



Managing Children and Young People's Identified Health Needs Statement and Procedures

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Silverdale School:

Silverdale School is committed to reducing the barriers to participating in school life and learning for all its children and young people. This procedure document sets out the steps which we will take to ensure, as far as is reasonably practical, access to learning for all our children and young people who have medical/health needs. Medicines should only be brought in to school or the setting where it would be detrimental to a child/young person's health if the medicine or medical intervention were not administered during the school/setting day. It is the head teachers responsibility to ensure this procedure is brought to the attention of all staff (including supply/volunteers) parents/carers and other relevant professionals.

1. **Managing prescribed medicines which need to be taken during the school day.**
 - 1.1 Parents/carers must provide full written information about their child's medical needs, along with a formal written request to administer, to the school where their child attends.
 - 1.2 Short-term prescription requirements should only be brought to the school if it is detrimental to the child or young person's health not to have the medicine during the school day, such medicines must be in their original packaging and will only be administered if a formal written request is received by school and approved by the head teacher. If the period of administering medicine is prolonged for any reason (more than 8 days including weekends) **an individual health care plan** with input from a medical professional will be required.
 - 1.3 The school will not accept medicines that have been taken out of the container as originally dispensed, which aren't labelled with the child's full details or make changes to prescribed dosages on parental or child instructions. In all cases the information must include:
 - Name of child
 - Name of medicine, expiry date, dose and method of administration
 - Time/frequency of administration
 - Any side effects that the school/setting needs to know about
 - 1.4 The school will not regularly administer medicines that have not been prescribed by a Doctor, Dentist, Nurse Prescriber or Pharmacist Prescriber, unless it is done as part of an individual health care plan. Regular/repeated parental requests to administer non-prescribed medicines will be referred to the school (NHS) nurse.
 - 1.5 Some medicines prescribed for children (e.g. methylphenidate, known as Ritalin) are controlled by the Misuse of Drugs Act. Members of staff are authorised to administer a controlled drug, in accordance with the prescriber's instructions. A child may legally have a prescribed controlled drug in their possession, however to minimise risks to all pupils **this school will keep all controlled drugs in a safe and secure place on behalf of pupils, to which only named staff will have access. A record of access to the container will be kept.** Misuse of a controlled drug is an offence, (i.e. the use of medicines for purposes other than their prescribed intended purpose) and will be dealt with under the school's behaviour or code of conduct policy.
- 1.5 Young people who are competent to manage their own medication/care will be supported to do so, where written parent consent is given or young people are judged to be Gillick competent.

2. Procedures for managing medicines on trips or during sporting activities

- 2.1 The school will consider what reasonable adjustments might be made to enable children with medical needs to participate fully and safely on visits. Reference should also be made to our **school off site activities policy and procedures**.
- 2.2 If staff are concerned about how they can best provide for a child's safety, or the safety of other children on a visit, they should firstly review care plans and individual child specific risk assessments as well as seeking parental views, and advice from a health professional or the child's GP.
- 2.3 The school will support children/young people wherever possible in participating in physical activities and extra-curricular sport. There should be sufficient flexibility for all children and young people to follow in ways appropriate to their own abilities. Any restriction on a child's ability to participate in PE should be recorded on their health care plan.

All adults should be aware of issues of privacy and dignity for children and young people with particular needs. Reference should be made to a school **specific privacy and dignity policy or procedures if appropriate**.

- 2.4 Some children/young people may need to take precautionary measures before or during exercise, and may need access, for example, to asthma inhalers. Staff supervising sporting activities should be aware of relevant medical/health conditions, and will consider the need for any specific risk assessment to be undertaken.

3. The roles and responsibilities of staff managing administration of medicines

- 3.1 Close co-operation, and the use of a standard approach between school, parents/carers, health professionals and other agencies will provide a suitably supportive environment for children/young people with medical needs.
- 3.2 It is important that responsibility for child safety is clearly defined within school and that each person responsible for a child with medical needs is aware of and trained and competent to undertake what is expected of them.
- 3.3 The school will always take full account of authorised volunteers, temporary, supply and peripatetic staff when informing staff of arrangements in place for the administration of medicines and care.
- 3.4 The school will always designate a minimum of two people it considers suitable and competent to be responsible for the administering of medicine to a child to ensure back up arrangements are in place for when the principal member of staff with responsibility is absent or unavailable. All such staff will undertake appropriate training in respect of the administration of medicines or undertaking a medical intervention. Staff are required to record medications given and or refused.

In our school the administration of Rectal Diazepam requires 2 adults and where possible at least one of the same gender as the child to be present because of its invasive nature. Staff must consider any potential reactions between medications (especially where a child is taking) a prescribed and a non-prescribed medication at the same time

- 3.5 National Guidance states: '**A child under 16 should never be given aspirin-containing medicine unless prescribed by a doctor**'. The school will inform parents/carers of this policy.
- 3.6 Any controlled drugs which have been prescribed for a child/young person will be kept in safe and secure custody by a nominated person within the school.
- 3.7 If a child/young person refuses to take medicine, staff will not force them to do so. Staff will record the incident by recording 'refused to take' on the appropriate form, alerting the head teacher or other

nominated senior member of staff and the child's parents/carers of the refusal on the same day. If refusal results in an emergency, the schools normal emergency procedures will be followed.

