

The absence of chaperone documentation does not mean that a chaperone was not used at the time of examination; but it is a concerning issue which needs to be highlighted both to improve the quality of care given to patients and provide medical legal protection to clinicians. We recommend that the GMC and MDU guidelines be followed stringently to ensure optimum patient safety and legal protection to clinicians. Where a chaperone is not possible patients should have the option to wait for one to become available. Chaperones should not include family members or friends but are health care professionals who have received appropriate training. Trust induction and e-modules should include GMC chaperone guidelines. Patients waiting to see a clinician should be asked at triage if they would like a chaperone, so one can be arranged.

Findings of our audit have been presented at the association of surgeons in training (ASIT) and associated surgeons of Great Britain and Ireland (ASGBI). We are currently in the process of re-designing our surgical pro-forma to include a chaperone section and encourage all other surgical units to do the same. A further audit will be undertaken once our surgical proformas have been redesigned to incorporate an area for the chaperone to sign and we encourage other surgical units to do the same.

Ethical approval

N/A.

Sources of funding

Nil.

Author contribution

Nikhil Sharma – Audit conception and proposal, study design, data-collection, data-analysis, presentation and write-up.

Aideen K Walsh – Article proof-reading.

Siriram Rajagopalan – Study-design, data-analysis and proof-reading.

Conflicts of interest

Nil.

Guarantor

Nikhil Sharma.

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