St James Infant & Pre-School

Positive Touch Policy
Intimate Care,
Continence and Changing Policy

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Annual review

Introduction:

St James Infant & Pre-School is committed to a child-centred approach in which physical contact is used only to meet a child's care, communication, learning, comfort or safety needs. Appropriate touch can be an important part of working with young children. It must always be professional, proportionate, respectful and in the child's best interests.

The school does not operate a blanket "no contact" approach. Staff use professional judgement, consider the child's age, development, SEND, communication needs, culture, previous experiences and any known trauma, and consider whether a non-contact alternative would meet the need. A child's words, behaviour and non-verbal communication about touch are taken seriously.

Aims:

This policy aims to protect children's dignity, privacy, safety and right to inclusion; give staff clear boundaries for appropriate touch and intimate care; promote independence and toilet learning; and ensure that any restrictive intervention is lawful, necessary, proportionate, recorded and followed up.

Rationale:

Warm, secure relationships and safe, appropriate physical contact can help young children feel safe, communicate, participate in learning and regulate emotions. The need for touch, however, belongs to the child rather than the adult.

Some children may seek more physical reassurance; others may find touch distressing because of sensory difference, disability, communication need, culture, previous experience or trauma. Staff should notice the child's response, ask or explain before touching where practicable, and stop or adapt contact if the child indicates discomfort, unless immediate lawful action is needed to prevent harm.

Planned physical support, including increased physical contact for a child with SEND, should be co-produced with the child as far as possible, parents/carers and relevant professionals, with clear parameters in the child's care, behaviour support or risk plan.

All physical contact must be open to scrutiny. Staff must avoid contact that is unnecessary, prolonged, secretive, sexualised, could reasonably be misinterpreted, or is primarily for the adult's reassurance or enjoyment. Any concern about an adult's use of touch must be shared under the school's safeguarding, allegations and low-level concerns procedures.

This policy should be read alongside the Safeguarding and Child Protection Policy, Staff Code of Conduct, Behaviour and Relationships Policy, SEND Policy, First Aid/Medical Needs procedures and the school's Restrictive Intervention procedures. Prevention, co-regulation, de-escalation and the school's Therapeutic Thinking principles are the starting point.

From 1 April 2026, the school must have procedures for recording and reporting significant incidents involving force, and all incidents of seclusion and restraint covered by the statutory framework. Records are made in writing as soon as practicable, with staff aiming to complete them on the same day, and parents/carers are informed in accordance with the statutory reporting duties.

Positive Touch

Different types of appropriate touch

1. Everyday, supportive and incidental touch

Appropriate contact may include giving first aid, holding a young child's hand to guide or escort them, comforting a distressed child, congratulating or praising a child, or demonstrating an activity in PE, music or another curriculum area. Staff should use the least intrusive contact that meets the need and remain alert to the child's response.

2. Comfort and co-regulation

Safe touch may support a frightened, sad or dysregulated child when the child welcomes it. Staff should use calm, brief, developmentally appropriate contact in an open and observable context. Routine tickling, rough-and-tumble play, massage or other contact that blurs professional boundaries is not used. Therapeutic massage or specialist physical programmes are only used where formally planned, appropriately trained and agreed with parents/carers and relevant professionals.

3. Play, curriculum and physical support

Staff may use appropriate physical support to help a child access play, equipment, movement, PE, messy play, positioning or a learning task. The adult explains what they are doing where practicable, supports the child to do as much as possible independently, and reduces physical assistance as soon as it is no longer needed.

4. Restrictive intervention and reasonable force

All school staff have a legal power to use reasonable force only in limited circumstances, including to prevent or stop a pupil injuring themselves or others, committing a criminal offence, damaging property or causing disorder. Any force must use no more force than is necessary for the least amount of time. Force must never be used as punishment or simply to secure compliance or to calm a child. Staff must avoid any technique that affects airway, breathing or circulation, pressure to the neck or abdomen, and ground restraint; if a child is unintentionally held on the ground, staff should release or move to a safer position as quickly as possible.

Recording, reporting and follow-up

A significant incident is one where force goes beyond appropriate physical contact. Each significant use of force must be recorded in writing as soon as practicable, with the staff involved aiming to record it no later than the same day. Parents/carers must be informed as soon as practicable, with the school aiming to do so no later than the same day, and the information should be provided in writing. The statutory safeguarding exception applies where reporting to a parent would be likely to result in serious harm to the child; in that situation the DSL/senior leader follows the statutory reporting route.

Seclusion is not a disciplinary sanction. If used as an emergency safety measure, it must only protect others from harm while a pupil is highly dysregulated, the pupil must be supervised at all times and allowed to leave as soon as the immediate risk has reduced. Every incident of seclusion and every restraint covered by the 2025 Regulations, including restraint without direct physical contact, must be recorded and reported.