- 3.8 If in doubt about a procedure, the interactions between medications or any evident side effects staff will stop and or not administer the medicine or care procedure, and will check immediately with the parents/carers or a health professional before taking further action.

4. Parent/carer responsibilities in respect of their child's medical needs

- 4.1 It is the parents/carers' responsibility to provide the head teacher with sufficient written information about their child's medical/health needs if treatment or special care is required.
- 4.2 Parents/carers are expected to work with the head teacher to reach an agreement on the school's role in supporting their child's medical needs, in accordance with the schools procedures.

Responsibility for administering non-prescribed medicines or common remedies to a child or young person in a school or other setting lies with the child/young person's parent/carer.

It is the child/young person's parent/carer who is responsible for providing permission for the issuing of non-prescribed medicines in the first instance. It requires only one parent/carer to agree to or request that medicines are administered to a child. It is likely that this will be the parent/carer with whom the school has day-to-day contact. Parent/carers will be advised that the school will not administer non prescribed medications for a period exceeding 8 days (including weekends) without a written care plan.

- 4.3 The head teacher should have written parental agreement before passing on information about their child's health to other staff including transport staff. Sharing information is important if staff and parents/carers are to ensure the best care for a child. Where a care plan is appropriate, parent/carers should have input into such a plan and must be prepared for all to share its information.
- 4.4 In some cases parents/carers may have difficulty understanding or supporting their child's medical condition themselves and in these cases they should be encouraged to contact a health professional or key health worker, to advocate for them, either the school nurse, social worker or the health visitor, as appropriate.
- 4.5 It is the parents/carers' responsibility to keep their child/ren at home when they have an infectious condition and or are acutely unwell.
- 4.6 Prior written agreement should be obtained from parents/carers for any medicines to be given to a child/young person, except where a member of staff acts in loco parentis and gives non-prescribed medication in exceptional circumstances.

5. Supporting children with long-term or complex medical needs

- 5.1 Where there are **long-term medical needs** for a child, including administration of medicine for a period of 8 days (including weekends) or more, a **health care plan must be completed**, this process must involve the school, both parents/carers and relevant health care professionals.

A health care plan must clarify for staff, parents/carers and the child the help that can and cannot be provided. It is important for staff to be **guided by a health care professional like the school nurse** or the child's GP or paediatrician.

- 5.2 In developing the health care plan the school will work in partnership with parents/carers, pastoral support staff, the School Nurse and/or specialist teams as appropriate, to develop in-school care plans to ensure evidence based care is provided. Specifically the School Nurse or Health Care

Professional must support the development of healthcare assessments/plans, facilitate training in the delivery of individual healthcare plans and monitor the delivery of these plans.

The school will agree with parents/carers and document how often they should jointly review the health care plan. It is **sensible to do this at least once a year**, but much will depend on the nature of the child's particular needs.

- 5.3 The school will assess each child/young person's needs individually as children and young people vary in their ability to cope with health needs or a particular medical condition. Plans will also take into account a child/young person's age and ability to take personal responsibility. Whilst it is not intended for the plan to be onerous it must contain appropriate detail for the needs of the individual child.
- 5.4 When dealing with the needs of children with the following common conditions school will refer to Section A of our framework which provides further guidance on managing the needs of children with these long term conditions:
- Asthma
 - Epilepsy
 - Diabetes
 - Anaphylaxis
 - Continence

6. Staff support and training in dealing with medical/health needs

- 6.1 The school will ensure that there are sufficient members of support staff who manage medicines. This will involve participation in appropriate training.
- 6.2 Any member of staff who has responsibility for administering prescribed medicines to a child will receive appropriate training, instruction and guidance. They will also be made aware of possible side effects of the medicines, and what to do if they occur. The type of training necessary will depend on the individual cases. All such training should be relevant to the individual child's needs and formally documented.
- 6.3 For staff where the conditions of their employment do not include giving or supervising a pupil taking medicines, agreement to do so will be voluntary. However within schools head teachers have a legal duty of care to their pupils that includes meeting their health needs to enable them to participate in education. It is therefore the head teacher's responsibility to ensure systems are put in place within school to ensure that the health needs of their pupils are met.
- 6.4 The head teacher or member of staff in charge of school will agree when and how training takes place, in partnership with the health professional and parents/carers involved.
- 6.5 Staff who have a child/young person with medical/health needs in their class or group will be informed about the nature of the condition, and when and where the child may need extra attention.
- 6.6 The child/young person's parents/carers, health professionals, and school staff must work in full partnership to provide the information specified above.
- 6.7 All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs.
- 6.8 Back up arrangements must be in place in advance and any relevant training provided for when the member of staff with principle responsibility is absent or unavailable.

