Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Personal Intimate Care Guiding Principles

Guiding Principles Subgroup Policy: Provision of Personal Intimate Care - Schedule V no. 4 Health Care Act 2007, Regulations 2013. Version 1. Approved by the Independent Governance Review Group April 17 2019

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Contents

Introduction:

These Guiding Principles are intended to support services when revising the local policies and procedures developed to meet the Schedule V requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for persons with disabilities) Regulations 2013.

The Guiding Principles –
The set of Guiding Principles has been developed following an international literature review which was validate using the AGREE tool along with the preferences and views elicited from service users. These Guiding Principles reflect the key elements that should be incorporated in your local policy and procedure. The references which were used to identify these principles are attached to the end of the Guiding Principles document.

Impact Assessment (Appendix I) –
This Impact Assessment has been developed to assist services during the implementation of the revised local policy and procedure and is intended as a guide to provide a structure for measuring the impact of the revised policy in four key areas:

1. Stakeholder Perspective
2. Internal Business Processes Perspective
3. Learning and Growth Perspective
4. Financial Perspective

This tool should be used by the local policy and procedure development or steering group when the policy revision is close to completion. There is an action plan to record what needs to happen under each of the four headings to support the implementation of the policy.

Audit Tool (Appendix II) –
This document is intended to act as an audit tool when a service is revising their local policy and procedure. The purpose is to ensure that each of the questions in the audit tool is addressed in the local policy and procedure. This includes a question at the end of the audit tool to ensure that experts by experience or people who use the service have been involved in developing or reviewing the policy in a meaningful way.

Verification of Literature using AGREE Tool (Appendix IV) –
This document is included in the packet to assure services that the Guiding Principles were developed in a robust manner and that the literature was validated against this accredited tool (AGREE) as well as giving a synopsis of the engagement with service users. It is for information purposes.

Personal Intimate Care Guiding Principles:
The National Guiding Principles Group, under the auspices of the National Quality Improvement Office, HSE Disability Operations, has identified 8 guiding principles to assist organisations in developing and revising local policies and procedures for the provision of personal intimate care.

Guiding Principles:

1. **Choice** – Adults have the right to make their own choices in relation to all aspects of their life including decisions around their personal intimate care needs. Therefore, staff members should provide all necessary support to enable individuals to make choices in this area and so maximise the amount of control people have over their care. This includes choice of whom the person wishes to receive support from.

2. **Dignity and Privacy** – Staff members will support individuals with their personal intimate care in a respectful manner which enhances the dignity of the individual and upholds their right to privacy.

3. **Culturally Appropriate Support** – Staff members will seek to establish the culturally specific needs and preferences of people from minority ethnic communities with respect to their personal intimate care.

4. **Independence** – Staff members will provide appropriate support to enable individuals to develop the psycho-motor and social skills necessary to self-care in relation to practical personal intimate care tasks.

5. **Same gender care:** it is accepted that it is generally preferable for the same gender to provide intimate care but recognises that this may now always be possible and/or the person may have a different request. Every effort should be made to accommodate the person's choices on who provides intimate care.

6. **Personal Intimate Care Plan**– Every person who requires personal intimate care will have a full assessment of their needs carried out using a collaborative approach that includes the person, the circle of support (if appropriate) and staff resulting in a documented Personal Intimate Care Plan being put in place.

7. **Training** – Organisations must promote a learning environment that values the role of staff in the provision of personal intimate care and ensures that staff are appropriately trained in providing intimate care

8. **Sexual Expression –** Within an organisational learning culture, organisations should encourage dialogue around situations where persons become sexually aroused during the provision of intimate care, with appropriate guidance developed. This should be done in a

way that respects the dignity of individuals and supports staff to continue providing the appropriate care.

