Managing Intimate Care and Supported Toileting in Solihull Schools

Non-statutory Guidance

November 2016

ACKNOWLEDGEMENT

This document is based on the Plymouth City Council document Managing Intimate Care and Supporting Toileting in Schools and Settings. Non-statutory Guidance and Norfolk County Council Guidance has also been referred to.

DOCUMENT HISTORY AND CHANGES

First draft April 2016

Consultation with Community Nursing Team, Solihull Health and Safety Support Team and Solihull Early Years and Education Improvement Service followed by consideration at the Policies and Procedures Sub Group June 2016.

Feedback from Trade Union Staff Panel provided July 2016

Redraft October 2016

This policy will be reviewed in September 2017.

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(1.0) INTRODUCTION/CONTEXT

The purpose of this guidance and policy is to set out a framework within which staff who provide intimate care to children with additional support needs can offer a service and an approach which acknowledges the responsibilities and protects the rights of everyone involved. The additional support needs of children and young people might arise from a variety of reasons, including learning disabilities, physical, visual, hearing or speech and communication impairments. These children and young people may attend all phases of education and types of setting including those designated as both mainstream and special.

In schools and the early years provision within them, children may require assistance with toileting, including nappy changing because they have not yet achieved full continence.

This guidance therefore applies to everyone involved in the intimate care of children and young people schools the early years provision within them.

The intention of this guidance is to support the process of policy and procedural development. It is the responsibility of schools to develop their own policy and procedures in partnership with staff, pupils, parents and other members of the school community. These guidelines have been developed by the local authority in partnership with other stakeholders.

Policies and guidance include (but not exclusively) the following:

- Childrens and Families Act 2014
- Keeping Children Safe in Education DfE 2016*
- Working together to Safeguard Children DfE 2015*
- Special Educational Needs Code of Practice 2015
- Equality Act 2010
- The Health and Safety at Work Act 1974
- Management of Health and Safety at work regulations 1999
- Excellence in incontinence care NHS England 2015
- Supporting Pupils at School with Medical Conditions DFE 2015
- Guidance for safer working practice for those working with children and young people in education settings, Safer Recruitment Consortium 2015*
- Solihull Accessibility Strategy 2016-19
- Medicines in Schools and Settings, Solihull MBC 2015
- Designated Safeguarding Leads Handbook, SMBC 2016*
- Safer recruitment and selection guidance for education providers, SMBC*
- Managing Allegations Against Employees, SMBC*

* Available from: http://www.solgrid.org.uk/safeguarding/
Solihull Health and Safety Support Team can offer support and training in the creation of risk assessments.
http://socialsolihull.org.uk/council/auditservices/about-us/health-safety-consultancy-support-and-training/

(1.1) PURPOSE OF GUIDANCE

This guidance aims to:

- Keep children and young people safe by clarifying which behaviours constitute safer practice and which behaviours should be avoided.
- Support governors and head teachers and proprietors in setting clear expectations of behaviour and/or codes of practice relevant to the provision of intimate care.
- Assist adults working with children and young people to establish what safe, respectful and appropriate intimate care involves and the importance of regular line management, supervisory support and needs led training.
- Strengthen safeguarding procedures.
- Minimise the risk of misplaced or malicious allegations made against adults who work with children and young people.
- Ensure that processes are in place so that children and young people, parents and carers can easily influence intimate care policy and procedures, in particular, Individual healthcare plans.
- Support staff to respectfully and safely teach or consolidate independent self-care for the children and young people with whom they work. Staff will work towards enabling each child or young person to do as much for themselves as possible.
- Provide templates to support the creation of intimate care plans and robust record keeping of intimate care interventions.

(1.2) DEFINITION OF INTIMATE CARE

Intimate care can be defined as ‘Care tasks of an intimate nature, associated with bodily functions, body products and personal hygiene which demand direct or indirect exposure of the genitals and/or other private parts of the body’.

Examples include:

- Exposing genitals and/or other private parts of the body to administer medicines in accordance with (2014/09) DoE Supporting pupils at school with medical conditions.
- Managing incontinence and providing toileting support.
- Help with personal hygiene - washing and bathing.
- Menstrual management.
- Supervision of children involved in intimate self-care.

(1.3) GUIDING PRINCIPLES FOR APPROPRIATE INTIMATE CARE

These three fundamental guiding principles are paramount and should be evident whenever intimate care involving children or young people is considered:

1st principle
Every intimate care procedure must be completed within an environment and atmosphere of total respect and dignity both for the individual receiving care and for the person involved in providing care.

2nd principle
Every plan supporting intimate care must demonstrate how the child/young person can be enabled to develop their independence as far as is reasonably practical for the child/young person.

3rd principle
The number of adults engaged in the care should only reflect the minimum needed to perform the task safely and respectfully. Each situation should reflect both the safety and vulnerability of children/young people and staff.

(1.4) UNDERPINNING PRINCIPLES

Intimate care should be a positive experience for both the child or young person and staff. It is essential that care is given gently, respectfully and sensitively and that every child or young person is treated as an individual. As far as possible, the child or young person should be allowed to exercise choice and should be encouraged to have a positive image of his/her own body.