7. Off-site education or work experience for children and young people

- 7.1 The school has responsibility for an overall risk assessment of any off-site activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the school or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on their site.
- 7.2 The school will refer to all appropriate guidance including trust policies, the DfE guidance Work Related Learning and the Law DfES/0475/2004 and the Health and Safety Executive.
- 7.3 The school is also responsible for pupils with medical needs who, as part of Key Stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or further education college. The school will comply with procedures on the conduct of risk assessments before a young person is educated off-site or has work experience.
- 7.4 The school is responsible for ensuring that a work place provider has a health and safety policy which covers each individual student's needs.
- 7.5 Parents/carers and pupils must give their permission before relevant medical information is shared on a confidential basis with employers or other third parties.

8. Record keeping

- 8.1 Parents/carers must tell the school about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However staff should make sure that this information is the same as that provided by the prescriber. Any change in prescription should be supported by either new directions on the packaging of medication or by a supporting letter from a medical professional. School will not accept medicines if the label and/or packaging instructions have been altered or tampered with.
- 8.2 The school will use appropriate forms to record administration of medicines and for parental permissions for both the short-term and long term administration of medication, with all consent forms delivered personally by the consenting parent/carer to the school office/medical room. Staff must check that any details provided by parents, or in particular cases a health professional, are consistent with the instructions on the container.
- 8.3 It is the parent/carer's responsibility to monitor when further supplies of medication are needed in the school/setting. It is not the school's responsibility. This will be highlighted in the school prospectus or website. In addition it is the parent/carers responsibility to dispose of any unused medication at the end of the prescribed period or if it is out of date.

9. Safe storage of medicines

- 9.1 The school will only store supervise and administer medicine that has been prescribed for an individual child unless written consent to administer a non-prescribed medicine has been given by the parent/carer or by the individual acting in loco parentis. Medicines will be stored securely and strictly in accordance with product instructions paying particular note to temperature and in the original container in which dispensed.
- 9.2 Staff will check that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine, the method and frequency of administration, the time of administration, and the expiry date. School staff must not alter or add to the label. Medicines that do not comply with these requirements will be returned to the parent/carer immediately.

- 9.3 Where a child needs two or more prescribed medicines, each will require a written consent and be provided in a separate container.
- 9.4 Children/young people will be informed where their own medicines are stored and how to access them. All emergency medicines (e.g inhalers,) must be readily accessible.
- 9.5 It is the parent/carer's responsibility not schools to monitor when further supplies of medication are needed in the school/setting. This will be highlighted in the school prospectus or website. In addition it is the parent/carers responsibility to dispose of any unused medication at the end of the prescribed period or if it is out of date.
- 9.6 School will allow children/young people to carry their own inhalers. If the child is too young/ immature to take personal responsibility, staff will make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.
- 9.7 Other non-emergency medicines will be kept in a secure place not accessible to children/young people, unless the appropriate form has been completed by the parent/carer providing permission for the child / young person to carry their own medication.
- 9.8 Some medicines need to be refrigerated. They *can* be kept in a refrigerator containing food but *must* be in an airtight container and clearly labelled. There will be restricted access to a refrigerator holding medicines.

10. Disposal of medicines

- 10.1 Staff must not dispose of medicines. Parents/carers are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. Return of such medicines to parents/carers will be documented by the school.
- 10.2 Parents/carers should also collect medicines held at the end of each term. If parents/carers do not collect all medicines, they will be taken to a local pharmacy for safe disposal. This process will be documented.

11. Hygiene and infection control

- 11.1 All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Sharps boxes will always be used for the disposal of needles.
- 11.2 Staff will have access to protective disposable gloves to avoid infection or risks of cross contamination when administering medicines/lotions, in addition staff will take care when dealing with spillages of blood or other body fluids, and disposing of dressings or equipment. Guidance on the disposal of clinical waste is available from the schools health & safety adviser.
- 11.3 The Education (School Premises) Regulations 1999 requires every school to have a room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. Our school adheres to this and the medical room allocated provides a washbasin and is reasonably near a water closet. It **must not** be teaching accommodation. If this room is used for other purposes as well as for medical accommodation, the governing body responsible **must** formally consider whether dual use is satisfactory or has unreasonable implications for its main purpose.

12. Access to the school/setting's emergency procedures

- 12.1 As part of general risk management processes our school has arrangements in place for dealing with emergency situations. Where medical needs are known the care plan will document all

emergency information. In addition other children/young people should know what to do in the event of an emergency.

- 12.2 All staff should know how to call the emergency services, staff should never take an extremely sick child to hospital in their own car. Guidance on calling an ambulance is provided in our staff handbook/Intranet and is also displayed in other prominent locations in school. A member of staff will always accompany a child taken to hospital by ambulance, and will stay until the parent arrives.
- 12.3 Health professionals are responsible for any decisions on medical treatment when parents/carers are not available.
- 12.4 Individual health care plans must include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency. Those with responsibility at different times of day (e.g. lunchtime supervisor) will need to be very clear of their role and responsibilities.