After a restrictive intervention, the school checks for injury and wellbeing, offers appropriate support, gathers the child's views in a developmentally appropriate way, reflects with staff, repairs relationships and reviews any behaviour support or risk plan. Patterns, including disproportionate use affecting pupils with SEND, disabilities, protected characteristics or other vulnerabilities, are monitored by leaders.

5. Using touch to communicate and teach

Some children may need touch to support communication, on-body signing, orientation, physical prompts or access to learning. Staff should explain or signal the contact before it happens, use the least intrusive prompt, give processing time and follow any agreed communication, care, therapy or support plan. Increased physical contact should be clearly described in the child's plan and reviewed with the child and parents/carers.

How do we use touch safely?

Hugging

When a child seeks comfort, staff may offer a brief, child-led "school hug", normally side-on where practical. The child must be free to move away. Staff should use particular care with prolonged or front-on contact and consider whether sitting alongside, handholding or verbal reassurance would meet the need.

Handholding

Young children may hold an adult's hand for reassurance, guidance or safe movement. Staff should ask or invite the child where practicable and respect refusal unless immediate safety requires lawful intervention.

Lap sitting

Sitting alongside an adult is preferred. For very young children, brief child-led lap sitting may sometimes be appropriate for comfort when it is in an open, observable setting and the child is clearly comfortable. It should not become a routine or exclusive pattern. Staff should help children develop other age-appropriate ways to seek reassurance as they mature.

A positive touch policy does not require a member of staff to touch a child, and it does not give an adult permission to override a child's discomfort. If a child withdraws, says no, freezes, becomes distressed or otherwise indicates that contact is unwelcome, staff should stop and use an alternative wherever this can be done safely. This does not prevent reasonable force being used lawfully where immediately necessary.

6. Intimate care, self-care and changing

Intimate care includes help with toileting, nappy or pad changing, washing, dressing and other personal care that a child cannot manage independently. Children will be supported to do as much as they safely can for themselves. Planned intimate care is agreed with parents/carers through an individual care plan where appropriate, taking account of the child's communication, medical, SEND, moving/handling, sensory, cultural and safeguarding needs.

Safeguarding expectations for intimate care and changing

The child is told what will happen, in language or communication they can understand. Staff seek the child's cooperation/assent at each stage and offer choices where possible. Planned parental consent does not replace listening to the child in the moment.

EYFS privacy must be balanced with safeguarding and support needs. Care is provided in a suitable hygienic area that protects dignity without creating unnecessary isolation. Doors are not locked in a way that prevents appropriate safeguarding access.

Routine intimate care will normally be provided by one suitably checked and competent member of staff, with another member of staff aware that the care is taking place and available if needed. A second adult should be present where an individual care/risk plan, moving and handling need, the

child's distress, a safeguarding concern or the circumstances indicate that this is safer. Two adults are not automatically required for every routine change.

Only staff whose role and checks allow them to undertake personal care will do so. Intimate or personal care is regulated activity even if it occurs only once. Visitors or ad-hoc volunteers will not provide intimate care unless the school has confirmed that the person is suitable, appropriately checked and authorised for that role.

For ordinary clothing changes, including wet clothes, PE kit or uniform, children change independently wherever they can. Staff provide privacy and only the assistance needed. If help involves intimate areas or personal hygiene, the intimate-care safeguards in this policy apply.

No photographs or recordings are taken during intimate care. Personal mobile phones or personal devices must not be used in the changing/toileting area.

Any unexplained mark, injury, disclosure, unusual distress, regression in toileting or other safeguarding concern is reported promptly to the DSL and recorded under safeguarding procedures. Staff must not question the child beyond what is necessary to clarify an immediate concern or delay a safeguarding report.

CONTINENCE AND CHANGING SOILED OR WET CHILDREN POLICY

Aims:

St James will meet children's continence and personal-care needs with dignity, inclusion and without shame. A child will not be excluded from normal school or pre-school activities because they are not toilet trained or need intimate care. Where continence needs arise from disability, the school will make reasonable adjustments in line with the Equality Act 2010.

The DfE's toilet-training guidance encourages early years settings to work in partnership with parents/carers, support children to develop independence and seek appropriate advice where a child is finding toilet learning difficult, including for children with SEND.

This section sets out school procedures for responding promptly to wet or soiled children, maintaining hygiene, respecting privacy and safeguarding children during all personal-care routines.