These principles of intimate care can be put into practice by:

- Taking into account the child/young person's method and level of communication which may include words, signs, symbols, body movements and eye pointing.
- Ensuring that the child/young person's methods of communication are clearly identified in the care plan and staff have the ability to understand and communicate with the child/young person.
- Ensuring that when a child/young person is unable to verbalise a preference, other means should be explored including determining their wishes by observation or reactions to intimate care.
- Agreeing on the appropriate terminology used by staff for the description of private parts of the body and bodily functions.
- Ideally allowing the child/young person, whenever possible and appropriate, to choose who provides their intimate care
- Ensuring a sufficient number of trained staff, both male and female are available to provide intimate care as required throughout the school day.
- Avoiding a situation where intimate care relies on one or two members of staff, thus improving choice for the child/young person and capacity for trained staff able to provide intimate care.
- Enabling the child/young person to indicate if they find a member of staff's practice to be unacceptable.
- Allowing the child/young person a choice over the arrangement of care, ensuring privacy wherever the intimate care is taking place.
- Allowing the child/young person to care for him/herself as far as possible.
- Being aware of and responsive to the child/young person's reactions.
- The views of the child/young person should be actively sought, wherever possible, when developing and reviewing intimate care plans. As with all individual arrangements for intimate care needs, agreements between the child/young person, parents/carers and the school/setting must be negotiated and recorded.
- When the plan is completed, consideration should be made as to whether the underpinning values and principles are reflected.
- Given the right approach, intimate care should provide opportunities to teach children/young people about the value of their own bodies, to develop their personal safety skills and to enhance their self-esteem. Whenever children/young people can learn to assist in carrying out aspects of their own intimate care they should be encouraged to do so.

(2.1) GOOD PRACTICE IN INTIMATE CARE

The following positive approaches will assist in promoting good practice for intimate care:

- Each school and setting has an up to date intimate care policy which reflects the needs of the learning community and which sets out principals and protocols for intimate care and toileting support.
- Intimate care practice is consistent across home, school and other settings as far as possible.
- A designated environment is identified which ensures the safety and dignity of the child/young person and intimate care providers.
- Suitable resources and equipment are always available to reduce any biological risk and to ensure the health and safety of children/young people and intimate staff.
- Staff who provide intimate care will have access to training and regular supportive supervision/line management.
- Staff should ensure that the child/young person's privacy, modesty and dignity is respected and protected at all times.
- An appropriate written Individual healthcare plan for intimate personal care is agreed with the child/young person and their parent(s)/guardians/carers. Each plan will also consider strategies that support and encourage children/young people towards independent intimate care/toileting where possible.
- Staff should agree with the child/young person and their family the appropriate terminology to be used for private parts and bodily functions. Best practice in personal safety work would be to use the correct anatomical names for intimate body parts.
- Staff always communicate in an age appropriate way taking into account the child or young person's developmental level and their preferred communication method.
- When a newly designated member of staff providing intimate care is appointed, they are familiar with and understand the child's intimate care plan, get to know the child/young person well beforehand and became familiar with his/her temperaments and methods of communication.
- In cases where a child/young person has limited communication abilities, intimate care providers should enable the child or young person to be prepared for or anticipate events while demonstrating respect for her/his body, for example by giving a strong sensory or verbal cue such as using a sponge or pad to signal intention to wash or change.
- Staff should speak to the child personally by name so that he/she is aware of being the focus of the activity.
- Staff should have knowledge and understanding of any religious and cultural sensitivities related to aspects of intimate care and take these fully into account. Any religious or social requirements would be clearly noted in the child's/young person's intimate care plan.
- If a child/young person becomes incontinent and requires toileting support, the child should be discreetly removed from the learning environment so that intimate care can be provided in the designated location by the child's preferred intimate care provider.
- Planning for learning outside the classroom takes into account how safe and dignified intimate care can be provided at venues outside of the school/educational setting. Planning also ensures that a designated intimate care provider is present and suitable materials for cleaning and changing are available.
- Staff should keep records which, in accordance with the child/young person's intimate care plan, detail any intimate care provided, note their response to intimate care and note any changes in behaviour.
- Regular communication and exchanging information with parent(s), guardians or carers is essential. Systems should be established ensuring that confidential information can be shared securely.

(2.2) DUTY OF CARE

All adults who work with and on behalf of children and young people are accountable for the way in which they exercise authority, manage risk, use resources and safeguard children and young people.

This means that adults should:

- Understand their responsibilities, which are part of their employment or agreed role.
- Always act, and be seen to act, in the child's/young person's best interests.
- Avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Take responsibility for their own actions and behaviour.

The Children Act 2004 places a duty on organisations, including schools and settings to safeguard and promote the welfare of children and young people. This includes the need to ensure that all adults who work with or on behalf of children and young people are competent, confident and safe to do so. It follows that the duty of care is exercised through the behaviour of the adult, whom at all times should demonstrate integrity, maturity and good judgement.

The School's Admissions Code (Department of Education, 2012) states that it is for admission authorities to formulate their admission arrangements, they must not discriminate against or disadvantage disabled children or those with special educational needs. This is in line with the Equality Act 2010 which states that a person has a disability if they have a physical or mental impairment, which has a substantial and long term adverse effect on that person's ability to carry out day to day activities. It is not acceptable to refuse admission to school to children who are delayed in achieving continence. Education providers are required to make "reasonable adjustments" for pupils and staff who have a disability. This duty covers all areas of education including schools, colleges and universities.

Employers also have a duty of care towards their employees, both paid and unpaid, under the Health and Safety at work act 1974. This requires employers to provide a safe working environment for adults and provide guidance about safer working practices. The Human Rights Act 1998 and Equality Act of 2010 set out important principals regarding the protection, equal opportunity and treatment of both paid and unpaid adults. Employers are responsible for the provision of personal protective equipment, including disposable gloves, aprons and where necessary other disposable protective clothing. Employers have a duty of care to protect employees from violence and aggression in the workplace.