13. Risk assessment and management procedures

- 13.1 This procedure will operate within the context of the schools Health and Safety Policy, ensuring that risks to the health of everyone are properly controlled.
- 13.2 The school will provide, where necessary, individual risk assessments for pupils or groups with medical needs and ensure that school insurances are in place.
- 13.3 The school will be aware of the health and safety issues relating to dangerous substances and infection.

14. Home to school travel and transport

- 14.1 The school will ensure that there is timely effective liaison with drivers and escorts providing home to school transport.
- 14.2 Prior to transport commencing, transport staff must be fully briefed about the health needs of pupils being transported. There should be regular reviews of the needs of the child undertaken between the school and drivers/escorts, so that everyone has up-to-date information, support and training.
- 14.3 Where pupils have complex health needs, individual health care plans (or specific essential information from the plan) should be carried on vehicles. The care plans should specify the steps to be taken to support the normal care of the children and young people, as well as the appropriate responses to emergency situations.

Date Procedures Reviewed & Approved by SLT: 19/9/14

Date Procedures Due to be Reviewed: September 2015

Annex A: Information on long term conditions

Asthma

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time, for example when the pollen count is high, or during cold weather. Asthma is a variable disease which comes and goes. Each child's asthma presents itself in a unique way, with different trigger factors and different symptoms.

However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens.

Information about individual children/young peoples' asthma should be supported by health care plans, asthma school cards and regular training and support for staff. Health care plans for children/young people with mild and well-controlled asthma can be brief and may be supplemented or replaced by annual individualised self-management care plan produced by the child's GP / Practice Nurse. An example would be a completed copy of 'My Asthma Care Plan' available from Asthma UK. Children with significant or severe asthma should have a more thorough individual health care plan in place.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school/nursery day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms, and are also taken during an asthma attack. They are sometimes taken before exercise. Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits. Some children with exercise induced asthma may choose to take their reliever inhaler before PE or bedtime.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:

- coughing

- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. **An ambulance should be called if:**

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to complete sentences
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents/carers of children and young people with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child should have a regular asthma review at their GP surgery, usually with a practice nurse who has specialised training. Some pharmacists who have received specialised asthma training may also be able to conduct a review. Parents/carers should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children should expect to have control of their asthma. National guidelines define control as:

- No daytime symptoms
- No night time awakening due to asthma
- No need for rescue medication
- No attacks
- No limitations on activity including exercise

Reluctance to participate in physical activities should be discussed with parents/carers, staff and the child/young person. However children with asthma should not be forced to take part if they feel unwell. Children/young people should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children/young people with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents/carers or attendance officers as appropriate

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and managing identified health needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK: http://www.asthma.org.uk/how_we_help/schools_early_years/index.html). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year as appropriate. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack. Asthma UK provides useful training materials for school/setting staff which can be used to provide detailed information to staff (see 'A school healthcare professional's resource' at www.medicalconditionsatschool.org.uk).

School staff are in an ideal position to be able to provide valuable information to parents/carers of children with asthma, and to GP surgeries. Good working relationships and communication between GP surgeries and schools should be encouraged, in order to support the control of children's asthma.

Records show that in September, many more children go to hospital with increased asthma symptoms than at any other time of year. This increase in asthma symptoms may be due to the fact that some children experience fewer symptoms during the summer holidays, and sometimes forget to take their asthma medication regularly. Schools/settings could send a reminder out to parents/carers to remind them of the importance of ensuring that their child takes their "preventer" asthma medication during the summer holidays and throughout the year to help their child control their asthma.

Epilepsy

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child experiences a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual “feelings” reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. Arrangements must be in place for two adults, where possible at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8's day care require the registered person to ensure the privacy of children when intimate care is being provided.

Diabetes

What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly and they are resistant to insulin (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They usually have to have multiple daily injections of insulin given via an insulin pen or an insulin pump. They should monitor their blood glucose levels and have regular meals and snacks according to their own personal dietary plan. Children with Type 2 diabetes may be treated with diet and exercise, tablets or insulin.

Each child may experience different symptoms of low or high blood glucose levels and this should be discussed when drawing up the health care plan.

Needing to go to the toilet more frequently, being thirsty, tiredness and weight loss may indicate poor glucose control [high blood glucose levels] and staff should report such symptoms to the parents/carers. Poor control will significantly increase the risk of long term complications of diabetes including damage to the eyes, kidneys and nerve endings. Frequent episodes of low glucose levels should also be reported as changes to the insulin doses may need to be made.

Medicine and Control

The diabetes of the majority of children is controlled by multiple daily injections of insulin. This will include an injection immediately before or after lunch in school or a dose delivered by the insulin pump. The dose of insulin for the food eaten will be calculated and then extra units of insulin will be added if the blood glucose result is above the target range. The amount will differ from child to child and will need to be discussed as part of the health care plan. Most children will manage their own injections or pump but will require supervision and a suitable private place to do this. Younger children will need help to inject or to be injected.

Older children will be taught how to adjust their insulin doses according to the amount of carbohydrate in their meals and snacks to enable them to have more flexibility around food. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give.

