Kent and Medway
NHS and Social Care Partnership Trust

Intimate Personal Care Policy

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DOCUMENT TRACKING SHEET

Intimate Care Policy

Version	Status	Date	Issued to/approved by	Comments
1.0	Approved	Feb 2009	Patient Focus Group	
1.1	Reviewed	2012		
2.0	Approved	Nov 2012	Patient Experience Group	Ratified
2.1	Reviewed	Oct 2015	Lead Nurse	Section on Children's services removed
3.0	Approved	Nov 2015	Trust Wide Patient Safety Group	Ratified
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4.0	Final	May 2019	Trust Wide Patient Safety and Mortality Review Group	Ratified
4.1	Draft	June 2022	Deputy Heads of Nursing Acute , Older Adults and Community Recovery Care groups	Reviewed and commented
5.0	Final	April 2023	TWPS and MRG	Re submitted for ratification

REFERENCES

Catheter Care- a guide for Nurses. Royal College of nursing
Code of Professional Conduct – Nursing & Midwifery Council (2018).
GIRES the Gender Identity Research and Education Society, on, www.gires.org.uk
Human Rights Act (1998)
Guidelines for Professional Practice, 1996, UKCC;
Essence of Care 2010 DOH
Mental Capacity Act 2005
Chief Nursing Officer Bulletin May 2009 DOH

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Concerns and Complaints Policy	KMPT.CorG.019
Consent to Treatment Policy	KMPT.CliG.049
Safeguarding and Protecting Children and Young People Policy	KMPT.CliG.030
Safeguarding Vulnerable Adults Policy	KMPT.CliG.006
Raising Concerns Whistleblowing Policy and Procedure	KMPT.HR.002
Delivering Same Sex Accommodation	KMPT.CliG.139
Investigation of Serious Untoward Incidents, Complaints & Claims Policy	KMPT.CorG.020
Chaperone Policy	KMPT.CliG.062
Interpretation and Translation Policy	KMPT.CliG.053
Promoting safe services: Restrictive Practice Policy	KMPT.CliG.218.01
Physical health and examination Policy	KMPT.CliG.026.07

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
2022			References updated
2022			Links to policies added - Promoting safe services: Restrictive Practice Policy Physical health and examination Policy Allegations against staff and People in a Position of Trust Policy
2022			Reflect new reporting system – InPhase

CONTENTS

1 INTRODUCTION AND PURPOSE

1.1 This policy identifies the approaches registered and non-registered health care staff must take when providing any form of intimate personal care. This policy provides a framework for models of best practice in any given situation, promoting patient choice and protection for clinical staff.

1.2 Patients may find it difficult and embarrassing to receive intimate personal care regardless of their age, ability, gender, ethnicity or cultural background and it is always a sensitive issue. There is also a higher incidence of a history of abuse, particularly sexual ,amongst people with mental health problems and/or disability which present a particular challenge to those receiving and providing intimate personal care.

2 DEFINITIONS

2.1 There is a difference between intimate personal care and intimate touch. Intimate personal care will involve an intervention by a clinician, which necessitates contact to intimate parts of the patient's anatomy, e.g. male and female genitalia, buttocks and breasts.

2.2 The reasons for this contact may be:

- 2.2.1 Washing
- 2.2.2 Bathing
- 2.2.3 Catheterisation
- 2.2.4 Shaving
- 2.2.5 Dressing intimate areas
- 2.2.6 Changing underwear
- 2.2.7 Toileting
- 2.2.8 Removing soiled sanitary wear
- 2.2.9 Gluteal (buttock) or Vastus Lateral (thigh) Injections
- 2.2.10 Searching for hidden objects
- 2.2.11 Administering pessaries/suppositories
- 2.2.12 Being present in a supervisory role when someone is bathing, dressing etc.

2.3 It needs to be recognised that intimate personal care always involves attention to intimate parts of the anatomy, whilst intimate touch is about fulfilling a need within an appropriate mutual consenting relationship and as such has no place in a professional caring relationship.

3 OBJECTIVES

3.1 To ensure that all patients within the Trust who require forms of intimate personal care receive it in a safe, timely and responsive manner and are treated with dignity and respect throughout the procedure.

4 SCOPE AND RESPONSIBILITY

4.1 All professional/vocational/clinical staff must adhere to their own professional code of conduct and to this policy. The implementation of this policy rests inevitably with all Ward Managers/Team Leaders and members of the multidisciplinary team.

4.2 All staff are reminded that they have a legal obligation and duty to report immediately any untoward incident that they perceive may cause harm to a patient, be that harm emotional, physical, neglectful, sexual or psychological. Concerns such as these should be reported to the nurse in charge or line manager. A safeguarding referral must be made for all staff allegations of abuse or harm reported by patients. An incident reporting form must also to be completed. Please refer to the KMPT safeguarding and allegations against staff policy to ensure appropriate staff and patient safeguarding actions are undertaken.