The understanding of what constitutes a duty of care should also include an awareness and understanding of other policies and guidance that contribute towards the safe and dignified provision of intimate care and toileting.

(2.3) SAFEGUARDING AND VULNERABILITY

Disabled children and young people are particularly vulnerable to abuse and discrimination. It is vitally important that all staff members are familiar with the school's Safeguarding and Child Protection policy and procedures.

Disabled children can be more vulnerable to abuse because:

- They often have less control over their lives than their peers.
- They do not always receive appropriate sex and relationships education, or if they do may not understand it, so are less able to recognise abuse.
- They may have multiple carers through residential, foster or hospital placements.
- Changes in appearance, mood or behaviour may be attributed to the child's disability rather than abuse.
- They may not be able to communicate what is happening to them.

Intimate care that involves touching the private parts of a disabled pupil may leave staff more vulnerable to accusations of abuse. It is unrealistic to eliminate all risk, but the vulnerability places an important responsibility on staff to work in accordance with agreed procedures.

If a member of staff has concerns about physical changes in a child or young person's presentation, for example unusual anxiety, bruising, soreness the member of staff must immediately report their concerns to the designated lead for safeguarding and log the concern in the intimate care records for the child/ young person.

Female Genital Mutilation
There is a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under eighteens which they identify in the course of their professional work to the police.

For the purpose of the criminal law in England and Wales, female genital mutilation (FGM) is mutilation of the labia majora, labia minor or clitoris. FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such.

Teachers, along with health and social care professionals, are required under a new mandatory duty in the Serious Crime Act (2015), to report any cases of known Female Genital Mutilation disclosed by anyone under the age of 18yrs to the police.
https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Where Female Genital Mutilation is known either through disclosure or the observation of physical signs (through normal day to day practice e.g. nappy changing, personal care etc., school staff should:

- follow their school's child protection policy and report any case of known Female Genital Mutilation to the Designated Safeguarding Lead immediately, ensuring a written record of the concern or disclosure.
- the teacher should immediately make a report to the police (orally or in writing – recommended route: call 101).

All staff should be aware of risk factors, warning signs and indicators of FGM as part of their duties around safeguarding. Schools should also be aware of what to say (and what not to say) if a girl/young woman discloses that they are at risk of or have suffered FGM.

The Solihull LSCB webpages provide comprehensive guidance and advice for frontline professionals and their managers, individuals in Solihull's local communities and community groups such as faith and leisure groups on:
http://solihulllscb.proceduresonline.com/chapters/p_fem_gen.html#intro

(2.4) ONE TO ONE SITUATIONS WHEN PROVIDING INTIMATE CARE

Currently there is no statutory expectation placed upon schools that require more than one member of staff be present when undertaking intimate care procedures. At all times, reasonable and sensible precautions should be taken. Clear procedures and safeguards should be in place when working one to one or in the presence of an additional adult

- Each school will consider the impact of one to one intimate care practice and ensure that the guiding principles and good practice protocols are reflected in their own bespoke and needs led provision of Intimate Care and Toileting Policy.
- To mitigate the impact of one to one intimate care practice on both staff and children/young people, it is essential that each school has more than one individual providing intimate care across the whole school.
- Where one to one intimate care procedures are inevitable, school leaders will need to undertake a risk assessment in relation to the specific nature and implications for one to one work. These assessments should be reviewed regularly and take into account the individual needs of the child/young person and the individual worker. Every attempt should be made to ensure the safety and security of children and young people and the adults who work with them.
- The possibility that intimate care may be provided on a one to one basis will need to be clearly identified in each individual healthcare plan. Individual healthcare plans will be developed in partnership with all parties involved, including the child/young person and parents/guardians/ carers.
- Each individual healthcare plan will include an assessment of the child/young person's capabilities in terms of what intimate care tasks they can achieve for themselves (for example wiping; washing; changing) and what tasks will need to be undertaken by the intimate care practitioner. There should be no ambiguity about what is expected of the intimate care provider on a case by case basis.
- The second key principal requires that 'every plan supporting intimate care must demonstrate how the child/young person can be enabled to develop their independence as far as is reasonably practical for the child/young person'. Regular reviews of the child/young person's capabilities strengthened by teaching and learning both at school and in the home environment may realise an improvement towards independence, thus reducing the tasks needed to be performed by the Intimate care provider.
- Staff providing intimate care on a one to one basis should be offered appropriate training and regular needs led supervision which addresses any anxiety.
- Accurate record keeping following each intimate care procedure and providing regular updates to parents/carers is essential.

Potentially there is positive value in both male and female staff being engaged in intimate care, and there is no legislation that suggests otherwise – hospital environments manage the same challenge.

However, it is recognised that there are sensitivities involved; some children/young people and/or their parents may prefer a same-sex staffing arrangement in intimate care situations. The religious and cultural values of children/young people and their families must also be taken into account.

(3.1) DEVELOPING INDIVIDUAL HEALTH CARE PLANS (SEE APPENDIX E)

Where a routine procedure is required, for example as a result of developmental delay resulting in a child/young person not meeting age related continence expectations, an individual healthcare care plan should be written. The plan should be developed through discussion with the child/young person, school staff, parents/carers and any assigned health professional. The plan should be signed by all who contribute and reviewed on an agreed basis. A six monthly review would be recommended but this would need to be more frequent if the circumstances are changing. Children who require intimate care as a result of expected levels of toileting competence for their age would not necessarily require an individual health care plan.