Children with diabetes need to keep their blood glucose levels within a target range and will check their blood glucose levels before lunch, before and after exercise or more regularly if they are experiencing symptoms of high or low blood glucose. Younger children who cannot express the symptoms of high or low blood glucose may need to be tested at morning and afternoon breaks as well.

Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

When staff agree to do blood glucose testing and or insulin injections they should be given training by the appropriate health professional, usually the Paediatric Diabetes Specialist Nurses.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff who are managing lunchtimes should also be aware of any children who need to eat their meals at a certain time, or who need their plate/lunch box checking to ensure they have had an appropriate amount of carbohydrate.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor

- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hypoglycaemic episode [hypo] the child should not be left alone or sent to another part of the school alone. A fast acting sugar should be administered immediately such as dextrose/glucose sweets/tablets, lucazade or sugary drink, if the child is unable to take these then a sugary gel should be given [glucogel]. If the child were not about to eat a snack or lunch then a slower acting starchy snack should be given such as a plain biscuit, glass of milk or piece of fruit.

The blood glucose level should be re-checked 10 minutes later to ensure the treatment has been effective, if not then the treatment should be repeated again.

An ambulance should be called if the child has had 3 lots of treatment and the blood glucose level is not responding [risen above 4 mmols] or if the child becomes unconscious or is having a fit.

Some children may experience hyperglycaemia [high blood glucose levels] particularly when unwell in any way. If the child has vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone on the breath this can be a sign of ketosis which is extremely dangerous to a child with diabetes and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan.

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may

continue as normal for all concerned.

Continence

The Disability Discrimination Act (DDA) requires all education providers to re-examine all policies, consider the implications of the Act for practice and revise their current arrangements. In the light of historical practices that no longer comply with new legislation, changes will particularly be required wherever blanket rules about continence have been a feature of a setting/school's admissions policy. Schools and settings will also need to set in motion action that ensures they provide an accessible toileting facility if this has not previously been available. The Department of Health has issued clear guidance about the facilities that should be available in each school (Good Practice in Continence Services, 2000).

Agreeing a procedure for personal care in your setting/school

Settings/schools should have clear written guidelines for staff to follow when changing a child, to ensure that staff follow correct documented procedures and are not worried about false accusations of abuse. Parents should be informed of the procedures the school will follow should their child need changing during school time.

Your written guidelines will specify:

- who will change the nappy
- where nappy changing will take place
- what resources will be used (cleansing agents used or cream to be applied?)

- how the nappy will be disposed of
- what infection control measures are in place
- what the staff member will do if the child is unduly distressed by the experience or if the staff member notices marks or injuries

Schools may also need to consider the possibility of special circumstances arising, should a child with complex continence needs be admitted. In such circumstances the child's medical practitioners will need to be closely involved in forward planning.

Resources

Depending on the accessibility and convenience of a setting/school's facilities, it could take ten minutes or more to change an individual child.

This is not dissimilar to the amount of time that might be allocated to work with a child on an individual learning target, and of course, the time spent changing the child can be a positive, learning time.

However, if several children wearing nappies enter foundation stage provision of a setting/school there could be clear resource implications. Within a school, the foundation stage teacher or coordinator should speak to the SENCO to ensure that additional resources from the school's delegated SEN budget are allocated to the foundation stage group to ensure that the children's individual needs are met. With the enhanced staffing levels of provision within the private, voluntary or independent sector, allocating staff to change the children should not be such an issue, although there may be circumstances within an individual setting that merit an application for additional funding being made through the Early Years Support Link Teacher.

Keys to success

It is not helpful to assume that the child has failed to achieve full continence because the parent hasn't bothered to try. There are very few parents for whom this would be true. In the unlikely event this is the only reason why the child has not become continent then continence achievement should be uncomplicated if a positive and structured approach is used.

Remember that delayed continence may be linked with delays in other aspects of the child's development, and will benefit from a planned programme worked out in partnership with the child's parents.

There are other professionals who can help with advice and support. The School Nurse or Family Health Visitors have expertise in this area and can support parents to implement toilet training programmes in the home. Health care professionals can also carry out a full health assessment in order to rule out any medical cause of continence problems. The Specialist Community Child Health Services has produced a helpful publication 'Toileting Issues for Schools and Nurseries' which you may send for (See Further Information and Guidance) to get additional information on continence issues.

Parents are more likely to be open about their concerns about their child's learning and development and seek help, if they are confident that they and their child are not going to be judged for the child's delayed learning.

Partnership working

In some circumstances it may be appropriate for the setting/school to set up a home-setting/school agreement that defines the responsibilities that each partner has, and the expectations each has for the other. This might include:

- *the parent*
 - agreeing to ensure that the child is changed at the latest possible time before being brought to the setting/school
 - providing the setting/school with spare nappies and a change of clothing
 - understanding and agreeing the procedures that will be followed when their child is changed at school –including the use of any cleanser or the application of any cream
 - agreeing to inform the setting/school should the child have any marks/rash

- agreeing to a 'minimum change' policy i.e. the setting/school would not undertake to change the child more frequently than if s/he were at home.
- agreeing to review arrangements should this be necessary

• *the school*

- agreeing to change the child during a single session should the child soil themselves or become uncomfortably wet
- agreeing how often the child would be changed should the child be staying for the full day
- agreeing to report should the child be distressed, or if marks/rashes are seen
- agreeing to review arrangements should this be necessary.