References:

Aras Attracta Swinford Review Group, July 2016- Time for Action

Cambridge P, Carnaby S (2000) A personal touch: Managing the risks of abuse during intimate and personal care. The Journal of Adult protection. 2, 4, 4-16

Carnaby S, Cambridge P, (2006). Intimate and personal care with people with learning disabilities. London: Jessica Kingsley Publishers

Carnaby S; Cambridge P, (2002). Getting personal: an exploratory study of intimate and personal care provision for people with profound and multiple intellectual disabilities; Journal of Intellectual Disability Research, 46(2) 120-132

Clarke, J, (2006). Intimate Care, theory, Research and Practice, Journal of Learning Disability Practice, 9 (12) 12- 16

Clark, J (2010). Defining the concept of dignity and developing a model to promote its use in practice, Nursing Times; 106: 20, early online publication

Clark, J (2006) Providing intimate care: the views and values of carers, Journal of Learning Disability Practice, 9 (3) 10 -15

Cope Foundation – Policy and Guidelines on Supporting people with intellectual Disability and/ or Autism with Personal and Intimate care, 2014

Health Information and Quality Authority Nov 2013 -Guidance for Designated Centres – Intimate Care

Health Service Executive, (2013) National Consent Policy

Health Service Executive (2005) Trust in Care Policy

HSE Social Care Division, (2014) Protecting Vulnerable Adults at risk of Abuse Policy

Kalman, Hildur; Andersson, Katarina, (2012). Framing of intimate care in home care services; European Journal of Social Work, 15(3): 402-414

McCormack, B. Kavanagh, D. Caffery, S & Power, A. (2005). Investigating sexual abuse: Findings of a 15 year longitudinal study. Journal of Applied Research in Intellectual Disabilities. 18, 217-227

O'Lynn, C. (2011). How Should I Touch You? A Qualitative Study of Attitudes on Intimate Touch in Nursing Care. AJN, 111(3), 24-31

O'Lynn C, Cooper A, Blackwell L, (2016). Perceptions, experiences and preferences of patients receiving the clinician's touch during intimate care and procedures: a qualitative systematic review protocol, Joanna Briggs Institute

Policy and legislation that has informed this work includes:

1	An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework
2	Aras Attracta Swinford Review Group July 2016- Time for Action
3	Cope Foundation – Policy and Guidelines on Supporting people with intellectual Disability and/ or Autism with Personal and Intimate care, 2014
4	Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with disabilities) Regulations 2013
5	Health Information and Quality Authority Nov 2013 -Guidance for Designated Centres – Intimate Care
6	Health Information and Quality Authority (2013) National Standards for Residential Services for Children and Adults with Disabilities
7	Health Service Executive, National Consent Policy, 2013
8	Health Service Executive (2005) Trust in Care

9	Protecting Vulnerable Adults at risk of Abuse Policy, 2014- HSE Social Care Division
10	The Assisted Decision Making (Capacity) Act, 2015

APPENDIX I – Impact Assessment

Impact Assessment:

The purpose of an impact assessment is to 'assist leaders to fully understand the extent and complicity of the change' and will ensure that an integrated approach to managing the change is adopted (McAuliffe *et al.*, 2006). The Balanced Score Card provides a structure for measuring Impact (Kaplan & Norton, 1993). It has 4 key areas and as the name suggests we need to keep a balanced approach to all four. We also need to pay attention to how these interact with each other- for example training and education for staff may be a requirement to introduce something new- how does that impact on finances?

- **Stakeholder Perspective:** This perspective is about how the Policy will impact on stakeholders.

- **Internal Business Processes Perspective:** This perspective ensures the stability and sound operation of your business. What systems/ structures/ referrals/ recording do you need to change or introduce to fully implement this policy?

- **Learning and Growth Perspective:** This perspective consists of training and improvements required for the workforce to implement the policy. It ensures that your employees have the skills to implement the policy. This area also considers the need for data relating to the implementation of a policy- do you need records of how the policy is implemented, eg- the number of referrals to a department, the number of staff who have been trained? Do you need an audit tool?

- **Financial Perspective:** This perspective indicates whether your Policy impacts on the bottom line. Not for profit companies consider the financial perspective last. This however is often a challenging area in public service and requires attention before a policy is 'launched' into a system that is not financially able to support its implementation/ sustainment.

There are a series of questions for each of the four areas of the Balanced Score Card that should be considered by a Policy Steering Group/ Policy Development Group when the policy is close to

completion. There is an action plan to record what needs to happen under each of the four headings to support the implementation of the policy.

1: Stakeholders; who does the policy impact on? What level of impact is there? How do we engage with the stakeholders to maximise the positive impact of the policy and minimise the perceived negative impact of the Policy?