In developing the plan the following should be considered:

a) Implications for settings

- The importance of working towards independence.
- Arrangements for home-school transport, sports day, school performances, examinations, school trips, swimming and so on.
- Who will substitute in the absence of the appointed intimate care provider?
- Strategies for dealing with pressure from peers for example teasing/bullying.
- Time required implementing and managing the plan.

b) Classroom management

- Consider the child/young person's seating arrangements in class so that they can leave class with minimal disruption to the lesson.
- Avoidance of missing the same lesson due to routines.
- Awareness of a child/young person's feelings about their own intimate care needs which could affect learning.
- Implications for PE, swimming and so on, for example discreet clothing, additional time for changing.

All plans must be clearly recorded to ensure clarity of expectation, roles and responsibilities. A procedure should also be included to explain how concerns arising from the intimate care process will be dealt with.

(4.1) ENVIRONMENTAL CONSIDERATIONS

Consideration needs to be given to the most appropriate space and facilities for the intimate care to take place. Advice can be sought about how to provide a suitable environment which takes into account the needs and choices of the child/young person and of other users of the building. It is necessary to look at issues such as proximity to the classrooms, how to ensure privacy and dignity, the types of equipment needed, how to alert for assistance if required etc.

(4.2) MOVING AND HANDLING

Assisting in personal care tasks may present challenges for moving and handling. At all times the child/young person's wishes and choices must be considered, but procedures must also take into account the safety of staff involved in intimate care tasks. Employers are advised to follow Solihull's guidance in the creation of their intimate care policies.

In the same way as an individual health care plan is required, there also needs to be a risk assessment conducted for the moving and handling procedures required for the task. This should clarify who and how these procedures are to be undertaken. This also requires regular review to address any changing circumstances. At minimum, Moving and Handling training is required every three years and more frequently in the event of changing staff or circumstances.

If the school or setting provide specialist pieces of equipment such as hoists and slings, then consideration should be given to their maintenance and safe use. All moving and handling equipment must comply with LOLER (Lifting Operations and Lifting Equipment Regulations 1998) and should be inspected before use and serviced every six months. Staff should be trained and deemed competent in the use of equipment and this should be an essential component of the induction process or on going professional development.

(5.1) STAFFING

- Parents need to feel confident that effective safeguarding procedures have been followed in the recruitment and selection of staff to undertake personal and intimate care.
- Intimate care can only be provided in schools and settings by those who have specifically indicated a willingness to do so, either as part of their agreed role profile/job description or by other arrangements.
- Training should be provided in good working practices. Individual staff must be supported in the specific types of intimate care that they carry out and fully understand their rights and responsibilities including; safeguarding, health and safety and where appropriate, moving and handling.
- Whole school staff awareness-raising will enable all staff to recognise the demand placed on an intimate care provider, thus fostering a culture of good practice and a whole school approach to facilitating and managing the demand for intimate care.
- Trained staff should be available to substitute and undertake specific intimate care tasks in the absence of the appointed person.
- Both school and individual staff must keep a dated record of all training undertaken.

(5.2) RECRUITMENT

- The selection of candidates for posts involving intimate care tasks should be made following the usual DBS checks, equal opportunities and employment rights legislation. Candidates should be made fully aware of what will be required as an intimate care provider and details about the role should be clearly and comprehensively included in the job description, so that candidates are fully informed before accepting the post.
- Enquiries should be made into any health related restrictions the candidate may have which will impede their ability to carry out the tasks involved. This will enable employers to identify, make reasonable adjustments and provide necessary support as required and outlined in the Equality Act.(2010)
- Where possible, pupils may be involved in the recruitment process, depending on their age and ability to understand. It is recommended that candidates have an opportunity to meet the children/young people with whom they will be working.
- Staff who are newly recruited to providing intimate care should be closely supervised until completion of a successful ‘probationary’ period.

(6.1) LINKS WITH OTHER AGENCIES

Positive links with other agencies will enable school/setting based plans to take account of the knowledge, skills and expertise of other professionals and will ensure the child's wellbeing and development remains paramount. In addition to the advice and guidance provided by parents or carers, it is recommended good practice for schools to know and, with the permission of parents/carers, engage with agencies involved with the child/young person. This may include the school or community paediatric nurse, a community continence adviser Physiotherapist and Occupational Therapists.

(6.2) FURTHER READING

ERIC – Education and Resources for Improving Childhood Incontinence: www.eric.org.uk
A Guide to Helping Early Years Settings and Schools to Manage Continence, 2012
http://www.eric.org.uk/assets/downloads/104/The%20Right%20To%20go%20WEB%20%20Guide%2012.2012.pdf

Promocon (2006) 'Managing Bowel and Bladder Problems in Schools and Guidelines. Early Years Settings for good practice' available at
www.disabledliving.co.uk/DISLIV/media/promocon/PromoconBooklet.pdf

Promocon (2006) 'Teaching Pack Healthy Bladder and Healthy Bowels - Incontinence' available at http://www.disabledliving.co.uk/disliv/media/pdf/teachingpack.pdf

Promocon; 'Promoting Continence in Schools' [website accessed] 21/01/15 available at:
http://www.disabledliving.co.uk/Promocon/Children/Promoting-Continence-in-Schools

Muscular Dystrophy UK. Inclusive Education for Children with muscle wasting Conditions, a guide for schools and parents Third edition 2016 www.muscluardystrophy.uk

(7.0) APPENDIX (RANGES A-J)

APPENDIX A: FREQUENTLY ASKED QUESTIONS

What if we have nowhere to change children?
The key concern here must be the safety and dignity of the child/young person and member of staff providing intimate care. If changing in the pupil's toilet is the only remaining option, then extra consideration needs to be made to safeguard and protect the dignity, health and safety of the child/young person. Most children can be changed in a standing position and can be changed in a cubicle. A 'do not enter' sign (visually illustrated) can be placed on the toilet door to ensure that privacy and dignity are maintained during the time taken to change the child.

