health support planning

in education and children's services

Partnerships for health care and education

2006

Government of South Australia
Department of Education and Children's Services

Health support planning in schools, preschools and childcare services:
partnerships for health care and education.
Department of Education, Training and Employment, South Australia
First published 2001

Revised edition 2006 Health support planning in education and children's services:
partnerships for health care and education

Produced by Department of Education and Children's Services
Designed by Kerry Waye and Onsite Imaging
Printed by Finsbury Green Printing, South Australia.

ISBN 0 7308 7675 6

Foreword

Health support planning in education and children's services—Partnerships for health care and education was first published in 2001 to assist education and childcare workers, in partnership with families and health professionals, to plan safe, reasonable and consistent health support for all children and students.

The guidelines were informed by health literature and research which indicate that approximately one third of children and students at any one time have a health condition or care need that could impact on their attendance and participation in education and childcare programs. This can require short or long-term emergency first aid planning, supervision for safety, routine health and personal care support and occasionally, complex and invasive care.

This edition of *Health support planning* contains the original guidelines, but the appendices have been removed. This follows feedback from worksites, health services and families who asked for these to be published electronically for ease of access and update. This material can now be found on the *child health and education support services (chess)* website www.chess.sa.edu.au. This website also gives information about how to order a wide range of material in print and electronic form.

The *chess* website contains other useful information including details of the interagency *Statement of collaborative intent 2005-2010:* the shared commitment by the education, childcare, health and disability sectors to work together to support child and student health, learning and wellbeing.

I commend this booklet and the *chess* resources to all education and children's services workers as a comprehensive and practical guide to ensure safe and inclusive participation in programs, and hence quality of life, for children and students with health support needs.

Chris Robinson
CHIEF EXECUTIVE
Department of Education and Children's Services

Further information

In South Australia, families and health professionals can seek further information about health support planning from the manager of the service in which the child or student is enrolled or planning to enrol.

Department of Education and Children's services district personnel can assist worksites to plan support for children and students with additional needs. These services can be contacted through district offices (see www.decs.sa.gov.au). General enquiries can be directed through the Department's toll free telephone number on 1800 088 158.

Copies of this book and related material, training programs and services can be accessed at www.chess.sa.edu.au. This site gives detailed information about the South Australian *child health and education support services (chess)*.

Acknowledgments

This book has been developed in consultation with a wide range of education, childcare, disability and health professionals and services. Families and communities have also generously given advice and share their experiences. Their contribution is greatly acknowledged.

Appreciation is also expressed to representatives of the Australian Education Union (SA Branch), the Public Service Association of SA Inc Community and Public Sector Union and the Australian Nursing Federation (SA Branch) who provided valued advice regarding the roles and responsibilities of education and childcare workers in supporting children and students with health care needs.

Disclaimer

The health-related information in this book is accurate at the time of going to print. Readers are encouraged to check with their doctor or local health service provider for more recent information.

Copyright notice

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1 The health support planning process

This resource describes practical steps for education and childcare workers to anticipate, plan and manage health support within their service. This reflects the fact that in most cases, schools, preschools and childcare services do not have a mandate to provide a health service.

Sections 1 and 2 of this resource describe a step-by-step health support planning process and the allocation of health support tasks. Sections 3 to 6 describe categories of health support.

Specific references to South Australia appear in some sections, while the body of the document has relevance to all education and childcare workers.

Health support planning in schools, preschools and childcare services has four basic steps:

Step 1	**Before enrolment** Provision of general information to families and a supportive environment for children and students
Step 2	**When a need is identified** Collection of individual health care information (and agreement about interim measures)
Step 3	**The planning process** Negotiation of an individual health support plan
Step 4	**Monitoring and review** Ensuring special measures are current and effective

Step 1 Before enrolment

Provision of general information to families and a supportive environment for children and students

School principals, centre directors and home-based care providers should ensure that families are informed about the scope and limits of health support which can be provided within their service. They must also ensure a safe environment for all staff and children/students. This includes a process to address individual health support needs.

Step 2 When a need is identified

Collection of individual health care information (and agreement about interim measures)

At the initial meeting with families, prior to acceptance of enrolment, principals, centre directors and home-based care providers should specifically ask whether a child or student has any individual emergency or routine health and personal care support needs, for example:

- predictable emergency first aid associated with, for example, anaphylaxis (severe, life threatening allergy), seizure management or diabetes
- routine supervision for health care safety, such as supervision of medication
- personal care, including assistance with personal hygiene, continence care, eating and drinking, transfers and positioning, and use of health-related equipment.

If there is an indication that individual health care may be needed, the parent, guardian or adult student should be asked to provide a health care plan, written by a relevant health professional. The care plan should document recommended emergency and routine health and personal care support for the child or student. Information about medical conditions (such as asthma, epilepsy and incontinence) must be provided by a doctor or, in some cases, a clinical nurse consultant working under the direction of a doctor. A therapist (for example, a physiotherapist or a speech pathologist) will usually document information about therapeutic care such as transfers and positioning, and mealtime assistance.

Some children and students will have a health care need identified after enrolment. The same steps should be followed. An interim health support plan might be needed. ***For example, a child has her first anaphylactic shock reaction after she has commenced attending. The child is prescribed adrenalin to be administered via an Epi-Pen. Until staff can establish a support plan based on a doctor's care plan, the family and the worksite agree on an interim strategy that fits with their current expertise: that is, call an ambulance immediately.***

Step 3 The planning process

Negotiation of an individual health support plan

An individual health support plan can be negotiated, based on the health care plan from the health professional and family. A range of questions can be asked in planning support:

Is it necessary to provide the support during the care or learning session or the school day?