4.3 In all circumstances, the patient will need to be asked to give their consent. For example, in procedures outlined in 2.2 of this policy and other that are invasive or constitute treatment or an examination. In these instances, the Consent to Treatment Policy must be followed with reference to the Mental Capacity Act where appropriate.

4.4 Staff have a responsibility to consider where practices can be least restrictive when delivering intimate personal care to patients. Restrictive practices' is an umbrella term to describe a range of interventions that in some way restrict a person's liberty. The Skills for Care and Skills for Health, a Positive Practice Workforce (2014) provide a simple definition: "Making someone do something they don't want to do or stopping someone doing something they want to do."

4.5 When planning to deliver intimate personal care please consider the following: -
a) Blanket restrictions.
b) Physical restrictions.
c) Forced care.
d) Cultural restrictions.
e) Decision making.
For further details please refer to the Restrictive Practice Policy.

4.6 On occasions, restrictions, notably the use of physical interventions (restraint) are required for intimate care procedures. All uses of physical interventions must be the least restrictive, used for the shortest time necessary and only after other non-restrictive options have been considered. All uses of physical interventions must be necessary to prevent harm to the patient who lacks capacity, and is a proportionate response to the likelihood of the patient suffering harm. Staff must be trained in the use of physical interventions and fully document all uses of physical interventions in accordance with the restrictive practice policy, i.e. Incident report, RIO notes.

5 PATIENT CHOICE

5.1 It must be acknowledged that patients' choice is an important consideration at all times. However, due to some people's lack of capacity to make a choice, staff will need to be clear about who makes that choice on their behalf and consider if there is an advance directive in place. Where a patient's mental capacity to consent to intimate personal care is in question, a formal mental capacity assessment must be completed and a best interest decision made. Refer to the KMPT Mental Capacity Act Policy and Consent to Treatment Policy for further guidance. Intimate personal

care, because of its sensitive nature, brings another dimension to the concept of patient choice.

5.2 Patient care must be individual and personalised. It should be agreed by the patient and care team and documented within their care plan. The patient should be central to all decisions being made in relation to their care and treatment.

5.3 There are five clearly distinguishable issues that influence the provision of intimate personal care and patient's choice.

5.3.1 Patient choice must be routinely offered. If exceptionally it is not operationally possible to meet the patients preferred choice, the patient should be offered choice within the options that are possible. Staff need to feel comfortable with and fully understand their role when providing intimate care and must be aware that their involvement may not be the patient's preferred option. Staff should make themselves aware of the recommended options illustrated in this policy.

5.3.2 It is acknowledged that ethnicity, religion and cultural background may influence the choice of the gender of the clinician. This need must always be taken into consideration as a priority when planning and delivering patient care.

5.3.3 Sexuality will also influence choice with the needs of the lesbian, gay, bi-sexual population whose needs and preferences must be respected.

5.3.4 The transgender population need consideration. The recommendations regarding the care of transgender people in same sex accommodation included in the Chief Nursing Officer's Letter to Trusts in 2009 should be used as a guide. This states that:

a) Transgender people should be accommodated according to their presentation, the way they dress and the names and pronouns they currently use

b) This may not always be in accordance with the physical sex appearance of the chest or genitalia

c) It does not depend upon their having a gender recognition certificate (GRC) or legal name change

d) It applies to toilet and bathing facilities (except for instance that pre-operative transgender people should not share open shower facilities).

e) Views of family members may not accord with the transgender patients wishes, in which case the trans patients views take priority.

5.3.5 Further information is available from GIRES the Gender Identity Research and Education Society, on, www.gires.org.uk.

5.4 The above acts in the best interest and protection of the patient and endeavours to provide protection for the clinician. The provision of patient choice cannot be looked at in isolation. It is intrinsically linked to the role function and availability of gender mixed staff teams.

6 THE ROLE OF THE CARE WORKERS

6.1 The following provides a framework for the provision of intimate personal care in a variety of situations and settings. These are influenced by the age, physical and intellectual ability of the patient and the availability of gender mix teams.

6.2 Once patient choice has been offered where possible or appropriate, the role of the clinician is threefold, depending on the situation or setting.

6.3 **Supervisory:** The key elements of the supervisory role are:

6.3.1 Empowering - giving control to the patient. Encouraging self-reliance and not promoting independence.

6.3.2 Enabling - creating an environment for optimum involvement by the patient.

6.3.3 Instructing and guiding – using the situation for an opportunistic learning and/or re-learning of skills and techniques in a safe and supervised environment.