This kind of agreement should help to avoid misunderstandings that might otherwise arise, and help parents feel confident that the setting/school is taking a holistic view of the child's needs.

Promotion/Management of Continence

Introduction

Continence problems have wide ranging physical, emotional, social and psychological consequences and are common in children of all age groups. The effects on self-esteem, and confidence must not be underestimated. They can be a source of bullying and social isolation and family stress and require a great deal of sensitivity and understanding.

The acquisition of continence, both bladder and bowel, is a developmental milestone often taken for granted. However not only does each child mature at differing rates but there are many factors which affect the ability of a child to become and remain continent. For some children the goal of attaining continence can be unrealistic and unachievable

Parents are sometimes made to feel guilty if their child is not continent at school entry age and may be denied entry. The acquisition of continence should not be prerequisite policy for school entry as this contravenes the DDA and is therefore discriminatory. Education providers have an obligation to meet the individual needs of children with continence problems, ensuring they are not discriminated against and have the same rights and access as other children to pre-school and school activities. This includes after school clubs/ school trips and residential. It is vital therefore that school staff respect the need of the child and family for confidentiality, support and understanding with all aspects of the child's management.

Causes of continence problems

Achieving and maintaining continence is reliant on many factors; not only on developmental ability but also on a child's anatomy and pathology, communication skills and behaviour. The majority of children with continence problems have no specific illnesses or abnormalities but have, for instance developed severe constipation which often results in both faecal and urinary incontinence. However some children are born with (congenital) or develop significant abnormalities which impair their ability to pass stool or urine. There are therefore many causes of continence problems the most common groups are highlighted below.

Constipation and soiling

Constipation occurs in 29% of ½ year olds in the UK and 27.5% of 9 ½ year olds and approximately 1% of 12year olds (ERIC).

There are a variety of causes of constipation including; poor fluid intake, poor diet, illness, withholding or toilet avoidance, toilet phobias, changes in daily routine, poor toileting routines and anxiety/emotional upset. If not recognised or treated effectively it can become a chronic problem and its effects are often misunderstood and not managed sensitively in school. As constipation builds up, children often experience abdominal pain, lose the sensation to have their bowels opened and have accidents or soiling/overflow diarrhoea. The child has no awareness or ability to prevent this from happening. Behaviour, concentration, learning and school attendance can be affected. The anxiety and embarrassment can also sometimes result in school refusal.

Treatment of constipation is dependent on compliance with laxative therapy combined with good toileting routines and good fluid intake. There are often periods of regression during treatment or difficulty finding most effective dosages of medication which can lead to intermittent soiling. For some children these problems can continue for years before completely under control.

Urinary problems

Dysfunctional voiding is a term given to a range of bladder problems which can develop at any age and can result in daytime wetting, urinary tract infections, an inability to hold on and the need to visit the toilet very frequently. Day wetting occurs in 1 in 75 children over the age of 5yrs and can be very stressful and cause great anxiety in school. It can be caused by poor toileting habits (e.g. holding or infrequent voiding), inadequate fluid intake, anxiety/ stress, urinary tract infections or a consequence of constipation.

Treatment: In all bladder problems there is a need for a good fluid intake and bladder retraining programmes. Medication may also be required. Voiding difficulties take time to resolve and require a lot of motivation, support and understanding.

Some children may have bladder, and bowel dysfunction and may therefore have both wetting and soiling accidents.

Nocturnal enuresis

30% of 4 ½ year olds wet the bed at night this falls to 9.5% by the age of 9 ½ yrs. It is important for school staff to recognise that some children with nocturnal enuresis may experience interrupted sleep which can affect concentration and learning at school. It also needs to be considered when planning school trips and residential, as it can be a source of great anxiety for children and parents. Some children with nocturnal enuresis may also have daytime symptoms including urgency frequency and wetting.

Congenital abnormalities;

Children can be born with a range of different abnormalities which can affect the kidneys, bladder, urinary tract or bowel, or a combination of these. Common examples of these include spina-bifida, sacral agenesis, imperforate anus, Hirshsprungs disease. Many of these children require surgery and sometimes alternative ways of managing continence. These alternative methods may include intermittent catheterisation, permanent indwelling catheters or stomas. For some of these children the ultimate goal of continence may not be attainable or may take years to achieve and require different medical interventions.

Conditions affecting learning and development may delay or prohibit acquisition of continence. Examples included cerebral palsy, global developmental delay, Down's syndrome, Autism and ADHD. Intensive toileting programmes and support and patience is often necessary to promote continence for these children.

Children with severe learning disabilities may not be able to achieve continence and may require continence pads/products to be changed on a regular basis during the school day.