For example, some medication can be taken at home and does not need to be brought to the school, preschool or childcare site. Similarly, any therapy undertaken by education workers should relate directly to the child's or student's learning while enhancing dignity, comfort and safety.

How can the recommended support be provided in the simplest manner, with minimal interruption to the education and care program?

For example, students using nebulisers can often learn to use puffers and spacers at school; children prescribed rectal diazepam are sometimes safely supported in a childcare setting by the calling of an ambulance for immediate assistance.

Who should provide the support?

The principal, centre director or home-based care provider should conduct a risk assessment for staff and ask:

Does the support fit with assigned staff duties and standard training? If so, can it be accommodated within current resources? If not, is there standard training available (for example, anaphylaxis management or seizure management)?

Is this support complex and/or invasive, and therefore should not be undertaken by the workers in this service? If care is complex and/or invasive and requires the involvement of a registered nurse, how can it be provided within this environment? (In South Australia, involvement of a registered nurse is negotiated through the *Access Assistant Program*.)

How can the support be provided in a way that respects dignity, privacy, comfort and safety and enhances learning?

If it is determined that individualised emergency or routine care must be provided for the child or student, the health support plan details the duties workers will undertake.

Step 4 Monitoring and review

Ensuring special measures are current and effective

A health care plan supplied by a relevant health professional should have a review date. It might also have a request for staff to document behaviour observations to advise the health professional's review and care recommendations.

The health support plan should also have a review date which takes into account the review date of the health care plan.

All health support plans should be monitored and reviewed at least every 12 months and earlier if a worker or the family has concerns or if there is any change in the support needs of the child or student.

The health care plan can be sent back to the doctor or therapist for review or a new proforma can be issued.

Further information

www.chess.sa.edu.au

Information

2 Roles and responsibilities

2.1 Allocation of roles and responsibilities

Education, childcare, health and welfare legislation and policy collectively frame obligations in planning health support in education and childcare services.

Generally, schools, preschools and childcare services are unable to provide for ill and recuperating children and students. Staff require children and students to have relatively stable health and clear care plans. For example, education and care workers can generally safely supervise a child with a chronic health condition such as asthma or diabetes where the individual's health is relatively stable and predictable and care recommendations have been documented and agreed to by the service. If, however, a child or student has recently contracted an illness, is infectious and/or needs rest and recuperation, his or her care generally should be the responsibility of the family.

The obligations of education and childcare workers to provide planned health support and the related roles of parents, guardians and adult students can be described in the following way.

Employer (or self-employed worker)

The employer of education and care providers, or a self-employed childcare provider, has an obligation to provide safe and healthy work environments, taking all reasonable measures to eliminate risk of harm. In relation to planning health support, this means:

- all workers can access first aid training and provide a basic first aid response
- there is a process to plan for and provide health support so that all children and students have reasonable and safe access to services. This process should involve families and health professionals.

School principal or centre director

School principals and centre directors should ensure that workers and families understand and follow the worksite's health support procedures. It is the principal's or director's responsibility to:

- alert families to the need for health care plans if children or students need individual support
- develop, monitor and review worksite health support procedures
- manage health support planning
- involve relevant workers in health support planning, including staff risk assessment
- manage confidentiality
- ensure staff training requirements are fulfilled
- ensure delegated staff responsibilities reflect duty statements
- ensure facility standards are met
- be aware of health care services, including nursing and therapy services, which visit the worksite
- manage archives of documented information.

Parent, guardian and adult student

Parents and guardians are primarily responsible for the health and well-being of their children. Adult students not under a care order can take this responsibility themselves. It is the responsibility of parents, guardians and adult students to:

- provide relevant health care information
- liaise with health professionals to provide care plans which create minimum disruption to learning programs
- assist children or students for whom they are responsible to self-manage, as much as is safe and practical, their health and personal care needs.

Child or student

Wherever possible, children and students should be supported to learn responsibility for their own health and personal care needs in non-emergency situations. Children in the early years will need supervision of their medication and other aspects of health care management. Older children can take responsibility for their own health care, in line with their age and stage of development and capabilities. Self-management should

follow agreement by the child or student and his or her family, the worksite and treating health professionals.

Education and childcare workers

A worker's first duty is to the children or students in his or her care. For children or students with health support needs, this means the worker:

- helps families understand health support planning procedures at the worksite
- provides basic first aid
- facilitates individual health support plans
- develops learning and care programs which accommodate health support plans
- offers alternative programs where participation in the planned program could place children or students with health issues at risk
- supports a range of curriculum access options (for example, distance or hospital-based schooling with support from peers through the enrolling or local school)
- reports to parents and guardians any observations which could indicate health-related concerns
- delivers learning programs that support safe and effective health care management.

Where a child or student has a particular health issue, any curriculum dealing with that issue should be addressed in a confidential, one-step-removed, and sensitive manner. For example, if a student is newly diagnosed with diabetes or epilepsy the teacher might offer curriculum about caring for and about oneself and others. The teacher should not, however, make the student the topic of study.

All workers must take reasonable care to protect their own health and safety and that of others on the worksite. In providing child and student health support they must, therefore:

- become familiar with policies and procedures that guide work performance
- follow instructions related to health and safety
- contribute to risk assessment processes
- accept responsibility for safe working conditions within their control. This includes the responsibility to notify their employer (where the

worker is not self-employed) should their own health, including their infection status, pose any risk to others
- safeguard the privacy of health information, using privacy principles
- use equipment provided for health and safety purposes
- assist with the maintenance of clean and safe equipment and premises
- apply standard precautions against transmission of infections
- perform tasks in line with the training received.