Name of Stakeholder	**How much are they affected? High/Med/Low**	**How much influence do they have on the implementation of the policy? High/Med/Low**	**Do we have a plan to engage with/ inform this stakeholder about the policy?**
Service Users			
Families			
Clinical staff			
Frontline staff			
Local Managers/ PIC's			
Senior Managers/ Regional Managers			
CHO Disability Managers			
National Disability Team			
HIQA			
Voluntary Agencies			
Other agencies / service providers			

Actions required relating to stakeholders:

1.

2.

3.

2: Internal Processes: How will this Policy impact on internal processes?

Operations Management: delivering services to service users:

Is there a current practice/ procedure that needs to change?

Do we have a governance structure to support the implementation of the policy?

Do we need to develop/ update assessment process associated with this policy?

Is there a new/ updated referral pathway required?

Do all staff know how to access information/ training/ support to implement the policy?

Do we have a review process in place for the policy?

Do we need resources (eg- new equipment/ access to computers, access to documents/ etc)

Regulatory Requirements – Does this Policy support compliance with a set of regulations?

What will the impact be on the compliance levels?

Does it have an impact on GDPR compliance?

Does it have an impact on Assisted Decision Making (Capacity Act)

Does it support compliance with the Health Act?

Does it support the introduction of New Directions for Day Services?

Are there other regulatory implications? (eg- Health and Safety Legislation, Safeguarding Policy requirements,

Are there regulatory risks associated with implementing the policy?

Actions required relating to internal processes:

1.

2.

3.

3: Learning and Growth: How will this Policy impact on learning and growth needs in the organisation?

Data: Is there accurate, timely and complete information available to make management decisions?

What data is available and what data is required?

Can we leverage the data we have to support the implementation of this policy?

What data will help us to report on the implementation of this policy?

Training: Are education and training interventions required?

Do we have a training provider who will provide training?

Have we considered how many staff will need training and education?

Can we record staff training and include it in HR records?

Are there 'backfill' costs for staff to attend the training?

Is it going to be 'mandatory' training?

Can we do some online elements?

Is the training based on the Policy?

HR/IR: Are there IR/ HR issues to be dealt with?

Are there role specific HR implications?

Do job descriptions need to be updated?

Do we need to engage with representative bodies/unions/professional bodies?

Are the management team clear about the processes for implementing this policy and their role in it?

Do we have a HR process to manage people who do not implement the policy?

Do we need new posts to support this policy? Do we have agreement that these posts can be filled?

Actions required relating to Learning and Growth:

1.

2.

3.

3: Finances: How will the implementation of this Policy impact on Finances?

Have we considered the financial implications associated with the policy?

Consider: staffing, new equipment, training, new data collection systems, computers/ hardware/software/

Where will the costs be located: Locally? Regionally? Organisationally? Nationally?

Is there an agreement in place to fund the implementation of the policy?

If funding is not available are we going to do it anyway? – is this sustainable?

Do we need to pilot it and examine the cost of implementation before a wider role out?

Are there risks associated with finances?

Actions required relating to Finances:

1.

2.

3.

References:

Kaplan, R. and Norton, D. (1993). Putting the Balanced Scorecard to Work. [online] Harvard Business Review. Available at: https://scanmail.trustwave.com/?c=6600&d=mtOP3Hd_PgUW7QSSAIx5Gk_RqyLJQxm3v95eDITWTQ&s=343&u=https%3a%2f%2fhbr%2eorg%2f1993%2f09%2fputting-the-balanced-scorecard-to-work [Accessed 8 Jan. 2018].

McAuliffe, E. *et al.* (2006) *Guiding change in the Irish health system*. Report. Health Service Executive (HSE). Available at: http://www.lenus.ie/hse/handle/10147/78553 (Accessed: 8 February 2018).

APPENDIX II – Audit Tool

Organisations/ Local Communication Policy Audit Tool: Personal and Intimate Care

Guiding Principles to be included Personal and intimate Care policy	Yes/ No	Action Required
Does the policy define what personal care is and what Intimate care is?		
Does the policy set out how the person will be supported to make choices in how they are supported with personal and intimate care?		
Does the policy provide guidance on how to ensure a person's dignity and privacy are respected?		
Does the policy include guidance on the provision of culturally appropriate support?		
Does the policy promote the maximum independence of the people being supported?		
Does the policy set out a statement on same gender care?		
Does the policy provide clear guidance on how to manage situations where the person's wishes cannot be met in relation to the gender choice?		
Does the policy set out the requirement for every person to have a Personal and Intimate Care support plan if these supports are required?		
Does the policy set out the required training for all staff to include intimate care?		
Does the policy provide guidance on how to manage situations where intimate care stimulates sexual arousal for the individuals being supported?		
Have experts by experience or people who use the service been involved in developing or reviewing the policy in a meaningful way?		