Won't it mean that adults will be taken away from the classroom or setting?
Depending on the accessibility and convenience of a setting's facilities, it could take ten minutes or more to change an individual child. This is not dissimilar to the amount of time that might be allocated to work with a child on an individual learning target, and of course, the time spent changing the child can be a positive learning time.

It is OK to leave a child until parents arrive to change them?
No. Asking parents to come and change a child is likely to be a direct contravention of the Equality Act 2010, and leaving a child in wet or soiled clothing for any length of time pending the return of the parent is inappropriate and may be determined as a form of abuse.

Who is responsible for providing nappies/continence wear?
Parents are responsible for providing nappies and continence wear. Schools should provide gloves, other disposable clothing and personal protective equipment.

How do we dispose of nappies?
Check with your refuse collection service provider. For occasional use you may single wrap wet and double wrap soiled nappies and use ordinary waste bins.

What if no one will take responsibility to change nappies?
Consider your provision of intimate care procedures for when a child accidentally wets or soils, the same procedures could be used for this. Staff cannot be required to change nappies unless the task is clearly stated in the job description of an intimate care provider and the intimate care provider has agreed to undertake the role. It is good practice for a familiar adult to undertake this task who has undergone intimate care training.

I am worried about lifting
Risk assessments must be undertaken for each child, where manual handling in the form of support is required staff should receive advice or training. Children must not be physically lifted if over the weight of 16kg, but encouraged to get on/off any changing beds themselves, many are height adjustable. Suitable equipment, such as hoists should always be used for children who are unable to help themselves, this will reduce the risk of injury to both the child and staff – training will be required. Hoists should be serviced regularly and staff should be trained on the equipment that they will be using.

How can I help a child to communicate when they need to use the toilet?
Children with communication difficulties may need tools to help them communicate. Picture symbols and signs can be used to reinforce spoken words. For children who are learning English as an additional language, it is helpful to learn how to say the appropriate words in their home language.

Parents won't bother to toilet train their child will they?
Most parents are as anxious as you for their child to be out of nappies. You will need to make it clear that your expectation is that all children of statutory school age will be out of nappies, but that you will support children and families through any difficulties. For school based early years settings it is not appropriate that your expectation is that all children will be out of nappies prior to starting nursery.

Is it true that men can't provide intimate care because of child protection issues?
No, there are many men in childcare/ education who provide intimate care on a daily basis. DBS checks are carried out to screen for any known risks. Safe and appropriate practice is determined by good training and supervision and not according to gender. DBS is the Disclosure and Baring Service (previously CRB checks). Staff providing intimate care tasks will be required to have an enhanced DBS check; this will normally be arranged by the employer.

What if a child reacts defensively to intimate care?
Is the child otherwise anxious about adults? Is it new or changed behaviour? Is this behaviour occurring in other areas of school life? Ask the parent/carer whether anything has happened which may have led to the child being anxious or upset about being changed. Has there been a change in the household/school? If you are still concerned, consider whether there may be any safeguarding issues and follow the school child protection policy.

What if a member of staff refuses to change a child/young person who has soiled?
The Equality Act 2010 is clear that children should be protected from discrimination, and therefore a child who has soiled should be attended to in order to return to the classroom/setting without delay. The issue should not arise if designated support staff have been appointment on the basis that the provision of intimate care will form part of their job role. Members of staff where the provision of intimate care does not form part of their job role may volunteer but cannot be required to do so if they refuse. This emphasises the need for serious consideration being given to the inclusion of intimate care within job roles.

APPENDIX B: WRITING AN INDIVIDUAL HEALTH CARE PLAN

Where a routine procedure is required for a child/young who has not yet achieved age expected continence, an individual health care plan should be agreed in discussion with the child/young, school staff, parents and relevant health personnel. The plan should be signed by all who contribute and reviewed on an agreed basis.

In developing the plan the following should be considered:

- Staff ratios and procedures.
- Toilet arrangements and equipment (e.g. spare clothes and disposable gloves).
- Awareness of a child's discomfort which may affect learning.
- The importance of working towards independence.
- Who will substitute in the absence of the appointed person.
- Strategies for dealing with pressure from peers .e.g. teasing/bullying.

