

# Whingate Primary School

## Intimate Care Guidelines

**June 2023**



Ratified by the Governing Body on \_\_\_\_\_

Signature \_\_\_\_\_ Chair of Governors

Next Review Date: June 2025

(following LSCP Intimate Care Good Practice Guidelines Version 3 October 2018 / Document Review Date October 2023)

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## **Introduction**

### **What are these guidelines?**

This document provides all agencies who may provide a level of intimate care to children and young people with clear guidance when developing an internal set of good practice guidelines.

### **Why do we need these guidelines?**

Children and young people who receive intimate care have the right for this to be provided in a dignified and appropriate way consistent with their level of need and is agreed by everyone involved (agency/organisation, child or young person and their parents or carers). These guidelines provide an overview of things to be considered in order to provide consistent and appropriate levels of intimate care.

### **Who are these guidelines aimed at?**

Organisations which deliver a level of intimate care to children and young people including those with a disability up to their 25<sup>th</sup> birthday.

The key contact for comments about this policy is: [lscp.info@leeds.gov.uk](mailto:lscp.info@leeds.gov.uk) **Definitions**

The following definitions are based on those with the document "Intimate care and toileting; Guidance for early years settings and schools" 2014, Surrey Council.

### **Definition of intimate care**

Intimate care can be defined as care tasks of an intimate nature, associated with bodily functions, bodily products and personal hygiene, which demand direct or indirect contact with, or exposure of, the sexual parts of the body. Help may also be required with changing colostomy or ileostomy bags, managing catheters, stomas or other appliances. In some cases, it may be necessary to administer rectal medication on an emergency basis.

Intimate care tasks include:

- Dressing and undressing (underwear)
- Helping someone use the toilet
- Changing continence pads (faeces and urine)
- Bathing/ showering
- Washing intimate parts of the body
- Changing sanitary wear
- Inserting suppositories
- Giving enemas
- Inserting and monitoring pessaries.

## **Definition of personal care**

Personal care generally carries more positive perceptions than intimate care. Although it may often involve touching another person, the nature of this touching is less intimate and usually has the function of helping with personal presentation and hence is regarded as social functioning. These tasks do not invade conventional personal, private or social space to the same extent as intimate care and are certainly more valued as they can lead to positive social outcomes.

Personal care tasks include:

- Skin care/applying external medication
- Feeding
- Administering oral medication
- Hair care
- Dressing and undressing (clothing)
- Washing non-intimate body parts
- Prompting to go to the toilet

Personal care encompasses those areas of physical and medical care that most people carry out for themselves but which some are unable to do because of disability or medical need.

## **Definition of intimate examination**

Includes examinations of breasts, genitalia and rectum. Cultural and diversity influences may affect what is deemed 'intimate' to a patient and particular regard should be taken of social, ethnic and cultural perspectives.

This document is specifically concerned with providing best practice in relation to intimate care, however it should be recognised that the definitions are potentially interchangeable depending on the needs of the child and their parents.

## **Vulnerability to abuse**

By its definition intimate care may involve touching the private parts of the child / young person's body, increasing the vulnerability of the child / young person. Leeds SCP recognise that children who experience intimate care may be more vulnerable to abuse:

- Children with additional needs are sometimes taught to do as they are told to a greater degree than other children. This can continue into later years. Children who are dependent or over-protected may have fewer opportunities to take decisions for themselves and may have limited choices. The child may come to believe they are passive and powerless.
- Increased numbers of adult carers may increase the vulnerability of the child, either by increasing the possibility of a carer harming them, or by adding to their sense of lack of attachment to a trusted adult.
- Physical dependency in basic core needs, for example toileting, bathing, dressing, may increase the accessibility and opportunity for some carers to exploit being alone with and justify touching the child inappropriately.
- Repeated intimate care may result in the child feeling ownership of their bodies has been taken from them.
- Children with additional needs can be isolated from knowledge and information about alternative sources of care and residence. This means, for example, that a child who is physically dependent on daily care may be more reluctant to disclose abuse,

since they fear the loss of these needs being met. Their fear may also include who might replace their abusive carer.

‘Abuse and children who are disabled: a training and resource pack for trainers in child protection and disability, 1993.’

When developing intimate care policies and / or individual intimate care plans practitioners should be aware of these increased vulnerabilities and seek to address these.

Should a child disclose abuse or harm as a result of intimate care this should be responded to in line with the agency’s child protection procedures.

Due to the nature and degree of contact intimate care may also leave staff more vulnerable to accusations of abuse. Any allegations against a member of staff should be considered in line with the agency’s procedures and LADO procedures.

