Leeds Safeguarding Children Partnership

Leeds SCP Children and Young People's Intimate Care Good Practice Guidelines

Version	3
Date Document Amended	October 2018
Document Review Date	October 2021
JFDI Level	Level 2 – Residential settings, Health (LTHT, LCH, LYPFT), Education (SILCs), Nurseries and Childrens Centres. Level 1 – all other agencies.

Contents

1. 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 25th birthday.

The key contact for comments about this policy is: **lscp.info@leeds.gov.uk**

2. 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.[1]

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.

3. 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.

[1] Policy for the Chaperoning of Patients During Examination, Investigation or Clinical Recording, The Leeds Teaching Hospital Trust

- 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 believes 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.

4. 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 / careers.

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.

Guidelines for good practice (adapted from the Chailey Heritage Centre).

1. **Involve children, young people and parents / cares in devising intimate care plans**
   Parents / carers and the child or young person 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 or young person as well as being held within the child's records.

   The agency'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 staff, children, young people and parents/carers.

2. **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. Intimate examinations should adhere to the medical agencies chaperone policy.

   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 or young person - 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 or young person. 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. Agencies 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.

3. **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.

4. **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.

5. **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 the agency, but 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?

6. **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, such as rectal examinations, must only be carried out by nursing or medical staff. Medical procedures, such as giving rectal valium, suppositories or intermittent catheterisation, must only be carried out by staff who have been formally trained and assessed as competent.

7. ***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

   report any such incident as soon as possible to the manager or designated person in charge, inform parents/carers and record it. This is for two reasons: first, 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 person for child protection 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 organisations manager, 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 agency's child protection procedures.

8. **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.