The individual health care plan should include the following details:

- Staff to wear disposable gloves and aprons while providing care.
- Changing area to be cleaned after use according to local policy and guidelines.
- Hot water and liquid soap available to wash hands as soon as the task is completed.
- Hot air dryer or paper towels available for drying hands.
- Labelled bins for the disposal of wet & soiled nappies/pads (soiled items being 'double bagged').
- Supplies of suitable cleaning materials; anti-bacterial spray, sterilising fluid, hand wash etc.
- Nappy creams/lotions should be labelled with the child's name and used only if prescribed for that child - they must not be shared. Any creams should be used sparingly as if applied too thickly they can reduce the absorbency of a nappy.
- The child's skin should be cleaned with a disposable wipe.
- Supplies of appropriate clean clothing, nappies, disposal bags and wipes.
- Changing mat or changing bench.
- If at all possible children should be changed standing up. This makes it easier for the child to be involved in the process and start to make steps to becoming independent.
- If the child needs to be laid down to be changed, then once the child has been changed and has left the changing area, the surface should be cleaned with warm soapy water and left to dry.
- An effective system should be identified to alert staff for help in emergency.
- Easy access to a toilet and wash basin.
- A toilet cubicle of the correct size for the child.
- Space to manoeuvre, with or without mobility equipment.
- Toilet facilities near to where they are.
- Safe toileting space.

Specific advice re: interventions such as catheterisation or stoma care
If a child has a specific continence issue which needs to be addressed, such as a catheter or a stoma, the staff involved in the child's care need to be trained and fully understand the procedure. For children who have specific intimate personal care needs, there should be a health care professional involved, who can, in conjunction with the parent, teach staff and set up an individual health care plan.

APPENDIX C: RECORD OF AGENCIES INVOLVED AROUND THE CHILD/YOUNG PERSON

Child/young person's name: ……..

Date of birth: …….

Name/role	Contact address/phone/email
Parent/carer	
GP	
School Nurse/Health Visitor	
Community Paediatric Nurse	
Continence Adviser	
Physiotherapist	
Occupational Therapist	
Hospital Consultant	
SISS	
Educational Psychologist	
Engage worker	
Family Support Worker/Youth Worker	

APPENDIX D: INTIMATE CARE MANAGEMENT CHECKLIST

To inform the written Personal Care Management Plan

Child/young person's name: …….

Date of birth: …….

Intimate care provider(s) name(s): ……..

Facilities	Discussed	Actions
Have suitable facilities for the provision of intimate care been identified?		
Are any adaptations required to support safe and dignified provision of intimate care? For example: • Appropriate environment for cleaning and changing • Lifting and handling equipment (if required) • Changing mats with easy clean surfaces • Grab rails • Hot and cold water • Disposal facilities • Beeper for emergency assistance		

Parent/ pupil provided supplies	Discussed	Actions
Pads		
Nappies		
Catheter		
Wipes		
Spare clothes		
Other (specify)		

School/setting provided supplies	Discussed	Actions
Toilet rolls		
Wet wipes		
Urine bottles (if required)		
Bowl/bucket		
Antiseptic hand wash		
Sterilising fluid (Milton)		
Paper towels/soap		
Disposable gloves		
Disposable aprons		
Clinical waste (yellow sacks) if required		
What are the staff training needs?		
How will the perceptions of other pupils be managed?		

Requirements for inclusion in PE activities	Discussed	Actions
Are there any health related needs or requirements?		
Does the pupil have a health care plan?		
Has the pupil's GP, Paediatrician or health care professional prohibited the pupil from participating in certain PE activities?		
Is the need for intimate care likely during PE activity?		
Will a trained intimate care provider need to be available during PE activities?		
Will the pupil need access to separate/private changing facilities?		
Will any special arrangements need to be made for swimming activities?		
Does the pupil require discreet clothing or specialist apparatus to enable participation?		
Are there any lifting or manual handling requirements?		

Requirements for inclusion during out of school visits	Discussed	Actions
Is there sufficient Intimate care staff available to support the pupil during the out of school visit? (including visits that are residential)		
Is the current intimate care plan sufficient to accommodate the needs of the pupil during the visit?		
Does the venue have facilities that are sufficient to meet the needs of the pupil in a safe and dignified manner?		
Does the pupil have a health care plan; are there any medical needs that need to be taken into account?		

APPENDIX E: INDIVIDUAL HEALTH CARE PLAN

Developed from the Personal Care Management checklist and where appropriate, any behaviour management plan and associated risk assessment.

Child/young person's name: …….

Date of birth: …….

Individual health care plan
Reason for intimate care:
Details of assistance required:
Facilities and equipment (clarify responsibility for provision of suitable environment for intimate care procedures and supplies, for example parent/carer/school/other):

Staffing regular

Names:

1.

2.

3.

Time Plan:

Staffing back up

Names:

1.

2.

3.

Time Plan

Training needs (individual staff must keep signed/dated records of training received in addition to school and setting held records. A record should be completed when training has been delivered and kept as part of the care plan.

Curriculum specific needs:
Arrangements for trips/transport:
Procedures for monitoring and complaints (including notification of changing needs by any relevant party):

This current plan has been agreed by:

Name: ……

Role: ……

Signature: ……

Date:……..

Date for review: ……

APPENDIX F: TOILETING PLAN

Record of discussions with parents/carers

Child/young person's name: …….

Date of birth: ……

Class/year group: …….

	Detail/action	Date agreed
Working towards independence: For example taking child/young person to toilet at timed intervals, using sign or symbol, any rewards used.		
Arrangements for nappy/pad changing: For example who, where, arrangements for privacy.		
Level of assistance required: For example undressing, dressing, hand washing, talking/signing to child/young person.		

Infection control: For example wearing disposable gloves, aprons and safe disposal.		
Sharing information: For example if the child/young person has a nappy rash or any marks. Are there any family customs/cultural practices?		
Resources required: For example special seat, nappies/pull-ups/pads creams, disposable sacks, change of clothes, toilet step, disposal gloves.		

Signed: …….

Parent/carer: ……

Signed: ……..

SLT member's name and signature: ……..