APPENDIX III – Verification of Literature using AGREE Tool

HSE Disabilities - Operations
National Quality Improvement Office
GUIDING PRINCIPLES Subgroup

Preparation for validation of research - adapted from Agree Checklist[1]
To be used by working groups to document and present research undertaken in developing a set of Guiding Principles for review by the Expert Group within the National Guiding Principles Group

Title of Guiding Principles: Provision of Personal Intimate Care
DOMAIN 1: Scope and Purpose
1.1. The purpose of this GUIDING PRINCIPLES is: 1. To ensure that every adult person living in residential services for people with intellectual disabilities are provided with personal intimate care when required in a respectful, dignified manner and have an up to date Personal Intimate care support plan in place. **1.2. The scope of this GUIDING PRINCIPLES is:** 1.2.1. Describe the population (staff, people who use services etc) to whom the GUIDING PRINCIPLES is meant to apply. This GUIDING PRINCIPLES applies to the management; staff and volunteers working in HSE directly provided or funded Adult Intellectual Disability Residential Services. It applies to all people using residential services. It applies to all residential services including services in the community that may or not be Designated Centres. **1.2.2. Outside the scope of the GUIDING PRINCIPLES** Children's residential services and non residential services are outside the scope of this GUIDING PRINCIPLES.
1.3. OBJECTIVES *Report the overall objective(s) of the GUIDING PRINCIPLES:* The objective of this policy is to ensure that every person living in a HSE directly provided or funded Intellectual Disability residential service receives personal intimate care in a manner that is respectful, dignified, safe and to the level requested and agreed by the person.

[1] Agree Enterprise Website – Appraisal of guidelines, research and evaluation

1.4. QUESTIONS

Report the policy questions - PICO (Population, Intervention, Comparison and Outcome) covered by the GUIDING PRINCIPLES, particularly for the key recommendations:

1.4.1. To consider what is personal care and what is intimate care –

- P - people with learning difficulties and intellectual disabilities
- I – Provision of Personal Intimate care
- C – O – Appropriate Provision of Person Centered Personal Intimate care

1.4.2. Safeguarding/ Risks in the provision of Personal Intimate care:

- P – people with learning difficulties and intellectual disabilities
- I – Provision of Personal Intimate care
- C – Safeguarding/ Risks
- O - Evidence that provision of intimate care by same gender reduces any safeguarding risks. Improved patient experience; reduced stress, anxiety, embarrassment; avoidance of abuse. Empowerment, ethics, abuse and attitude

1.4.3. Consent – research around people not consenting to personal intimate care and their capacity to do so

- No research carried out – consideration of HSE National consent Policy and the Assisted Decision Making Act 2015

1.4.4. Review of documentation:

- Policies and procedures on Personal Intimate care as developed by Service providers
- Health Information and Quality Authority Nov 2013 -Guidance for Designated Centres – Intimate Care
- Aras Attracta Swinford Review Group July 2016- Time for Action
- Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with disabilities) Regulations 2013
- The Assisted Decision Making (Capacity) Act, 2015
- Health Information and Quality Authority (2013) *National Standards for Residential Services for Children and Adults with Disabilities*
- *An* Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework
- *Health* Service Executive (2005) Trust in Care
- Protecting Vulnerable Adults at risk of Abuse Policy, 2014- HSE Social Care Division
- HSE National Consent Policy, 2013

DOMAIN 2: STAKEHOLDER INVOLVEMENT

2.1 GROUP MEMBERSHIP

Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/rating the evidence and individuals involved in formulating the final recommendations.

A working group on the development of a GUIDING PRINCIPLES on the provision of Personal Intimate care was formed and included the following:

- Kevin Barnes, Team Coordinator, Walkinstown Association
- Evelyn McCormack, Assistant Director of Nursing, South side ID services (HSE)
- Maria Fitzpatrick , Clinical Nurse Specialist, Cheeverstown House
- Ann Sheehan, National Social Care – Disabilities Operations team
- Glyza Pedrosa, A/Clinical Nurse Manager ii, HSE Intellectual Disability Services Midlands HSE
- Mary O'Connor, Project Officer, Office of Nursing and Midwifery Services Division

2.2 TARGET POPULATION PREFERENCES AND VIEWS

Report how the views and preferences of the target population were sought/considered and what the resulting outcomes were.