School or governing council members, management committee members and other volunteer workers

School or governing council members, management committee members and other volunteer workers can ensure they are:

- informed about, and comply with, health support planning procedures
- maintain confidentiality in situations in which parents, guardians or adult students have released health information to them because of their supervisory role (for example, as a sports coach or a learning assistance program worker).

2.2 Health support duties undertaken in education and childcare services

In line with the roles and responsibilities previously outlined, school principals and centre directors should ensure that allocation of staff duties anticipates predictable short and long-term health support needs of children and students in their care.

Listed below are duties which education and childcare workers could be asked to undertake to support the health of a child or student in school, preschool or child care. There are also examples of work which should not be routinely expected of education and childcare personnel because they require the involvement of a registered nurse. In South Australia, involvement of a registered nurse is negotiated through the *Access Assistant Program* (for further information see Pathways on the *chess* website www.chess.sa.edu.au).

First aid

It is reasonable to expect that an education or childcare worker could, in line with their first aid training and duty statement:

- administer first aid for unpredictable illness or injury
- coordinate provision of first aid, including monitoring of equipment and facilities
- administer additional, individual first aid support as negotiated (for example, administration of adrenalin via Epi-Pen for anaphylaxis).

Invasive emergency care (such as administration of rectal diazepam for seizure management) is not a standard first aid procedure and so requires the involvement of a registered nurse.

Control and prevention of transmission of infection and infestation

All workers are required to comply with standard precautions for the control and prevention of the spread of infection, and to comply with additional precautions as instructed by health authorities.

It is reasonable to expect workers to assist families and communities to meet their obligations in relation to public health pests (for example, head lice, biting fleas, scabies and bedbugs).

Routine supervision for safety

Duties at a worksite should be allocated in relation to:

- management of health care-related records
- medication storage and supervision
- periodic documentation of behaviour observations
- sensitive monitoring of behaviour to minimise harm.

Personal care

It is reasonable to expect that an education or childcare worker could, in line with their training and duty statement and negotiated health support plans:

- support personal care in a manner which maximises privacy, dignity, independence, safety, comfort and learning

- support personal hygiene and assist, as needed, with hand washing, face cleaning, nasal hygiene and menstruation management
- provide assistance with oral eating and drinking including checking food texture, size and temperature against an individual care plan; food preparation (minimal in schooling); monitoring for safety the quantity and rate of eating and drinking; mealtime hygiene
- provide assistance with clothing and equipment for bladder and bowel care
- provide encouragement and reassurance for self-management of catheterisation
- transfer and position appropriately, using equipment as recommended in individual care plans
- assist with equipment, as agreed, including spectacles, walking and standing frames, sticks, splints and wheelchairs.

Invasive and/or complex personal care (such as management of a nasogastric feed or feeding by gastrostomy) requires the involvement of a registered nurse.

3 First aid

3.1 Definition

First aid support in schools, preschools and childcare services is the same as that provided in the wider community. It is provided in response to unpredictable illness or injury to:

- preserve life
- protect a person, particularly if the person is unconscious
- prevent a condition worsening
- promote recovery.

First aid incorporates basic life support; that is, emergency procedures to:

- recognise and manage a clear and open airway
- restore breathing or circulation
- monitor well-being, using techniques as described by approved first aid training providers, until the person recovers or is transferred to the care of an ambulance officer, nurse or doctor.

3.2 Provision of first aid in education and childcare services

It is reasonable to expect that every worker in a school, preschool or childcare service is trained and competent to deliver basic first aid. There should always be at least one adult who is competent in resuscitation. Section 5 describes the facilities and equipment that should be available to ensure workers can deliver first aid.

Some children and students require first aid procedures that are in addition to those taught in basic first aid training. The training that is available from accredited first aid training agencies is a helpful guide to what first aid could reasonably be expected from education and childcare

workers. If courses are routinely available (for example, in emergency use of oxygen) then this is a first aid procedure which staff can be trained to undertake. If first aid courses are not available (for example, in rectal administration of medication for seizure management) then staff and families can reasonably assume that this is not a procedure that can be managed by a person trained only in first aid. Assistance will be required from health professionals.

Within some jurisdictions, children and students may have a not-for-resuscitation (NFR) order as part of their palliative care plan to manage a deteriorating and life-threatening condition. It is reasonable for education and childcare staff supporting a child or student with an NFR order to still provide first aid to the individual. The first aid response which workers will provide in these circumstances should be agreed and documented with the family and a registered nurse before any such situation arises. Emergency or medical personnel will then make the assessment about whether the situation is one where the order should be applied.

First aid training

For further information about first aid and other training see Training on the *chess* website: www.chess.sa.edu.au.

3.3 Seeking emergency assistance

First aid training incorporates the obligation of the first-aider to seek emergency assistance in situations where his or her training is not sufficient to keep the child or student safe. Workers should not have to wait for parent or guardian approval to take this emergency action. Delays could compromise safety. The first-aider should, however, notify the child's or student's emergency contact person as a matter of priority to inform him or her of the action taken. School, preschool and childcare service procedures should ensure parents and guardians are aware of, and accept, this policy with its associated obligation for payment by families for ambulance and other emergency services.

In some cases, the worker providing first aid will assess that, while emergency medical services are not required, medical advice appears warranted (for example, where there is a blow to the head but no signs of concussion, or where there are reports by a child or student of persistent aches and pains). In these situations, the worker should ask the child's or

student's emergency contact person to collect him or her, suggesting that the advice of a medical practitioner should be sought. If there is a delay in collecting the child or student and the worker is concerned about deteriorating health and safety, the worker can call an ambulance.