It is unrealistic to eliminate all risk but this vulnerability places an important responsibility on staff to act in accordance with agreed procedures, and where possible and appropriate for children, young people and or parents / carers to be involved in the development of their intimate care plan so they know where it may have been deviated from. There should also be clear escalation routes should a practitioner, parent/carer or child or young person believe that intimate care is not being undertaken in line with the agency’s intimate care policy, the individual care plan or with dignity and respect.

### **Good Practice Guidelines**

It is recommended that where children require intimate care, good practice guidelines are drawn up within the establishment and disseminated to all staff, children and young people and parents / carers-Appendix 1

These guidelines should be viewed as expectations upon staff, which are designed to protect both children and staff alike. In situations where a member of staff potentially breaches these expectations, other staff should be able to question and consider this in a constructive manner, through discussing concerns with line managers, or other colleagues and their agency’s whistle blowing procedures.

Staff should be advised that if they are not comfortable with any aspect of the agreed guidelines, they should seek advice within the establishment. For example, if they do not wish to conduct intimate care on a 1:1 basis, this should be discussed, and alternative arrangements considered. For example, it may be possible to have a second member of staff in an adjoining room or nearby so that they are close to hand but do not compromise the child’s sense of privacy.

## **Whingate Primary School Guidelines for good practice.**

### **Involve children, young people and parents/carers in devising intimate care plans**

Parents/carers and the child should be involved in individual discussions and decisions in relation to how intimate care will be managed in order to draw up an agreed plan. The wishes and feelings of both the child and the parents/carers including cultural and religious beliefs should be sought and plans should be respectful and responsive to these, reflecting where possible usual home routines. A copy of this should be given to the parents (and the child where appropriate) as well as being held within the child's records.

When a member of staff changes a child, a record of intimate care should be completed.

#### Appendix 2

Whingate Primary School's intimate care plan should be reviewed regularly (at least annually) and any individual intimate care plans should have an agreed regular review to ensure needs or requests have not changed. Any changes should be communicated to appropriate staff, child and parents/carers.

### **Treat every child with dignity and respect and ensure privacy appropriate to the child's age and the situation**

Privacy is an important issue. Much intimate care is carried out by one staff member alone with one child. Leeds SCP believes this practice should be actively supported unless the task requires two people (for example lifting or moving), however the need for a chaperone should be considered, and offered, on a case by case.

Having people working alone does increase the opportunity for possible abuse. However, this is balanced by the loss of privacy and lack of trust implied if two people have to be present. It should also be noted that the presence of two people does not guarantee the safety of the child - organised abuse by several perpetrators can, and does, take place.

Therefore, staff should be supported in carrying out the intimate care of children alone unless the task requires the presence of two people. Leeds SCP recognises that there are partner agencies that recommend two carers in specific circumstances.

Where possible, the member of staff carrying out intimate care should be someone chosen by the child. For older children (eight years and above) it is preferable if the member of staff is the same gender as the young person. However, this is not always possible in practice.

Staff should consider the implications of using a single named member of staff for intimate care or a rota system in terms of risks of abuse.

### **Involve the child as far as possible in his or her own intimate care**

Try to avoid doing things for a child that s/he can do alone and, if a child is able to help, ensure that s/he is given the chance to do so. This is as important for tasks such as removing underclothes as it is for washing the private parts of a child's body. Support children in doing all that they can themselves. If a child is fully dependent on you, talk with her or him about what you are doing and give choices where possible.

### **Be responsive to a child's reactions**

It is appropriate to “check” your practice by asking the child – particularly a child you have not previously cared for – “Is it OK to do it this way?”; “Can you wash there?”; “How does mummy do that?”. If a child expresses dislike of a certain person carrying out her or his intimate care, try and find out why and record this in their notes/care plan. Conversely, if a child has a “grudge” against you or dislikes you for some reason, ensure your line manager is aware of this, that it is recorded and escalated if appropriate. In such circumstances every effort should be made to find an alternative person to undertake the care.

### **Make sure practice in intimate care is as “care planned” as possible**

Line managers have a responsibility for ensuring their staff have a “care planned” approach. This means that there is a planned approach to intimate care across school and one which is also flexible enough to be planned to meet the specific needs (and wishes as appropriate) of individuals. It is important that approaches to intimate care are not markedly different between individuals, but also reflect individual needs and wishes. For example, do you use a flannel to wash a child's private parts rather than bare hands? Do you pull back a child's foreskin as part of daily washing? Is care during menstruation consistent across different staff?

### **Never do something unless you know how to do it**

If you are not sure how to do something, ask. If you need to be shown more than once, ask again. Certain intimate care or treatment procedures must only be carried out by nursing or medical staff. Medical procedures must only be carried out by staff who have been formally trained and assessed as competent.