6.4 **Supporting:** The key elements of the supporting role are:

6.4.1 Teaching - the teaching element in the supportive role is fundamental as part of a supportive and ongoing learning process.

6.4.2 Assisting and encouraging - the emphasis must be on encouraging. The assisting needs to be seen as complementary to the process of encouraging.

6.4.3 Observing and Accessing- this forms part of a continuous process and should be recorded as part of any care plan.

7 OPERATIONAL

7.1 The key elements of the operational role are:

7.1.1 Physical undertaking - this is only acceptable practice when a patient is unable, for physical or psychological or cognitive reasons, to be involved in undertaking any part of the process for themselves. It is acknowledged that the clinician's role may incorporate supervisory, supporting and operational components in any one given situation and that patients' needs and abilities may alter.

7.1.2 If any staff observe any abnormality e.g. evidence of infection, discharge, trauma, lumps, poor skin integrity, pressure injuries or other unusual appearance or pain on contact in male or female genitalia, anus or breasts, these need to be reported to a senior member of staff. This may necessitate physical examination by a qualified practitioner to necessitate accurate diagnosis, treatment and referral to specialists where appropriate. If this is required the Trust's Chaperone Policy must be evoked. A serious untoward incident alert should be raised on InPhase if there is any doubt or suspicion as to how a trauma or infection has occurred and a safeguarding consultation or alert should be considered.

8 AREAS FOR BEST PRACTICE

8.1 This list has been developed to assist staff in the development of good practice when providing intimate care to their patients.

8.1.1 Always offer the choice of gender when delivering intimate personal care. If necessary, wait until appropriate staff are on duty; this may include members of other professional groups. If this is not possible advice should be sought from the line manager or clinical lead and an InPhase incident form should be completed.

8.1.2 Always ensure privacy and dignity.

8.1.3 Give patients time to make their preferences known.

8.1.4 Always endeavour to make embarrassing situations less so for the patient, for example, ensure as far as possible that single rooms are used for the delivery of intimate personal care; ensure that only the part of the body needed for access is exposed and do not leave the patient exposed at any point.

8.1.5 Always explore a variety of options to communicate with the patient including interpreters where a language barrier exists. Consider where pictorial diagrams or communication aids such as large print can support. Relatives should not be relied upon as interpreters as a matter of good practice.

8.1.6 Do not assume people who are severely disabled cannot communicate their needs.

8.1.7 Never assume a patient does not understand or has no means of communication.

8.1.8 Consider whether the patient has a history of trauma or abuse and whether this is relevant to their individual wishes for intimate personal care.

8.1.9 Consider gender mix when planning and delivering intimate personal care.

8.1.10 Never have two male staff with female patients.

8.1.11 It is important to remember that male sexual arousal could be a rapid and obvious response and can lead to embarrassment for patient and clinician.

8.1.12 Female sexual arousal could be subtler and less obvious to clinicians but patients may be embarrassed by these sensations.

8.1.13 During female menstruation, a male carer should not give intimate personal care.

9 TRAINING AND AWARENESS

9.1 The Trust has an obligation to ensure that staff are aware of the issues relating to the provision of intimate care and their particular responsibilities. This is to be carried out in a variety of ways.

9.1.1 This policy will be brought to the attention of all staff that will be providing intimate personal care to patients through the induction to their units/wards.

9.1.2 Working with the Universities – pre-registration nursing students will include intimate care within their basic training to ensure that they are competent and able to carry out care in line with this policy and best practice evidence.

9.1.3 Staff must make use of clinical supervision to discuss and reflect on any issues that the delivery of intimate care raises for them and their patients.

9.1.4 All staff providing intimate personal care must be up to date with their mandatory equality and diversity training.

10 AUDIT AND MONITORING

10.1 All incidents of concern regarding the carrying out of intimate personal care ,whether reported by a patient, family, or staff member will be treated as untoward incidents and reported and investigated by the manager using the InPhase system. This may reveal a serious incident which must then be dealt with under the Serious Incident Policy. Complaints should be dealt with as per the Complaints Policy.

10.2 The monitoring of policy implementation will be completed annually through the Chaperone audit (please refer to the Trust Chaperone Policy).

11 RECORD KEEPING

11.1 A patient's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council 2006, the Royal College of Psychiatrists 2009 and Nursing and Midwifery Council 2009 Standards and NHS Record Keeping - NHS Code of Practice for Record Keeping 2006).

11.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money and manage risks (NHS Litigation Authority, Information Governance Toolkit, Essential Standards). **Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record, RiO.**

11.3 For full details of the specific information needed to ensure compliance with this policy see the RiO training guides and the Care Group Standard Operating Procedures.

12 EQUALITY IMPACT ASSESSMENT

12.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

13 HUMAN RIGHTS

13.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights

of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.