Any child or student transported by emergency services should be accompanied by a worker from that worksite, unless that would leave the remaining children or students inadequately supervised, or if the student is over the age of medical consent (that is, 16 years old in South Australia) and does not choose to be accompanied.

Emergency services personnel advise that it is generally unsafe for a lay person to transport a sick or injured child or student in a private vehicle. On rare occasions, there can be an unavoidable need for a worker to transport a child or student to emergency care (for example, when an ambulance is not available, or when this is part of a child's or student's emergency plan). In such cases, at least two adults should accompany the child or student so that the driver is not distracted and the child or student can be constantly supervised. Employer guidelines should be followed.

3.4 Employer and employee liability

Despite the obligation of an employee to administer first aid when necessary, and contribute to planning for health support of a child or student, there is a possibility that common law action may be brought against the employee and his or her employer. The injured party would have to prove that the employee and/or employer in question acted in a negligent manner.

If the matter proceeds to trial, a court would take into account factors such as:

- the age of the child or student
- the child's or student's individual capabilities, including intellectual and physical impairment
- circumstances surrounding the incident
- the existence of a documented and agreed individual health support plan

- the extent of the initial injury or illness which required emergency care.

It would be necessary to establish whether the employee had any relevant training and the extent of that training. A person who has been trained is likely to provide more effective assistance to a sick or injured child or student than an untrained person. It can be argued that the advantages of training far outweigh the disadvantages provided the individual does not attempt procedures beyond those for which training has been received.

Further information

www.chess.sa.edu.au

Information

First aid

4 Prevention and control of transmission of infection and infestation

4.1 Standard and additional precautions

Prevention and control of transmission of infection in any setting encompasses:

- standard precautions, as the basic level of infection control to be used at all times
- additional precautions, which include immunisation and exclusion protocols.

These precautions are described and standardised by health authorities. In South Australia, the *Public and Environmental Health Act 1986* and Regulations and Amendments under that Act describe public health obligations. These are further described for schools and preschools in the South Australian Department of Health publication *You've got what? (*2005). This booklet includes exclusion periods for infectious diseases. Childcare services staff can refer to the publication *Staying Healthy in Child Care* (2006, Commonwealth of Australia).

Standard precautions

Standard precautions are work practices which ensure that the basic level of infection control is used at all times, in all work settings, by all employees, volunteers, children and students, to the best of their capability. Standard precautions include:

- good hygiene practices, particularly washing and drying hands before and after contact with contaminated objects
- the use of protective barriers which can include gloves and masks
- safe handling of 'sharps'
- use of sterile techniques.

Standard precautions should be used in the handling of blood, all other body fluids, secretions and excretions (excluding sweat), dried blood, and other body substances.

Additional precautions

Additional precautions are designed to interrupt transmission of infection by:

- air (for example, measles, chickenpox, tuberculosis)
- droplet (for example, mumps, rubella, pertussis (whooping cough), influenza).

Additional precautions include immunisation and exclusion protocols during outbreaks of communicable disease (as determined by Commonwealth and state health authorities). Additional precautions are used as well as, not instead of, standard precautions.

Exclusion requirements set by health authorities are based on minimising risk of transmission to others. Schools, preschools and childcare services might also advise that a child or student stay away from the site for a longer period of time, not because they are still infectious but because they remain unwell and need time to recuperate.

4.2 Prevention and control of transmission of infestation

Public health authorities determine procedures for the prevention and control of public health pests such as head lice, biting fleas, scabies and bedbugs.

School, preschool and childcare services are not public health authorities. They can, however, support the control and prevention of transmission of public health pests through a prompt and consistent response to a detected or suspected case.

Education and childcare workers might be the first to notice or suspect a child or student has head lice or some other public health pest. They can contribute to infestation control in the following ways:

- inform the parent or guardian as soon as practical, and at least by the end of the day or session, if a child or student is suspected of having an infestation

- inform the parent or guardian that proper treatment, as recommended by health authorities, must be carried out before the child or student returns to the site
- provide children and students with appropriate learning programs about this and other health issues
- send periodic reminders to families (for example, to check hair weekly as a preventative head lice measure, and to treat as necessary).

School, preschool or childcare workers should not be expected to:

- conduct mass head inspections for head lice or checks for other infestations—this is generally considered an ineffective strategy, with household-based approaches considered more effective
- treat children and students—this is a parental responsibility
- give expert advice in this area—this is the role of health authorities.

Managing a case, or an outbreak of head lice (to be adapted for other public health pests)

If a worker detects or suspects head lice in a child or student, the worker should:

- remove the child or student from direct contact with others. The child or student need not necessarily be isolated in another room—but being in close physical proximity creates a risk. Transmission occurs mainly via head-to-head contact. Head lice can also be transmitted through shared contact with items (such as hats and helmets) which have recently been in contact with infested hair. Lice do not jump but they crawl along surfaces. Steps to prevent transmission by removing a child or student from close contact with others must be undertaken sensitively
- notify the parent, guardian or emergency contact person to arrange for the child or student to be treated as soon as possible, and for household members to be checked and treated if lice are detected. It is desirable for the child or student to be collected immediately but, if necessary, he or she can stay until the end of the day or session. The sooner the child or student is treated the better, both for comfort and to prevent transmission. An infested child or student should not return until treated and free of lice. Where there is doubt about treatment effectiveness, a letter from the child's or student's general practitioner can be requested, declaring the child or student is free of head lice

- give the parent or guardian of the infested child or student, and parents or guardians of children or students in close contact, a copy of treatment information.

In the event that head lice are persistently detected in a group of children or students, the worksite manager or the home-based carer can seek assistance from local health authorities.