A meeting was held on Wednesday February 6, 2019 with seven service users who had Physical and Sensory Disabilities. One service user was accompanied by his key worker to support communication and understanding. Four of the service users were female and three male; and all lived in individual apartments on the campus of the Residential Care Facility. One gentleman was non-verbal but his key worker understood him and spoke on his behalf. The Person-In-Charge of the facility organised the meeting with the National Disability Quality Improvement Office and the Team Lead sat in on the meeting to support facilitation.

The QI facilitator from the National Disability Quality Improvement Office introduced herself and welcomed everyone and explained with the help of the head of advocacy, the purpose of the meeting. The group talked about what they understood by intimate care – shaving, going to the toilet, dressing, shower and bath, oral care, skin care, enemas, hair care, changing incontinence or sanitary pads were some of the examples that the group gave. The facilitator asked the group what was important to them when it came to staff helping them with their intimate care. The following were the key points of the discussion –

- Important that the staff have good hygiene and smell nice
- Should wear disposable gloves
- Always close the doors so I can have privacy

- Treat me the way you would like to be treated – good attitude
- Need plenty of time to do the job
- If there are two staff – don't talk to each other – talk to ME
- Explain what you are doing and what you are going to do next
- Give me choice – some days I don't feel like having a bath or shower, respect that
- Communication is everything
- I prefer to have a woman providing me with this care (this was from a woman, the men had no preference)
- When undressing me in my bedroom, put everything away neat and tidy – fold my clothes
- I really want to be as independent as I can so please let me do as much as I can myself
- I like to look good before going out – so like to have a shower then

A meeting was held on Monday March 11th 2019 with six service users who had Intellectual Disability. Three service users were accompanied by their key workers to support communication and understanding. Four of the service users were male and two female; some of the participants lived in their own apartments (the two women shared an apartment), two of the men had their own individual apartments and lived alone, one man lived at home with his family and one man lived in a residential care facility. That gentleman was also non-verbal but his key worker understood him and spoke on his behalf. The Head of Advocacy for the agency for the region organised the meeting with the National Disability Quality Improvement Office.
The QI facilitator from the National Disability Quality Improvement Office introduced herself and welcomed everyone and explained with the help of the head of advocacy, the purpose of the meeting. One of the service users works on the BOC National Policy Action Group and handed the facilitator the agency's National Policy on Intimate Care which had been developed by their group and was in Easy to Read Format. The group talked about what they understood by intimate care – shaving, going to the toilet, dressing, shower and bath, changing incontinence or sanitary pads were some of the examples that the group gave. The facilitator asked the group what was important to them when it came to staff helping them with their intimate care. The following is a synopsis of the discussion –

- Staff members need to know what my disability is and what my needs are
- People need to be trained before they are allowed to help me with intimate care
- I don't want staff to be rushing, I need them to take their time
- No mobile phones, other jobs when helping me with my bath or shower – I don't want to be left sitting after my bath while my carer goes off to do something else (saying she will be back in 10 minutes)
- Privacy is very important, close the door of the bathroom
- Only help me if I need help, let me do as much as I can by myself
- Don't presume I can't do stuff – open my belt, put on the brakes on my wheelchair, brush my teeth
- Tell me step by step what you are doing so that I know what is happening next
- Like to have the same staff as they get to know me – they know I like a bath better than a shower

- Staff should be happy and come in with a smile on their face
- Respect is important – staff respect me and I respect them
- Training in using the equipment (bed, hoist) is very important before they use it on me
- Don't care who provides the care as long as they know what they are doing (only one person said this, all of the others (men and women) had a preference for female staff to provide intimate care
- They need to be gentle and be in good humour
- I want them to wash their hands and wear gloves
- I want someone who is not going to criticize my body because that is embarrassing

DOMAIN 3: RIGOUR OF DEVELOPMENT

3.1 SEARCH METHODS

Report details of the strategy used to search for evidence:

Primary Database searched: CINAHL

Secondary Database searched: Medline; Ebsco Discovery

CINAHL and other relevant databases were searched using a combination of subject terms and keywords. The main CINAHL headings for the intervention were: "Touch" and "Grooming"; "intimate care" was also used as a search phrase. The CINAHL heading used for the population was "Intellectual Disability." The search strategies identified 39 references which were later appraised for relevance.

