Intimate Care Policy

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Approved By:	**Date:**
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Any signature required:	

All things are possible for those who believe. (Mark 9:23).
Learning together we grow in faith.

Intimate Care Policy

Introduction:

Little Heaton CE Primary School is committed to ensuring that all staff responsible for the intimate care of children will undertake their duties in a professional manner at all times. We recognise that there is a need to treat all children with respect and dignity when intimate care is given. No child should be attended to in a way that causes distress, embarrassment or pain.

Children's dignity will be preserved and a high level of privacy, choice and control will be provided to them. Staff that provide intimate care to children have a high awareness of safeguarding issues. Staff will work in partnership with parents / carers to provide continuity of care.

Definition:

Intimate care is any care which involves washing, touching or carrying out an invasive procedure to intimate personal areas.
Intimate personal care tasks can include:

- Body bathing other than to face, arms, and legs below the knee
- Toileting, wiping and care in the genital and anal areas
- Dressing and undressing
- Application of medical treatment other than to arm, face and legs below the knee
- Supporting with the changing of sanitary protection

Scope:

This policy applies to all staff undertaking personal care tasks with children but particularly to those who are in the Early Years Foundation Stage. The normal range of development for this group of children indicates that they may not be fully toilet trained. Due to parenting issues it may be that some may not even have commenced toilet training at this age.

In addition to this there are other vulnerable groups of children and young people that may require support with personal care on either a short, longer term or permanent basis due to SEN and disability, medical needs or a temporary impairment. This could include:

- Children and young people with limbs in plaster
- Children and young people needing wheelchair support
- Children and young people with pervasive medical conditions

Best Practice:

The management of all children with intimate care needs will be carefully planned. The child who requires care will be treated with respect at all times; the child's welfare and dignity is of paramount importance.

Staff who provide intimate care are fully aware of best practice. Suitable equipment and facilities will be provided to assist children who need special arrangements following assessment from the appropriate agencies.

It is essential that the adult who is going to change the child informs the teacher and/or another member of staff that they are going to do this (see Appendix A). There is no written legal requirement that two adults must be present. However, in order to completely secure against any risk of allegation, a second member of staff may be present where resources allow. In addition a record should be kept of all intimate care tasks undertaken and, where they have been carried out in another room, include a record of times left and returned. These records should be treated as confidential in individual folders that are available for parents / carers to view upon request.

Staff will wear disposable gloves and aprons where appropriate.

Staff will be supported to adapt their practice in relation to the needs of individual children taking into account developmental changes such as the onset of puberty and menstruation.

Staff involved in the meeting of intimate care needs will not usually be involved with the delivery of sex education to the same children wherever possible.

There will be careful communication with each child, with their preferred means communication (verbal, symbolic, etc.) to discuss their needs and preferences. Where the child is of an appropriate age and level of understanding permission should be sought before starting an intimate procedure.

Staff will encourage each child to do as much for his/herself as possible.

Children who require regular assistance with intimate care have written care plans (see Appendix B) agreed by staff, parents/carers and any other professionals actively involved, such as school nurses or physiotherapists. These plans include a full risk assessment (see Appendix C) to address issues such as moving and handling, personal safety of the child and the carer. Any historical concerns (such as past abuse) should be noted and taken into account.

Where a care plan is not in place, parents/carers will be informed the same day if their child has needed help with meeting intimate care needs (e.g. has had an 'accident' and soiled him/herself). It is recommended practice that information on intimate care should be treated as confidential and communicated in person - telephone or by sealed letter.

Every child's right to privacy will be respected. Careful consideration will be given to each child's situation to determine how many carers might need to be present when a child needs help with intimate care.

Wherever possible the child will not be cared for by the same adult on a regular basis. This will ensure, as far as possible, that over-familiar relationships are discouraged from developing.

The religious views and cultural values of families should be taken into account, particularly as they might affect certain practices or determine the gender of the carer.

Physiotherapy:

Children who require physiotherapy whilst at school should have this carried out by a trained physiotherapist. If it is agreed in the IEP or care plan that a member of the school staff should undertake part of the physiotherapy regime (such as assisting children with exercises), then the required technique must be demonstrated by the physiotherapist personally, written guidance given and updated regularly.

School staff must not devise and carry out their own exercises or physiotherapy programmes.

Any concerns about the regime or failure in equipment should be reported to the physiotherapist.

Medical Procedures:

Children with SEN or disability may require assistance with invasive or non-invasive medical procedures. These procedures will be discussed with parents / carers, documented in the care plan and will only be carried out by staff who have been trained to do so.

Any members of staff who administer first aid will be appropriately trained. If an examination of a child is required in an emergency aid situation it is advisable to have another child present.

Toilet Training:

Starting school or nursery has always been an important and potentially challenging time for both the children and the schools that admit them. It is also a time of growth and very rapid developmental change for all children. As with all developmental milestones in EYFS there is a wide variation in the time at which children master the skills involved in being fully toilet trained. For a variety of reasons children in EYFS may be:

- Fully toilet trained
- Be fully toilet trained but regress for a little while in response to the stress and excitement of beginning at a new setting / full-time school
- Be fully toilet trained at home but prone to accidents in new settings
- Not be toilet trained at all but likely to respond quickly to a well- structured toilet training programme
- Be fully toilet trained but have a serious disability or learning difficulty
- Have delayed onset of full toilet training in line with other development delays but will probably master these skills during EYFS
- Not be toilet trained at all due to parenting issues

Parents should be encouraged to train their child at home as part of their daily routine, and

schools should reinforce these routines whilst avoiding any unnecessary physical contact. Parents and schools should work together to form a toilet management plan (see Appendix B) where appropriate to further support this.

Parents / carers should provide spare nappies, wet wipes and a change of clothes, agree to change the child at the latest possible time before coming to school and inform the school if the child has any marks / rashes. It should also be agreed on a minimum number of changes and how often the child should be routinely changed and by whom.

Safeguarding:

Safeguarding Procedures and Multi-Agency Protection procedures will be adhered to. Where parents do not co-operate with intimate care agreements concerns should be raised with the parents in the first instance. A meeting may be called that could possibly include the Health Visitor and Head teacher to identify the areas of concern and how all present can address them. If these concerns continue there should be discussions with the school's safeguarding co-ordinator about the appropriate action to take to safeguard the welfare of the child.

If any member of staff has concerns about physical changes to a child's presentation, e.g. marks, bruises, soreness etc. s/he will immediately report concerns to the appropriate designated person for safeguarding.

If a child becomes distressed or unhappy about being cared for by a particular member of staff, the matter will be looked into and outcomes recorded. Parents/carers will be contacted at the earliest opportunity as part of the process in order to reach a resolution; staffing schedules will be altered until the issue(s) are resolved.