Planning for a child who needs continence or changing support

Where a child needs regular support, the school will work with parents/carers and, where relevant, the SENCo and health professionals to agree a care and toilet-learning plan. The plan should record the child's level of independence, communication, preferred routines, products/creams, frequency of checks or changes, moving/handling or medical needs, how distress will be responded to and when the plan will be reviewed.

Parents/carers

- Share relevant routines, communication, medical/SEND information and known toileting triggers, and help the school provide a consistent approach.
- Provide spare nappies/pads or underwear and sufficient changes of clothing where these are individually required; the school will maintain reasonable emergency supplies.
- Agree planned changing procedures and the use of any cleanser, barrier cream or other product. Medication or medicated creams are managed under the school's medical procedures.
- Tell the school about existing marks, rashes, soreness or changes in the child's continence that staff need to know about.
- Work with the school on toilet learning and independence. The child will be changed according to need and will not be deliberately left wet or soiled in order to follow a "minimum change" approach.
- Review arrangements with the school when the child's needs, independence or circumstances change.

School

- Respond promptly when a child is soiled or uncomfortably wet and provide care as soon as practicable, with dignity and reassurance.
- Agree the frequency of routine checks/changes according to the individual child's needs rather than a fixed minimum.
- Record planned intimate-care support as required by the child's plan, and record/report distress, injury, unusual marks or safeguarding concerns through the appropriate school system.

- Review support with parents/carers and relevant professionals and promote increasing independence wherever this is developmentally appropriate.

Toilet learning and independence

Staff use positive, matter-of-fact language and never shame or punish a child for an accident. Children are helped to practise the component skills of independent toileting, such as managing clothing, sitting safely, wiping, flushing and washing hands. The school works consistently with parents/carers and seeks SENCo, health visitor, GP or specialist advice where progress is difficult or there is a suspected medical or SEND-related need.

Hygiene procedures for changing a soiled nappy or soiled underwear/clothing

- Staff wear disposable gloves and an apron where there is a risk of contact with urine, faeces or other body fluids.
- Soiled nappies/pads and disposable cleaning materials are placed in the appropriate hygienic waste system. Soiled clothing is sealed securely for return to parents/carers unless another arrangement is agreed.
- The changing surface/area is cleaned and disinfected after use in line with the school's infection-control procedures.
- Hands are washed thoroughly with liquid soap and running water immediately after the task. Gloves do not replace handwashing.
- Hands are dried using disposable paper towels or another hygienic hand-drying method provided by the school.

Staff guidelines for dealing with a soiled or wet child

Intimate care is carried out by staff whose role includes care/support and who are appropriately checked, informed of this policy and trained for the child's needs. It is not restricted to teaching assistants and is not delegated casually to visitors or volunteers.

- Where regular intimate care is needed, named or familiar staff should be identified in the child's plan where practical, while avoiding arrangements that leave one adult as the child's only possible carer.
- Children are supported to clean and change themselves according to their age, development and level of independence. Adult help is limited to what is needed.

For a one-off accident, a child who can clean and change independently should be given privacy, clean clothing and discreet support. If adult assistance with intimate areas is needed, staff follow the same safeguarding, dignity and hygiene expectations as for planned intimate care. Soiled clothing is sealed securely for home and parents/carers are informed appropriately.

For children requiring adult support:

The member of staff lets a colleague know discreetly that they are taking a child for intimate care and where the care will take place.

The adult explains each step before it happens, uses the child's preferred communication and seeks cooperation/assent. The child is encouraged to do each part they can manage independently.

Care takes place in the designated toilet/changing area or another suitable area identified in the child's plan. Privacy is protected while maintaining proportionate safeguarding oversight and access.

The child uses the safest and most dignified position for their needs. Standing changes are used only where appropriate; any lifting or specialist positioning follows the child's moving-and-handling plan and staff training.

The adult wears disposable gloves and an apron where required by infection-control procedures.

Only the clothing necessary for the care task is lowered or removed, and the child is covered appropriately wherever possible.

The soiled pad, nappy or underwear is removed and disposed of or bagged safely.

Cleaning/wiping is carried out gently and hygienically, front to back where relevant, using only agreed products.

The skin is dried gently using suitable disposable materials; the child is encouraged to help if they are able.

Clean underwear, pad/nappy and clothing are replaced, with the child doing as much as possible independently.

The child is supported to wash and dry their hands.

The changing area is cleaned and waste/soiled items are dealt with under infection-control procedures; required care records are completed.

The adult removes PPE safely and washes and dries their own hands thoroughly.