Other problems

Children who have initially acquired continence can develop conditions which subsequently cause continence difficulties. Examples of this include food intolerances, Crohns disease and irritable bowel syndrome. Some children are so severely affected that they require surgery and stoma (colostomy) formation in order to manage symptoms effectively.

Management of continence

The management of continence problems, whatever the cause, can be considered in three groups.

- children who are unable to achieve continence and require continence pads/nappies either a) permanently due to their underlying condition or b)temporarily whilst they are undergoing/ awaiting treatment/surgery.
- Children who have continence difficulties requiring assistance with wetting and/or soiling accidents, fluid intake, bladder and bowel training/ toileting programmes
- Children who have alternative methods of managing their continence such as intermittent or permanent catheter, stomas/bowel irrigation systems

Younger children/children with learning/physical difficulties may require personal care to be done for them. The long term aim however is to encourage children where possible to be independent. All groups of children however, will require varying degrees of assistance and support throughout school and may need additional support during transition periods between classes and schools. For children with more complex problems it is recommended that multidisciplinary planning meetings should be arranged when transitioning or major changes in management occur.

Areas of consideration for schools

It is essential schools consider the following general areas when managing continence problems;

- facilities are appropriate and accessible
- there is easy access to drinking water
- support is available to meet the needs of individual children to deliver toileting programmes and continence management
- staff and children are protected from harm
- health and safety issues are addressed
- staff receive appropriate support and training

Facilities

The Department of Health has issued clear guidance about the facilities that should be available in each school (Good Practice in Continence Services, 2000). Current DFES recommendations are for purpose built foundation stage units to include an area for changing and showering children in order to meet the personal care needs of young children. A suitable place for changing children therefore, should have a high priority in any setting's/school's access plan. The Department of Health recommends that one extended cubicle with a wash basin should be provided in each school for children with disabilities. If it is not possible to provide a purpose built changing area, then changing mats should be provided and appropriate surfaces such as changing tables provided.

National and local surveys have repeatedly identified poor toilet facilities, restricted accessibility, lack of privacy, rationed/unsatisfactory toilet paper, as reasons for children to avoid using the toilet at school. This can lead to the development of bladder and bowel dysfunction and lack of compliance with treatment programmes. Every effort should be made to ensure:

- Toilets are clean and hygienic
- They should contain soap and appropriate hand washing facilities
- Toilet roll should be of good quality, easily accessible and not rationed
- Where necessary, wheelchair access should be provided to toilet facilities
- Reasonable Adaptations to accommodate alternative continence needs should be made. (The DDA requires schools to make reasonable adjustments to meet the needs of each child.)

Toilet access

Attention should be given to ensuring privacy. For some children, offering the use of staff toilets may be appropriate in the absence of disabled facilities or lack of privacy in communal toilets. 'Do not enter' signs may also be used to ensure that privacy and dignity are maintained during the time taken to undertake personal care.

- Toilets should be easily accessible to children throughout the school day
- Toilets should not be locked or require children to obtain keys for access. Delayed access to toilets may cause avoidable accidents and undue anxiety
- Staff should be aware of continence difficulties and allow children to leave the class as necessary without causing embarrassment or drawing undue attention to the child
- Use of toilet passes should be encouraged to aid communication, alleviate anxiety and maximise confidentiality

Toileting programmes

Children should be encouraged to visit the toilet regularly during the school day. Younger children in particular may well need reminding or support in this from school staff.

Access to drinking water

The importance of fluid intake in prevention and management of bladder and bowel problems has been previously alluded to. Clean, fresh water drinking facilities must be available throughout the school day. Children should actively be encouraged to drink at least 2-3 drinks during the school day at break times, lunchtimes and during lessons in order to promote good kidney and bladder function. Evidence has shown that when children use water fountains they fail to drink sufficient amounts and therefore the use of cups or water bottles is preferred. The table below shows the total volumes of oral fluid required per day as recommended in the NICE guidance 111.

	Female	Male
4-8 years	1000 - 1400 ml	1000 - 1400 ml
9-13 years	1200 – 2100 ml	1400 – 2300 ml
14 -18 years	1400 – 2500 ml	2100 – 3200 ml

[NICE clinical guideline 111](#)

Child protection

School staff act in loco parentis and have a duty of care to meet the continence needs of the child whilst they are in school. There should be no concerns regarding child protection, whether changing continence pads, assisting a child who has had an accident, helping with toileting routines or undertaking/assisting with alternative continence management. There are no regulations that indicate that a second member of staff must be available to supervise these processes in case of allegations of abuse. (DFES/CDC 2005) Few setting/schools will have the staffing resources to provide two members of staff to undertake this care and the mandatory CRB checks employed in childcare and educational settings are considered sufficient to promote the safety and wellbeing of the children concerned. Education/school managers are encouraged to remain highly vigilant for any signs or symptom of improper practice, as they do for all activities carried out on site.

If a child has an accident in school it is not acceptable to ask the parent to come into school to change the child. Nor is it acceptable to leave children in soiled clothing as this constitutes abusive behaviour.

It is however important that written consent is obtained from the parent (and child if old enough) for school staff to undertake intimate personal care in school and this agreement should be recorded in the school healthcare plan.