Conducting head lice inspections

Checking for head lice is a household responsibility. Health authorities recommend that all household members should have their hair checked weekly for eggs and lice. Even if every child or student in a school, preschool or childcare service was checked by staff for head lice, these pests would not be eliminated.

Any inspection by education or childcare workers of a child's or student's head requires the consent of the parent or guardian and the child or student. This can be obtained via a standard consent sought from parents and guardians on a routine basis and/or a request at the time of an incident. The adult conducting the head inspection should ask the child's or student's permission immediately before checking his or her head. If the child or student refuses, staff should not touch the child's or student's head and should inform the parent, guardian or emergency contact person.

Further information

www.chess.sa.edu.au

Information

Prevention and control

5 Routine supervision for safety

Routine supervision for health care-related safety aims to maximise every child's or student's access to, and safe and enjoyable participation in, education and childcare. This requires inclusive, and sometimes individualised, management of:

- health care records
- medication
- facilities
- equipment
- curriculum.

Schools, preschools and childcare services can be asked to provide individual supervision for safety which:

- is short-term and minimal (for example, during recovery from illness, injury or some emotional trauma)
- is long-term (for example, children or students with asthma, diabetes, epilepsy, otitis media, depression, schizophrenia, a tracheostomy or who require catheterisation)
- includes support for peers and possibly others, as well as the individual child or student. This occurs where a child or student has a medically fragile, deteriorating and sometimes life-threatening condition. It can include some children and students with severe and multiple disabilities, and some with cancer or a progressive neurological disorder. For some, palliative care is involved.

The following pages outline procedures for supervision for health care-related safety.

5.1 Management of health records

Responsibility for provision of health care information

Parents and guardians retain primary responsibility for ensuring that education and childcare services have relevant health care information about their child. Adult students can provide this information themselves. In some circumstances younger students will also provide information directly. For example, in South Australia the age of medical consent is 16 years. Students aged 16 and over might reasonably provide health care information directly from their doctor to school, particularly if they are no longer living in the care of parents or guardians.

Relevant health care information should be provided at the time of enrolment or transition and at least annually thereafter. Annual updates can be scheduled for any time during the year. It is reasonable to expect a medication authority to be reviewed more frequently *(see 5.2 Medication management)*. If up-dated health care information is not provided as requested, education and childcare workers can provide only first aid assistance, in accordance with their training.

Health care information should also be reviewed at any other time when the parent or guardian, child or student, doctor or others responsible for the child's or student's well-being identify a need to do so.

If, in providing first aid assistance, a worker suspects an undisclosed medical condition, or unsafe or illegal use of drugs, the worksite manager or home-based care provider can, based on his or her first aid training, suggest the child or student seeks medical assistance.

If the parent, guardian or adult student agrees, education and childcare workers can be requested to provide observations (rather than interpretations) of child or student behaviour. These observations can be used to assist the doctor in monitoring and planning for the child's or student's health care.

Health care plans: Information from health professionals

Education and childcare services should routinely ask parents, guardians and adult students to update emergency contact information and to advise whether the child or student has any medical condition which may require support from staff. If it appears that a child or student will need

individual health support, the service should ask the family to obtain a health care plan from the relevant treating health professional.

A health care plan outlines recommendations for routine and emergency health care, in the education or childcare setting, for a specified period of time. It should be authorised by the treating health professional and signed and released by the parent, guardian or adult student.

Most health care plans are authorised by a medical practitioner. In some cases, a specialist nurse will document a health care plan in consultation with the treating doctor and the family. Therapists can provide care plans for personal care (for example, a physiotherapist is the relevant professional to provide a plan for transfers and positioning and a clinical speech pathologist develops care plans for eating and drinking).

It should be emphasised that not every child or student with a health condition requires a health care plan. For example, many children have asthma. Most require minimal supervision and possibly standard first aid. The only children with asthma who would require a care plan for school, preschool and childcare settings are those unable to communicate and/or manage their own care, or whose asthma requires a planned, individualised intervention from supervising staff.

Health support plans developed by education and childcare services

Schools, preschools and childcare services should maintain two types of record keeping: health support plans and observation logs.

Health support plans

The principal, centre director or home-based care provider is responsible, with the family, for development of a health support plan where a child or student needs workers to undertake individualised care. The health support plan should be based on a health care plan and should incorporate a process for monitoring and review. It should be agreed to and endorsed by the worksite manager; other participating staff; the parent or guardian; and, where possible, the child or student.

A health support plan encompasses potential duties related to individualised first aid, supervision for safety, personal care and other issues. For a few children and students, other agencies will provide staff

(such as nurses, therapists and care workers) to undertake complex and/or invasive health care tasks. In these situations, the health support plan should simply detail how the worksite will enable the health worker to provide the agreed service.

Observation and other logs

Observation and other logs should be maintained to record first aid treatment and supervision of medication. These should be kept centrally, generally within the first aid facility.

Some children and students will have, as part of their support plan, an agreement about communication between home and school.

Sample observation logs have also been provided for optional use to assist communication and hence care.

For further information about management of health records see Pathways on the *chess* website: www.chess.sa.edu.au.

Confidentiality

Effective health-related record keeping relies on respectful and confidential communication between family, health professionals and the school, preschool or childcare service.

Information provided to medical personnel by clients, and a client's family, is done so in confidence. Such information remains the property of the children or students or their parents or guardians. Except in circumstances where there is a legal obligation to do so, health professionals are not free to divulge the personal data of clients without their parents', guardians' or their consent.

Health professionals can give general information about the processes involved in an illness or recovery from injury, as this information is freely available.