Review date: ……..

APPENDIX G: RECORD OF INTIMATE CARE INTERVENTION

Child/young person's name: ……

Date of birth: ……..

Date	Time	Procedure	Staff	Comments

APPENDIX H: AGREEMENT OF INTIMATE CARE PROCEDURES FOR A CHILD/YOUNG PERSON WITH COMPLEX NEEDS

The purpose for this agreement is to ensure that both parents/carers and professionals are in agreement with what care is given, who is providing the care and that appropriate training is given.

Teaching of the care procedures may be carried out by the parent/carer or by the professional experienced in that procedure where it is more complex/invasive.

When the parent/carer and/or professional are agreed the procedure has been learned and the intimate care provider feels comfortable with, and competent to administer that procedure this record should be signed by the parties. One copy should be given to the intimate care provider, one retained in the staff carer's personnel file and one filed in the child/young person's medical health record.

Child/young person's name: ……

Agreement of intimate care procedures for a child/young person with complex needs
Agreed intimate care procedures:
Names of designated intimate care providers:
Training received and (any) additional training needs of designated intimate care providers:

SLT member's name and signature: ……

Date: …….

Designated professional's name, role and signature: ……

Date: …….

Parent/carers name and signature: …….

Date: …….

APPENDIX I: USEFUL CONTACTS

Name/role	Contact address/phone/email
GP	
Hospital Consultant	
Paediatric Services	
Health Visitor	
School Nurse	
SISS	
Community Paediatric Nurse	
Property Services	
Solihull Health and Safety Support Team	
Occupational Health	
Physiotherapy	

APPENDIX J: SCHOOL INTIMATE CARE POLICY MODEL

[Insert name of school]

1) Principles

1.1 The Governing Body is committed to ensuring that all staff responsible for the intimate personal care of pupils will undertake their duties in a professional manner at all times. It is acknowledged that these adults are in a position of great trust.

1.2 This school takes seriously its responsibility to safeguard and promote the welfare of the children and young people in its care. Meeting a pupil's intimate personal care needs is one aspect of safeguarding.

1.3 The Governing Body recognises its duties and responsibilities in relation to the Equality Act 2010 which requires that any pupil with an impairment that affects his/her ability to carry out day-to-day activities must not be discriminated against.

1.4 This intimate personal care policy should be read in conjunction with the schools' policies as below (or similarly named):

- Safeguarding policy and child protection procedures
- Staff code of conduct and guidance on safer working practice
- 'Whistle-blowing' and allegations management policies
- Health and safety policy and procedures
- Policy for the administration of medicines
- Special educational needs policy
- Confidentiality policy

1.5 We recognise that there is a need to treat all pupils, whatever their age, gender, disability, religion, ethnicity or sexual orientation with respect and dignity when intimate personal care is given. The child/young person's welfare is of paramount importance and his/her experience of intimate and intimate personal care should be a positive one. It is essential that every pupil is treated as an individual and that care is given gently and sensitively: no pupil should be attended to in a way that causes distress or pain.

1.6 Staff will work in close partnership with parent/carers and other professionals to share information and provide continuity of care.

1.7 Where pupils with complex and/or long term health conditions have an individual health care plan in place, the plan should, where relevant, take into account the principles and best practice guidance in this intimate personal care policy.

1.8 Members of staff must be given the choice as to whether they are prepared to provide intimate care to pupils where they are acting voluntarily. The role will be written into the job descriptions of identified support staff either prior to appointment or through a formal review. The school will ensure sufficient numbers of staff are trained and fulfilling this role at all times so that a child/young person is not denied access to full involvement.

1.9 All staff undertaking intimate care must be given appropriate training.

1.10 This Intimate Personal Care Policy has been developed to safeguard children and staff.

It applies to everyone involved in the intimate care of children.

2) Child/young person focused principles of intimate and intimate personal care.

The following are the fundamental principles upon which this Policy and guidelines are based:

Every child/young person has the right to:

- be safe.
- personal privacy.
- be treated as an individual.
- be treated with dignity and respect.
- to be involved and consulted in their own intimate personal care to the best of their abilities.
- express their views on their own intimate personal care and to have such views taken into account.
- have levels of intimate personal care that are as consistent as possible.

3) Definition

3.1 Intimate personal care can be defined as any care which involves washing, touching or carrying out a procedure to intimate personal areas which most people usually carry out themselves but some pupils are unable to do because of their developmental stage, physical difficulties or other special needs. Examples include care associated with continence and menstrual management as well as more ordinary tasks such as help with washing, toileting or dressing.

3.2 It also includes supervision of pupils involved in intimate self-care.

4) Best Practice

4.1 Pupils who require regular assistance with intimate personal care have written individual health care plans agreed by staff, parents/carers and any other professionals actively involved, such as school nurses or physiotherapists. Ideally the plan should be agreed at a meeting at which all key staff and the pupil should also be present wherever possible/appropriate. Any historical concerns (such as past abuse) should be taken into account. The plan should be reviewed as necessary, but at least annually, and at any time of change of circumstances, e.g. for residential trips or staff changes (where the staff member concerned is providing intimate personal care). They should also take into account procedures for educational visits/day trips.

4.2 Where relevant, it is good practice to agree with the pupil and parents/carers appropriate terminology for private parts of the body and functions and this should be noted in the plan.

4.3 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 personal care needs (e.g. has had an ‘accident’ and wet or soiled him/herself). It is recommended practice that information on intimate personal care should be treated as confidential and communicated in person, by telephone or by sealed letter, not through the home/school diary.

