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| **Intimate Care Plan** |

### Confidential

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| --- | --- | --- | --- |
| **Name** |  | **Setting** |  |
| **Date of birth** |  | **Year Group** |  |
| **Date of plan** |  | **Date of Review** |  |

This plan has been agreed by:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Role** | **Signature** | **Date** |
|  | Child/Young Person (CYP) |  |  |
|  | Parent/carer |  |  |
|  |  |  |  |
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Advisory Teaching Service

Page 1

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| --- | --- | --- | --- |
| CYP'S NEEDS | | | |
| **Diagnosis** |  | | |
| **Continence needs** |  | | |
| **Level of Support** |  | | |
| **Other Needs** | **Individual Equipment/resources:**  Posture/mobility  Splints 🞏 Body brace/jacket 🞏 Standing Frame 🞏  Sticks/crutches 🞏 Walker 🞏 Gait Trainer 🞏  Manual/Electric Wheelchair 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Manual Handling  Hoist 🞏 Sling 🞏 Handling belt 🞏  Sliding sheet 🞏 Sliding board 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_    Continence  Stoma Bag 🞏 Catheter 🞏 Pads/products 🞏  Other \_\_\_\_\_\_\_\_\_\_\_\_\_    **Additional Needs:**  (e.g. sensory, other medical) | | |
| **Other professionals involved**  **(Form 1)** | Yes/No | **School support/EHCP links to Intimate Care Plan** | Yes/No |

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| NEEDS IN SCHOOL | | |
| Where will intimate care take place in school? | | |
| **Access Toilet** (provide details, e.g. location) Other | | |
| **What equipment does the CYP need?**  **(See form 3 for detailed checklist)** | | |
| Who provides this? **School** (highlight as appropriate)   |  |  |  |  | | --- | --- | --- | --- | | Plastic aprons | Latex-free gloves | Disposal system | Secure storage | | Hand-washing facility with anti-bacterial liquid soap & paper towels/hand dryer | | Accessible toilet, e.g. hand rails, step, etc | Home/school communication book |     **Pupil/Family** (highlight as appropriate)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Pads | Wipes | Spare clothes & pants | Catheter/ equipment | Stoma bag | | | |
| What adult assistance is needed? Where will records be kept? | | |
|  |  | |
| What does the CYP need to do? | | |
|  | | |
| Who will support the CYP? When? | | |
| Regular 1.  2.  Staff training received Yes/no | | Backup 1.  2.  Staff training received Yes/no  N.B. Need at least monthly experience of technique |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| When will the toileting take place? (Use Form 2 for exceptions) | | | | | | |
|  | Monday | | Tuesday | Wednesday | Thursday | Friday |
| Beginning of day |  | |  |  |  |  |
| Morning Break |  | |  |  |  |  |
| Lunchtime |  | |  |  |  |  |
| Afternoon Break |  | |  |  |  |  |
| End of day |  | |  |  |  |  |
| How will the process be monitored & how regularly? | | | | | | |
| E.g. School support or EHCP meetings/reviewsRecord chart Liaison with parents/carers | |  | | | | |

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| **Additional things to think about (e.g. reward system, time prompts, personalising toilet space)** |
|  |
| **Other issues to consider (e.g. anxiety, self-esteem, dignity, time out from learning, developing independence)** |
|  |

 **Data Protection Act -** This information is being collected for the purpose of determining the educational needs of the named pupil, but may also be shared with other relevant professionals such as teachers, health and social workers etc, to inform their work.

The information collected may also be used for the wider purpose of providing statistical data used to assist with Monitoring provision and/or determining areas of need in order to target future resources. For further information please contact Advisory Teaching Service Tel: 01452 426955

Form 1

|  |  |
| --- | --- |
| **Name/Role** | Contact address/phone/e-mail |
| Parent/carer |  |
| School Nurse |  |
| Continence Specialist Nurse |  |
| Physiotherapist |  |
| Occupational Therapist |  |
| Hospital Consultant |  |
| Hospital Consultant |  |
| Hospital Consultant |  |
| Hospital Education Service |  |
| Advisory Teaching Service |  |
| GP |  |
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**Form 2**

#### RECORD OF PERSONAL CARE INTERVENTION

**BY EXCEPTION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Time** | **Procedure** | **Staff signature** | **Second signature** |
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**Form 3**

**PERSONAL CARE FACILITIES & RESOURCES CHECKLIST**

(to inform the Intimate Care Plan)

| Facilities | Discussed | **Action** |
| --- | --- | --- |
| **TOILETING** | | |
| Suitable toilet(s) identified? |  |  |
| Adaptations required?, e.g. seating system, grab rails |  |  |
| Changing mat/table (easy clean surface) |  |  |
| Easy to operate locks at suitable height |  |  |
| Accessible/secure locker for supplies |  |  |
| Mirror at suitable height |  |  |
| Hot and cold water, lever taps |  |  |
| Disposal unit |  |  |
| Moving and Handling equipment |  |  |
| Bleeper/emergency help/pull cord working? |  |  |
| **PUPIL/FAMILY PROVIDED SUPPLIES** | | |
| Pads |  |  |
| Catheters/equipment |  |  |
| Wipes |  |  |
| Spare clothes |  |  |
| Others (specify) |  |  |
| **SCHOOL PROVIDED SUPPLIES** | | |
| Toilet rolls |  |  |
| Urine bottles |  |  |
| Antiseptic cleanser, cloths and blue roll |  |  |
| Anti-bacterial liquid soap |  |  |
| Paper towels/hand dryer |  |  |
| Disposable gloves/aprons |  |  |
| Disposal system |  |  |
| **STAFF TRAINING/COMMUNICATION** | | |
| Advice sought from medical personnel? |  |  |
| Specific training for staff in personal care role |  |  |
| Awareness raising for all staff |  |  |
| Curriculum specific issues |  |  |
| Other CYP awareness |  |  |
| Passcard system? |  |  |
| **PE ISSUES** | | |
| Discreet clothing required? |  |  |
| Privacy for changing? |  |  |
| Time for supporting personal care need |  |  |