Families of chronically ill or critically injured ill children or students might choose to limit the release of information for a range of reasons. Schools, preschools and childcare services need to be acutely conscious of the added pressure—and lack of trust—which can result from inappropriate sharing of information.

Adolescents can be particularly sensitive about information distribution. In particular, at the beginning of high school, it might require a great deal of work to persuade them that anyone should be told anything. Careful transition from primary school is critical.

Access to records

Child or student health care plans provided by health professionals via the family are confidential and therefore only accessed on a 'need-to-know' basis. In practice, this means the only people who have access to personal health records are:

- the child or student
- parents and guardians of children and students under the age of medical consent
- the medical practitioner, nurse or therapist
- the worksite manager or home-based care provider
- the officer(s) responsible for record management
- workers responsible for the safety and welfare of the child or student
- others identified in the health support plan
- emergency medical personnel.

5.2 Medication management

Requests for storage and supervision of medication

Education and childcare staff should store and supervise only medication that has been prescribed by a doctor for the individual child or student, for the period of time specified. This ensures the medication is medically warranted. Analgesics and other medications which can be purchased over the counter without a prescription should also be prescribed if staff members are to be asked to supervise their use. It should be noted that analgesics can mask signs and symptoms of serious illness or injury and should not, therefore, be used by education and childcare workers as a standard first aid strategy.

Storage of medication

It is reasonable for education and childcare workers to accept and agree to supervise only medication required during their period of supervision or care (for example, medication required three times a day is generally not required during a school day: it can be taken before and after school, and before bed). This minimises the quantity of medication held on site.

Medications must be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Some families supply thermal carry packs to maintain safe temperature storage and for ease of transport on excursions.

Storage should be secure with clear labelling and access limited to the staff responsible for medication storage and supervision.

Safe storage of medication requires, therefore, as a minimum standard, that the medication is:

- prescribed by a doctor
- provided by the parent or guardian
- within the expiry date of the product delivered to staff as a daily supply (or a week's supply at the most, except in long-term continuous care arrangements). This might require the family to organise a second labelled container from the pharmacy for safe storage at home
- provided with written instructions from the parent, guardian or doctor. These instructions must match those printed on the product packaging.

Supervision of medication

Education and care workers are generally trained to supervise oral and measured dose inhaled medication. They are generally not trained, and so cannot be expected, to routinely administer medication taken by other routes, for example eye and ear drops and ointments.

Everyone supervising medication needs to ensure that:

- the right child
- has the right medication
- and the right dose

- by the right route (for example, oral or inhaled)
- at the right time, and that they
- write down what they have observed.

Education and childcare workers can ask for a medication authority to be provided by the prescribing doctor to assist them with safe supervision of medication. This can be requested for over the counter medication as well as prescription-only medication. If a medication authority is not provided, staff should have written instructions from the parent or guardian. In all cases the instructions must match those on the pharmacy label.

The only exception is where medication is included in a first aid kit for use in a standard first aid procedure. At the time of writing, this is the case for asthma first aid.

Asthma first aid training is part of basic first aid training recommended for education and childcare workers. In South Australia this includes administration of reliever asthma medication provided as part of an asthma first aid kit, for use by trained personnel.

A child or student should not take his or her first dose of a new medication at school, preschool or in a childcare setting: the child or student should be supervised by the family or health professional in case of an allergic reaction.

Monitoring the effects of medication

Education and childcare workers can observe and document behaviour. In some cases—for example, attention disorders or epilepsy—such observations can be used by health professionals in determining care plans.

It is not the role of education and childcare workers to interpret behaviour in relation to a medical condition. Nor can they be expected to monitor the effects of medication. If workers are concerned for any reason about a child's or student's health, their first aid training requires them to enact standard first aid emergency procedures.

Medication error

If a child or student takes the wrong medication, the wrong amount of medication, or takes medication via the wrong route, the following steps should be followed:

- ring the **POISONS INFORMATION LINE 13 11 26**
- give details of the incident and client
- act immediately upon their advice (for example, if you are advised to call an ambulance)
- notify the child's or student's emergency contact person
- document your actions
- review medication management procedures at the worksite in light of the incident.

Workers in schools, preschools and centres should advise their manager. Generally the employer will require completion of a critical incident report and an accident and injury report form.

Self-management of medication

Staff should store and supervise medication for preschool children and junior primary aged students. Many worksites will also require that older students' medication is stored securely by staff. The exception is often asthma reliever medication where immediate access is required by the children or students for safety.

Older children and students can often, on the advice of their parent or guardian and doctor, carry and manage their own medication. This would be advisable only where:

- the medication did not have special storage requirements such as refrigeration
- the worksite manager or home-based carer was satisfied that the practice did not create a situation where there was potential unsafe access to the medication by other children or students (for example, the children or students had secure personal lockers).

Services should have an explicit procedure about medication carried and self-managed by children and students. This should include:

- the requirement that medication be in the original pharmacy-labelled container

- limitations on the quantity brought to the service (daily requirement preferred)
- an understanding that if staff members observe a child or student apparently self-medicating, they can sensitively and privately ask to see the original pharmacy container and check with the parent or guardian
- the option for the service to stop children and students storing their own medication, should there be any concern about the safety of the individual or others on the site
- the responsibility of all people on the site to respect others' medication and to keep one's own medication secure to minimise risk to others.

Further information about medication management

Clarification about an individual child's or student's medication should always be directed through the parent, guardian or adult student to the prescribing doctor.

General information about medication (that is, questions relating to safe medication practices but not identifying individual children or students) can be obtained from local or hospital pharmacists.

Information about safe medication management can be obtained from a registered nurse.