3.2 EVIDENCE SELECTION CRITERIA

Report the criteria used to select (i.e., include and exclude) the evidence. Provide rationale, where appropriate:

Research was confined to target group – adults with an intellectual disability. Therefore research on people with Mental Health disorders and research specific to the child or adolescent population was excluded.

3.3 STRENGTHS & LIMITATIONS OF THE EVIDENCE

Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies. Tools exist that can facilitate the reporting of this concept. GRADE is a commonly used tool with further information available through this link:

http://ktdrr.org/products/update/v1n5/dijkers_grade_ktupdatev1n5.pdf

Key questions to answer:

3.3.1 Are the results valid?

The results are valid in that the limited amount of research in this field is making the same recommendations. The limitations to the research is that it is dated, i.e. some of the research articles date back 15 years to 2002 and the main textbook that is considered to be the expert source in this area was published in 2006. The research is also limited in

that it relies on staff perceptions rather than service user experience due to the difficulty in getting consent in particular from service users with profound intellectual disabilities and the inability of this vulnerable group to communicate their experiences. There are some conflicting results in the research regarding the issue of same-gender intimate and personal care but the evidence would suggest that the issue of personal choice outweighs the need for same gender care principles.

3.3.2 What are the results?

A number of key issues are identified in the research regarding Personal Intimate Care practices.

1. Staff who provide Personal Intimate care feel undervalued by their organisations, by their families, and by society in general.
2. The policies that have been written to date are too generic and do not provide sufficient guidance on best practice in terms of the actual tasks and how they should be carried out.
3. There is no discussion at national (as a society) or local (in each centre) level around what is seen as an embarrassing topic which is resulting in the lack of available research into good practices and lack of consistency in practices even among individuals within centres – most of the discourse centres around the prevention of abuse.
4. Following on from number 3, there are no recognised training programmes in place to ensure best practice and consistency of practice.
5. The Personal Intimate Care policy must align very closely with Person Centred Planning.
6. Circumstances under which cross-gender care might be appropriate, such as service user preference, or safer than use of agency staff that would not be known to the services user, should be highlighted in the policy.

3.3.2 Are the results applicable to the population group?

Yes the results are applicable to the population group as all of the research was targeted at the adults with disability population group.

There is very limited research carried out in this area. We have relied significantly on work by S. Carnaby & P. Cambridge and the Health Information and Quality Authority Nov 2013 -Guidance for Designated Centres – Intimate Care

3.4 FORMULATION OF RECOMMENDATIONS

Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and the methods used to resolve them:

The recommendations were formulated by reviewing the limited amount of evidence available and seeking consistency in terms of the findings in those research articles. A subgroup comprised of experts in the area identified the research for review, agreed the most pertinent areas in each and discussed areas where there were inconsistencies, such as same gender practices, and made the recommendations following consensus.

Recommendations for GUIDING PRINCIPLES:

1. Support personal choice in the provision of personal care
2. Where possible and desired by the person, same gender should provide intimate care

3.5 CONSIDERATION OF BENEFITS AND HARMS

Report the benefits, side effects, and risks that were considered when formulating the recommendations: (may not be required)

Careful consideration was given to the implementation of the recommendation contained in the Swinford report that people should have a choice of gender in the provision of personal care. Research indicated that the provision of intimate care by the same gender reduced risk of sexual abuse. However, review of national systems such as the Confidential Recipient, NIM's and Safeguarding revealed no evidence to support this.

3.6 EXTERNAL REVIEW

Report the methodology used to conduct the external review: (discussion points only)

N/A

3.7 COMPETING INTERESTS

Confirmation that full group has completed a Declaration of Interest form: Yes

Any other information to bring to the attention of the Subgroup:

Signed: Ann Sheehan
Marie Kehoe-O'Sullivan
Lead for Working Group

Date: 15th October 2017
15th March 2019

For further information on these Guiding Principles please contact Marie Kehoe-O'Sullivan, National Quality Improvement Office, HSE Disabilities mariet.kehoe@hse.ie 087 1523454