4.4 In relation to record keeping, a written record should be kept in a format agreed by parents and staff every time a child has an invasive medical procedure, e.g. support with catheter usage.

4.5 Accurate records should also be kept when a child requires assistance with intimate personal care; these can be brief but should, as a minimum, include full date, times and any comments such as changes in the child's behaviour. It should be clear who was present in every case.

4.6 These records will be kept in the child's file and available to parents/carers on request.

4.7 All pupils will be supported to achieve the highest level of autonomy that is possible given their developmental stage and abilities. Staff will encourage each individual pupil to do as much for his/herself as possible.

4.8 Staff who provide intimate personal care are trained in intimate personal care (e.g. health and safety training in moving and handling, safeguarding) according to the needs of the pupil. Staff should be fully aware of best practice regarding infection control, including the requirement to wear disposable gloves and aprons where appropriate.

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

4.10 There must be careful communication with each pupil who needs help with intimate personal care in line with their preferred means of communication (verbal, symbolic, etc.) to discuss their needs and preferences. Where the pupil is of an appropriate age and level of understanding, permission should be sought before starting an intimate procedure.

4.11 Staff who provide intimate personal care should speak to the pupil personally by name, explain what they are doing and communicate with all children/young people in a way that reflects their age and developmental stage.

4.12 Every child/young person's right to privacy and modesty will be respected. Careful consideration will be given to each pupil's situation to determine who and how many carers might need to be present when s/he needs help with intimate personal care. Reducing the numbers of staff involved goes some way to preserving the child's privacy and dignity. Wherever possible, the pupil's wishes and feelings should be sought and taken into account.

4.13 An individual member of staff should inform another appropriate adult when they are going alone to assist a pupil with intimate personal care.

4.14 The religious views, beliefs and cultural values of children/young people and their families should be taken into account, particularly as they might affect certain practices or determine the gender of the carer. The care needs of the child/young person should be paramount.

4.15 Adults who assist pupils with intimate personal care should be employees of the school, not students or volunteers, and therefore have the usual range of safer recruitment checks, including enhanced DBS checks.

4.16 All staff should be aware of the school's confidentiality policy. Sensitive information will be shared only with those who need to know.

4.17 Health & Safety guidelines should be adhered to regarding waste products. If necessary, advice should be taken regarding disposal of large amounts of waste products or any quantity of products that come under the heading of clinical waste.

4.18 No member of staff will carry a mobile phone, camera or similar device whilst providing intimate personal care. See school policy on mobile phones etc.

5) Child Protection

5.1 The Governors and staff at this school recognise that pupils with special needs and who are disabled are particularly vulnerable to all types of abuse.

5.2 The school's child protection procedures will be adhered to.

5.3 From a child protection perspective it is acknowledged that intimate personal care involves risks for children and adults as it may involve staff touching private parts of a pupil's body. In this school best practice will be promoted and all adults (including those who are involved in intimate personal care and others in the vicinity) will be encouraged to be vigilant at all times, to seek advice where relevant and take account of safer working practice.

5.4 Pupils will be taught personal safety skills carefully matched to their level of development and understanding. This will include learning around consent, listening to what their bodies are telling them (protective behaviours), expectations of adults and how/who to ask for help.

5.5 If a member of staff has any concerns about physical changes in a pupil's presentation, e.g. unexplained marks, bruises, etc. s/he will immediately report concerns to the Designated Safeguarding Lead or Head teacher. A clear written record of the concern will be completed and a referral made to Children's Services Social Care if appropriate, in accordance with the school's child protection procedures. Parents/carers will be asked for their consent or informed that a referral is necessary prior to it being made but this should only be done where such discussion and agreement-seeking will not place the child at increased risk of suffering significant harm.

5.6 If a pupil becomes unusually distressed or very unhappy about being cared for by a particular member of staff, this should be reported to the Designated Safeguarding Lead. The matter will be investigated at an appropriate level (usually the Head teacher) and outcomes recorded. If the concern is about the head teacher then it should be reported to the chair of governors.

5.7 If a pupil, or any other person, makes an allegation against an adult working at the school, this should be reported to the head teacher (or to the Chair of Governors if the concern is about the head teacher) who will consult the Local Authority Designated Officer in accordance with the school's policy.

Managing allegations against employees (children and young people)

http://intranet/DesktopModules/Bring2mind/DMX/Download.aspx?portalid=0&EntryId=1833

5.8 Similarly, any adult who has concerns about the conduct of a colleague at the school or about any improper practice will report this to the head teacher or to the Chair of Governors, in accordance with the child protection procedures and 'whistle-blowing' policy.

6) Medical Procedures

6.1 Pupils who are disabled might require assistance with invasive or non-invasive medical procedures such as the administration of rectal medication, managing catheters or colostomy bags. These procedures will be discussed with parents/carers, documented in the individual health care plan and will only be carried out by staff who have been trained to do so.

6.2 It is particularly important that these staff should follow appropriate infection control guidelines and ensure that any medical items are disposed of correctly.

6.3 Any members of staff who administer first aid should be appropriately trained in accordance with LA guidance. If an examination of a child is required in an emergency aid situation it is advisable to have another adult present, with due regard to the child's privacy and dignity.

This policy was adopted by the Governing Body on…..…… (Date)

It will be reviewed ……..…….. (Date)
(NB recommendation - on a three yearly cycle)

APPENDIX K: CONTINENCE MANAGEMENT FLOW CHART