### **Report and record any concerns**

If you are concerned that during the intimate care of a child:

- You accidentally hurt the child
- The child seems sore or unusually tender in the genital area
- The child appears to be sexually aroused by your actions
- The child misunderstands or misinterprets something
- The child has a very emotional reaction without apparent cause (sudden crying or shouting)
- You suspect FGM has taken place

Please record and report any such incident as soon as possible to the Designated Safeguarding Lead, Mellanie Rose. This is for two reasons: firstly, because some of these could be cause for concern, and secondly, because the child or another adult might possibly misconstrue something you have done.

If a member of staff notices that a child's demeanour has changed directly following intimate care, e.g. sudden distress or withdrawal, this should be recorded in writing and discussed with the Designated Safeguarding Lead who will advise on the next steps.

If a member of staff has concerns about the way in which another practitioner is undertaking intimate care these should be recorded and escalated to the Co Headteachers Claire Beswick and Karen Loney, giving consideration for LADO procedures.

Should a child disclose abuse or harm as a result of intimate care this should be responded to in line with the Whingate's child protection procedures.

### **Supporting children/adolescents who are resistant to intimate care.**

In cases where children / adolescents are extremely resistant to intimate care and become distressed, staff must always use agreed strategies / techniques as outlined in the intimate care plan which will be informed by an understanding of their wider needs. At no point must staff forcibly hold children down to undertake intimate care, as this could result in injury / distress / trauma and / or increased anxiety for all parties concerned.

The intimate care plan should clearly identify an agreed plan of action between parents / carers and the setting on how to support the child / adolescent who is likely to be extremely resistant to intimate care, which could include, distraction techniques, notifying parents / carers of the situation, and an agreed way forward that is in the best interest of the child, without compromising their safety, dignity, health or causing emotional harm. This could include the name and details of an emergency contact(s) who will be asked to attend without delay. All behaviour should be understood as communication.

### **Dealing with allegations of abuse against staff**

Should a child disclose abuse or harm as a result of intimate care this should be responded to in line with the agency's child protection procedures. If a member of staff has concerns about the way in which another practitioner is undertaking intimate care these should be recorded and escalated to the organisation's manager, giving consideration for LADO procedures. Due to the nature and degree of contact intimate care may also leave staff more vulnerable to accusations of abuse. Any allegations against a member of staff should be considered in line with the agency's allegations management procedures and LADO procedures.

### **Encourage the child to have a positive image of her or his own body**

Confident, assertive children who feel their body belongs to them are less vulnerable to abuse. As well as the basics like privacy, the approach you take to a child's intimate care can convey lots of messages about what her or his body is "worth". Your attitude to the child's intimate care is very important.

As far as appropriate, and keeping the child's age in mind, routine care of a child should be enjoyable, relaxed and fun.

### **Training**

The requirement for staff training in the area of intimate/personal care will vary greatly between settings and will be largely influenced by the needs of the children / adolescents for whom staff have responsibility. Consideration should be given, however, to the need for training on an individual setting basis and for individual staff who may be required to provide specific care for an individual child/young person or small number of children / young people.

All members of staff responsible for intimate care should have appropriate training in good Health and Safety practices around hygiene, Safeguarding Training, Intimate Care Training and Positive Handling.

Whole staff group training should provide staff with opportunities to work together on the range of issues covered within this document thus enabling the development of a culture of good practice and a whole setting approach to personal care. Training should provide disability awareness, and opportunities for staff to increase knowledge and enhance skills.

More individualised training will focus on the specific processes or procedures staff are required to carry out for a specific child / young person. In some cases this may involve basic physical care which might appropriately be provided by a parent or carer. In cases of medical procedures, such as catheterisation, qualified health professionals should be called upon to provide training.

Designated staff may require training in safe moving and handling. This will enable them to feel competent and confident and ensure the safety and well-being of the child / adolescent. It is imperative for staff to keep a dated record of all training undertaken.

For intimate care needs, training and advice should be included for staff on how to deal with sexual arousal in the child / young person, if appropriate.

### **Other practical considerations**

- Is a risk assessment for Moving and Handling required?
- There should be sufficient space, heating and ventilation to ensure safety and comfort for staff and child / young person.
- Facilities with hot and cold running water. Anti-bacterial hand wash should be available.
- Items of protective clothing, such as disposable gloves and aprons should be provided. No re-use of disposable gloves.
- Special bins should be provided for the disposal of wet and soiled nappies / pads. Soiled items should be “double-bagged” before placing in the bin.
- There should be special arrangements for the disposal of any contaminated waste/clinical materials.
- Seeking advice on general continence issues through the school nurse or health visitor. For specific conditions, the school nurse, health visitor and / or parents / carers should be able to provide links with relevant specialists.
- Supplies of suitable cleaning materials should be available. Anti-bacterial spray should be used to clean surfaces.
- Supplies of clean clothes (the child or young person’s own where possible) should be easily to hand to avoid leaving the child unattended while they are located.
- Adolescent girls will need arrangements for menstruation in their plan.
- Settings should have a supply of sanitary wear which can be provided for girls in a sensitive and discreet way