Alternative procedures for managing continence i.e. catheterisation, stoma care should not be undertaken without appropriate training and proven competence (see education and training section).

Health and safety

Most schools will already have hygiene/infection control policies to address accidental wetting or soiling and sickness as part of their health and safety policy. These can be extrapolated to the changing of continence products, intimate care or alternative continence management procedures.

- Staff should wear disposable gloves and aprons whilst providing intimate care. These should be provided by the school
- Soiled materials should be double wrapped and placed in bins or placed in a hygienic disposal unit if the number produced each week exceeds that allowed by Health and Safety Executive's limit. Catheters may be alternatively disposed of in sanibins.
- There should be appropriate provision of hot water, liquid soap, hot air driers/paper towels for hand washing and for cleansing of the immediate environment where necessary.

Equipment and supplies.

There should be clear identification of the role and responsibility of parents in providing supplies and specialist equipment if needed.

The school should provide secure, accessible storage for each child's equipment/spare clothing. If more than one child requires supplies they should be kept separately and individually labelled.

Resources

All three categories of personal care can be undertaken by school staff. Generally the personal care roles are undertaken by care assistants, however sometimes dinner staff or office staff may also be considered.

Although individual children may require differing support with their continence needs most interventions take approximately 15-20 mins once or twice a day. Statement of educational needs are not usually required for continence support as the total time requirement is usually less than 3 hours per week and schools are usually required to fund this level of support from existing special needs budgets.

If the child has additional complex needs it may be appropriate to seek educational statement/extra resources. If there are several children with problems within one school, and there is a perceived lack of adequate resources to provide effective support, additional funding should be discussed with the education authority.

Education and training and support

There are many healthcare professionals involved in managing children with continence problems. The School Nurse or Family Health Visitors may be involved in managing basic continence problems and may be able to provide support to schools with toilet training programmes. The school nurse or other health care professional can support the development of the health care plan. For complex problems a variety of professionals may be involved from the relevant Children's Hospital Trust such as paediatricians, surgeons and specialist nursing staff from the continence team.

The healthcare plan should be negotiated with the parents and child (where appropriate) and address, where necessary, issues such as type of person care required, frequency/timing of personal care, provision of equipment and supplies, possible topical skin applications such as barrier creams, action in the event of complications/illness/emergency relating to continence problem, appropriate contacts.

Alternative intimate procedures

For carers undertaking procedures such as catheterisation or stoma care they should receive training and support from the continence specialist nurses within the continence team at the Children's Trust. Parents should not be expected to go into school to undertake these procedures as this contravenes the DDA and does not foster independence for the child/parent nor promote normality. Parents should not be responsible for training carers to do procedures as this will invalidate liability insurance. Collaboration with parents however, is essential when planning and implementing training programmes.

Healthcare professionals caring for each individual child are responsible for ensuring carers receive knowledge, information and training and support. It is recognised that intimate procedures may cause concern to school staff and so healthcare professionals should provide guidance and information to potential carers, for them to consider whether to volunteer to support the child concerned. Training and achievement of competency should be documented along with parental and carer consent.

Training and competency packages should be completed for each individual carer with each individual child. A carer assessed as competent caring for one child who requires catheterising should not assume competency to catheterise another child without specific training for that child. Documentation should include contact numbers for ongoing support and troubleshooting advice in the event of problems or complications. The healthcare plan may cross reference training documentation for children with more complex continence difficulties. All carers once assessed as competent to catheterise are entered onto a register kept by the risk management officer for education. This ensures liability insurance is validated.

Collaboration and communication

Communication between home and school is important to determine progress, potential difficulties and changes in management as medications etc may change on a frequent basis. Home school books can be a useful way to promote effective communication. Some children may require regular school reviews to consider levels of support and progress.

The distress caused to children and families by continence problems and the potential far reaching effects on educational, social and emotional development cannot be underestimated. Continence problems are often difficult and embarrassing for parents and children to talk about. This can result in parents not disclosing the full extent of a problem, or indeed that their child has a problem, for fear of stigmatisation or exclusion.

Successful management of children with continence difficulties requires approachability, sensitivity and understanding and is dependent on effective multidisciplinary, multi-agency communication and collaboration.

Further information and guidance

Enuresis Resource & Information Centre (ERIC) Telephone 0117 9603060, www.eric.org.uk

Promocon Management of bladder and bowels in schools and the early years setting www.promocon.co.uk

Including Me” Managing Complex Health Needs in Schools and Early Years Settings. Carlin J. (2005) Dfes/Council for Disabled Children. London

Good practice in continence services, 2000. Available free from Department of Health, PO Box 777, London SE1 6XH or www.doh.gov.uk/continenceservices.htm

NICE clinical guidance 111 nocturnal enuresis management of bedwetting in children and young people www.nice.org.uk/guidance111

NICE Clinical Guidance 99 Constipation in children and young people www.nice.org.uk/guidance99

NICE Clinical Guidance 54 UTI in children www.nice.org.uk/54