What to do if a child becomes distressed during the changing process

- Pause, reassure the child and explain simply what is happening. Offer choices and use the child's preferred communication, trusted adult or agreed regulation strategy where this may help.
- If distress means it is not appropriate to continue, stop unless there is an immediate health or safety reason that requires urgent action. Seek support from a colleague/senior leader and follow the child's individual plan where one exists.
- If care cannot be completed safely, contact parents/carers to agree the next step. The child must not be blamed, shamed or left without reasonable support.
- Record significant distress, whether care was completed, the action taken and parent/carer communication. Review the care plan if the child is repeatedly distressed.
- If the distress, behaviour or information shared by the child raises a safeguarding concern, report it immediately to the DSL/deputy and follow the Safeguarding and Child Protection Policy.

What to do if marks, redness, injury or another concern is seen

Record observations factually and report any unexplained, concerning or unusual mark, redness, injury, disclosure or change in presentation promptly to the DSL/deputy. Do not investigate, ask leading questions or use a personal device to photograph the child. Parents/carers should normally be informed, but where a safeguarding concern could involve a parent/carer or informing them may increase risk, staff must seek DSL advice before contact.

Access to relevant training

Staff undertaking intimate care receive guidance/training appropriate to their role and the child's needs, including safeguarding, professional boundaries, infection prevention, continence/toilet learning, communication and moving/handling where relevant. Staff likely to use restrictive interventions should receive training in safe and lawful practice, prevention and de-escalation. Training does not authorise force outside the law or the school's policy.

Relevant guidance and sources - reviewed August 2026

Department for Education: Restrictive interventions, including the use of reasonable force, in schools (effective from 1 April 2026).

Department for Education: Keeping children safe in education 2026 (comes into force 1 September 2026).

Department for Education: Early years foundation stage statutory framework for group and school-based providers (from 1 September 2026), section 3 - Toilets and intimate hygiene.

Department for Education / Help for Early Years Providers: Toilet training.

Education and Inspections Act 2006, sections 93 and 93A; Schools (Recording and Reporting of Seclusion and Restraint) (No. 2) (England) Regulations 2025; Equality Act 2010.

The Key: Intimate care - responsibility of school staff (reviewed 15 July 2026); Intimate care policy and plan - model and examples; Restrictive interventions, including reasonable force; How to record and report restrictive interventions.

KEY UPDATES FOR STAFF - WHAT HAS CHANGED (AUGUST 2026)

This summary highlights the main practice changes in this 2026-27 policy. Staff must still follow the full policy and individual child plans.

1. Positive touch is allowed and may be necessary. There is no blanket no-contact rule. Use professional judgement, the least intrusive appropriate contact and remain alert to the child's words, behaviour and non-verbal response.

2. Child voice and assent are explicit expectations. Explain and ask before touch or intimate care where practicable. If a child says no, withdraws, freezes or becomes distressed, stop or adapt unless immediate lawful action is needed for health or safety.

3. Professional boundaries are clearer. Routine tickling, rough-and-tumble play and massage are not used. Sitting alongside is preferred for comfort; any lap sitting must be brief, child-led, appropriate for a very young child and open to observation.

4. Changing and intimate care safeguards are strengthened. Use an individual care plan for regular support. Protect privacy while maintaining appropriate safeguarding oversight. Routine care will normally be by one suitable member of staff with another adult aware; use a second adult when the plan, risk, distress, moving/handling or safeguarding circumstances indicate this is safer. No personal devices or photographs are used during care, and ad-hoc visitors or volunteers do not provide intimate care.

5. Ordinary clothing changes are distinguished from intimate care. Children should change wet clothes, PE kit or uniform independently wherever possible, with privacy and only the help needed. If support involves intimate areas or personal hygiene, the intimate-care safeguards apply.

6. Continence support is needs-led and inclusive. There is no minimum-change approach. Children are changed promptly according to need, are never shamed or excluded because of continence needs, and are supported towards independence. Reasonable adjustments and partnership with parents/carers, the SENCo and health professionals are used where needed.

7. Restrictive intervention expectations have changed from April 2026. Reasonable force is only for limited lawful safety circumstances, using no more force than necessary for the least time, and never as punishment or simply to secure compliance. Staff must avoid techniques affecting airway, breathing or circulation, pressure to the neck or abdomen, and planned ground restraint.

8. Recording, reporting and follow-up duties are now explicit. Significant uses of force, and all seclusion and restraint covered by the statutory framework, must be recorded in writing as soon as practicable, with a same-day aim. Parents/carers must be informed as soon as practicable, also with a same-day aim and in writing, subject to the safeguarding exception. After an incident, check wellbeing, gather the child's views, debrief and review plans. Safeguarding concerns go promptly to the DSL; seek DSL advice before contacting a parent if doing so could increase risk.

If you are unsure: pause where it is safe to do so, use the least intrusive safe option, seek advice from the DSL/SLT, and make the required record.