### **Facilities:**

- Hand washing facilities are to be provided within the room for the child and member of staff
- The importance of privacy is maintained by ensuring the room can be seen to be in use and be secure from intrusion

## Assessing toileting support

When a child is soiling / wetting consider if this is a relatively isolated / new incident or if this is a recurring incident. The following pathways provide support in assessing toileting support:

Relatively isolated / new incident

Practitioner to consider:

- Is there a developmental delay?
- Is there a medical problem?
- Is there a concentration problem?
- Is there an underlying emotional problem?
- Does the child have special educational needs?
- Is there a possibility of a child protection issue?

Speak to parent:

- Is this a problem at home?
- Has medical advice been sought? Parent to consult GP or Health Visitor
- Is there a referral to a Paediatrician or incontinence nurse?
- If yes advice / information to be provided to school via School Nurse or Health Visitor and discuss with parent regarding management plan (see below).
- If no, discuss with parent regarding management plan (see below).

Discussion with parent – consultation on management plan:

- Toilet training if appropriate
- Facilities in school
- What is reasonable
- Staff involved – who
- Staff training
- Record keeping

Recurring incident

Practitioner to determine if the child has been toilet trained.

If the child has been toilet trained practitioner to consider if the child has special educational needs.

- If yes, involve the SENCO / School Nurse / Health Visitor / Area Sector and discuss with parent regarding management plan (see below).
- If no, speak to the parent:
  - Is this a problem at home?
  - Has medical advice been sought? Parent to consult GP or Health Visitor
  - Is there a referral to a Paediatrician or incontinence nurse?

- If yes advice / information to be provided to school via School Nurse or Health Visitor and discuss with parent regarding management plan (see below).
- If no, discuss with parent regarding management plan (see below).

Discussion with parent – consultation on management plan:

- Toilet training if appropriate
- Facilities in school
- What is reasonable
- Staff involved – who
- Staff training
- Record keeping

NB: always be aware of the possibility of Child Protection issues (in which case follow Child Protection Procedures).

**Please remember – if you have any concerns, discuss immediately with the Designated Safeguarding Lead or a member of the Safeguarding Team.**

## Appendix 1-Example Intimate Care Plan

<b>Name</b>	
<b>Date</b>	
<b>Date of Birth</b>	
<b>Assessor</b>	
<b>Relevant Background Information</b>	
<b>Setting</b>	
<b>Consent given</b>	
<b>Identified need – specific individual requirement e.g. cream applied</b>	<p><b>Actions:</b> (Example)</p> <ol style="list-style-type: none"> <li>1. Intimate care plan to be shared with all the staff in the setting.</li> <li>2.....to inform staff that his bowels have opened.</li> <li>3..... should be changed immediately when his bowels have opened, his trousers may need changing as well.</li> <li>4. Staff should encourage..... to wipe himself clean. However, if it is really runny and sticky, then staff are to support him.</li> <li>5..... to use the toilet to urinate.</li> <li>6. Staff to record all actions on the changing record.</li> <li>7. Mum to inform school when medical appointment is due.</li> <li>8. School to give mum records of changing for medical appointments and DVLA application.</li> <li>9. Mum to provide school with pull ups, wipes and nappy sacks every half term.</li> </ol>
<b>Communication</b>	Mum to meet with Inclusion Manager / SENCo once a year to update and amend any changes.
<b>Self-care skills</b>	Independent and supported when needed
<b>Mobility</b>	Independent
<b>Fine motor skills</b>	Independent: Can do – tapes/zips/buttons/taps/towels/adjust own clothing
<b>Moving and handling Assessment Step by step guide to what happens</b>	N/A
<b>Facilities</b>	Environment to provide dignity safety and handwashing Hygiene suite area identified in KS1
<b>Equipment</b>	Gloves, wipes, aprons, Pull ups, Wipes, Nappy sacks
<b>The disposal of soiled articles of clothing as agreed with parents/carers</b>	Solid waste into the toilet. Pull ups in nappy bag and disposed of in soiled hygiene bin Clothes sent home in tied plastic bag.
<b>Frequency of procedure required</b>	Classroom routine: 12.00 and 3.00pm, however, if bowel open before or after these times, ..... should be changed immediately.
<b>Review date</b>	

**I/we have read, understood and agree to the plan for Intimate Care**

Signed .....

Name .....

Relation to child .....

Date .....