For further information about medication management see Pathways on the *chess* website: www.chess.sa.edu.au.

5.3 Facilities

The facilities provided to enable health support in a school, preschool or childcare service should reflect the nature of the work to be undertaken within the facility. Education and childcare workers will generally be providing only first aid and supervision for safety and personal care. In some cases, visiting health professionals will offer a service on the site. Facilities should be provided accordingly.

First aid room or area

Some services will have recommended standards related to first aid facilities for employees and for children and students. Any first aid facility should provide for:

- first aid treatment
- administration, supervision of medication and treatment
- secure and safe storage of medication
- storage of first aid equipment
- approved waste (including biological waste) disposal systems
- access to health and medical records.

Basic first aid

All school, preschool and childcare services should provide at least basic first aid, involving provision of:

- standard precautions against infection
- reassurance and comfort, with a safe level of privacy
- short-term supervision, with a facility to summon additional assistance
- associated record keeping.

Facilities to enable provision of basic first aid care (and there could be a number on a large site) would therefore have as a minimum:

- an easily supervised, but not too public, location
- communication (to call for assistance)
- place to sit (including sitting upright)
- place to lie down, including capacity to elevate limbs (for example, a camp stretcher, folding bed, bean bag, pillows)
- access to the site record keeping system.

First aid treatment

In addition to the provision of basic first aid which may occur in or near classrooms or play areas, all sites should have a facility to provide first aid for minor cuts, scratches, bruising and for bodily injury.

This would require a facility that had at least the following:

- approved and complete first aid kits and equipment
- good lighting and ventilation

- safe and accessible power points
- storage for bedding, towels, spare dressings and bandages, antiseptics, soaps and cleaning agents
- secure storage for medication
- refrigerator access (for medication and ice packs)
- workbench and shelves
- soiled dressing container with disposable lining
- approved container for disposal of 'sharps' (for example, contaminated broken glass)
- bed or couch with bedding
- chairs, including facility for sitting upright to take inhaled medication
- toilet, with sanitary disposal unit
- sink
- hot and cold water
- storage for medical records
- signs directing to, and identifying, the first aid facility.

It may also contain a stretcher for trained personnel to carry an injured or ill person.

Visiting health services

Many schools and centres will have a facility that enables the provision of health services. This is because they have, or anticipate having, on-site children and students who will be assisted by visiting nurses, physiotherapists and/or a credentialed care worker to attend to, for example, catheters, blood testing, postural drainage, nebulised and injected medication, administration of oxygen, and associated record keeping.

These additional procedures could require an adjustable bed.

Wheelchair and other technical support

In those sites where children or students require a wheelchair or other technical support, the facility might need the following, in addition to the features documented above:

- height-adjustable toilet seat
- sink with extension shower

- sink with cistern
- nappy disposal bin or service
- hand drier
- adjustable change table
- portable toileting chair(s)
- lifting machine and harness, located in an area with sufficient space for a two-person lift.

Privacy and safety

In the provision of all facilities, paramount importance should be given to the principles of:

- child and student privacy, safety, dignity, comfort and independence to the degree possible
- employee (and volunteer) health, safety and welfare.

5.4 Equipment

First aid kits

First aid training agencies can advise on the content of first aid kits to be used by workers. The choice of kits will be determined by the level of staff training, the nature and setting of activities to be undertaken, and the age and stage of development of the children or students within the service. Agencies can also provide expert advice about the number and location of first aid kits for a particular site.

The contents of all first aid kits should be cleaned, restocked and checked after use and at least every six months by the accredited first aid staff member or other suitably qualified person.

For detailed lists of recommended first aid kits for schools, preschools and childcare services see Information on the *chess* website: www.chess.sa.edu.au.

An asthma first aid kit should be available where staff have been trained to use it. In South Australia, legislation specifically approves the purchase and use of reliever medication as part of standard asthma first

aid management. Asthma first aid kits are available from Asthma SA (see Pathways on the *chess* website: www.chess.sa.edu.au).

Provision, monitoring and maintenance of health-related equipment

Education and childcare workers are in some cases provided with equipment to alleviate problems associated with manual handling, especially associated with children or students who require transfers and positioning. Workers have a responsibility to use equipment provided for their and the children's or students' safety. They should ensure they are trained and competent to use it properly. The worksite manager should ensure the equipment is regularly checked and maintained in good working order and workers should report immediately any concerns with equipment safety *(see also section 6 Personal care support, particularly the section 6.4 Transfers and positioning including the use of therapeutic equipment).*

The only other equipment provided by the schools, preschools and childcare services is generally first aid kits. Parents, guardians or adult students in consultation with doctors and other health professionals should provide, transport and maintain any other equipment.

Worksite managers should give consideration to including child or student equipment in insurance provisions in the event of fire, vandalism or theft.

5.5 Curriculum

Education staff should take all reasonable steps to support continuity and relevance of curriculum for students with health support needs. This can include accommodation in curriculum design and delivery and in assessment for students who are in transition between home, hospital and school and for those who attend part-time or episodically.

Transition

When students are in hospital or recuperating at home, the enrolling or local school generally retains responsibility for managing the student's curriculum. This can mean liaison with a hospital-based teacher to

ensure provision of relevant programs and to acknowledge learning outcomes achieved through the hospital-based experience. It can also encompass liaison with therapists and education support personnel to determine learning strategies relevant to short and long-term changes in the student's physical, psychosocial and/or cognitive capabilities.

The enrolling or local school is also well placed to suggest and manage a referral to distance learning programs. Enrolment in and/or use of distance learning modes should not exclude the student from continuing social contact with his or her peers. A range of information technologies, including e-mail, facsimiles and video-conferencing, can maintain the student's sense of identity as a member of the local school community.

Planning and review processes should ensure continuity of access to the curriculum during transition between home, education service and hospital. While students should not be expected to maintain the pace of curriculum participation when they are unwell, they should have the opportunity to choose to participate if and when they are able. Enrolling or local school staff can assist through:

- planned strategies to continue communication with students whatever the setting for learning. Facsimiles, telephone calls, e-mails, education chat rooms and video-conferencing support social and curriculum contact
- liaison with hospital and/or open access teachers to maintain continuity of learning programs
- consideration of additional support to facilitate the ease of transition between the various learning settings; for example, linking with a volunteer (learning assistance) support worker
- planned re-entry after periods of absence due to illness or hospitalisation. It is not reasonable to expect assessment tasks to be completed immediately upon return to school. Similarly, planned support may be necessary to address the social and emotional impact of interrupted attendance.

Long-term planning

Health support planning encompasses long-term planning to ensure continuity of education as well as health care. Education services can take a range of measures to minimise difficulty for students, for example:

- establish, in negotiation with the student or family, an effective and sensitive information exchange system so all supervising staff

understand and make agreed curriculum accommodation and students do not have to repeatedly explain their circumstances. Planning should encompass relieving staff: some education services use a system of authorised diary notes or symbols on student identity cards to overcome the need for repeating information for a range of teachers and circumstances

- provide course overviews, with key assignments and timelines highlighted, and negotiated as relevant
- develop an individual learning management plan to maximise continuity of access to curriculum
- negotiate short and long-term curriculum access via distance learning modes maintaining, wherever possible, links between the home and school
- liaise with therapists to ensure opportunities are used within required curriculum to support therapy outcomes. Plan to integrate equipment to enhance curriculum access
- plan ahead for camps, excursions and other special events to ensure the student does not miss out either through poor timing, inappropriate expectations regarding participation, or lack of sensitivity to health and personal care support needs.

Some students will require special educational and other support provisions long after original notification to the school of the health-related needs. For example, some conditions, such as cancer, are now being managed as chronic conditions because of the long-term learning and lifestyle impact long after medical treatment is completed. This impact can be the result of the disease, or injury, itself; treatment (such as damage from surgery or drug therapy); and the traumatic nature of the experiences involved.

For further information about hospital (and other) education services see Education services on the *chess* website: www.chess.sa.edu.au.

Further information

www.chess.sa.edu.au

Information

Supervision

6 Personal care support

Personal care support is that daily living support usually provided by parents or guardians and which some children or students require either because of their young age, developmental delay, a medical condition, or other short or long-term circumstance.

Personal care support encompasses assistance with:

- personal hygiene (for example, hand washing, nose blowing and menstruation management)
- continence care
- eating and drinking
- transfers and positioning including the use of therapeutic equipment.

Personal care support needs can be:

- infrequent and situational (for example, a younger child might not make it to the toilet on time; another might need encouragement to eat when returning after an absence due to loss or bereavement). School, preschool and childcare staff have a duty of care obligation to provide assistance in these infrequent and situational circumstances
- for a short or limited time (for example, where a child or student is in plaster after traumatic injury or treatment or where a planned intervention is likely to be successful such as some toileting programs). Assistance in such situations will require a health support plan, and sometimes assistance from other services. The option of accessing education and care programs off-site may be considered if the child's or student's short-term support needs cannot reasonably be met
- long-term (for example, for a very young child, or where a child or student has complex support needs due to a medical condition such as incontinence or eating and drinking problems).

The need for personal care support should not exclude a child or student from a service. For very young children the provision of personal care support is part of routine childcare services. For older children, or children with individual needs, the service will need to develop an

individual support plan. Safety of the child or student and of the workers must always be paramount.

The following pages describe issues and procedures for planning personal care support in education and childcare services. There is an emphasis on planning support for preschool children and school students with an individual support need.

Guidelines for routine personal care support in child care are detailed in the publication *Staying Healthy in Child Care* (2006, Commonwealth of Australia). For further information see Pathways on the *chess* website: www.chess.sa.edu.au.

6.1 Personal hygiene

Many children and students need assistance with management of personal hygiene routines. Sometimes this will be part of the child's or student's progressive skill development. At other times, continuing hygiene support will be required because the child or student is unable to manage tasks such as blowing and wiping his or her nose and face and hand washing.

The hygiene care and learning plan can be used to involve children and students in the step-by-step processes of hand washing, face washing (for example, after eating) and blowing and wiping their noses. This model encourages education and care workers to maximise opportunities for individuals to self-manage components of these tasks, as far as possible, and to acknowledge the learning that has occurred when success is achieved.

As with all personal hygiene support duties, workers should follow standard precautions; for example, the worker should routinely:

- cover any personal cuts and abrasions with a water-proof bandage, and ensure the same has been done for the child or student who is being supported
- use other barriers for protection, such as double paper tissue material for blowing and wiping a nose and wearing gloves during provision of continence care

- minimise handling of body substances through the use of disposable materials where this meets the care recommendations of the family and service providers
- use safe waste (including biological waste) disposal techniques
- adopt additional precautions, such as immunisation where there is a predictable greater exposure to risk of infection, and post-incident medical testing if a needle stick or other body fluid contamination is suspected.

For further information about hygiene and personal care see Pathways on the *chess* website: www.chess.sa.edu.au.

Handwashing

Effective hand washing should be undertaken as a vital part of routine safe practice in this area for staff, children and students. Hand washing is an effective way of reducing the transmission of communicable disease. Many lifelong habits, including hand washing, are learned in childhood. Education and childcare workers have important roles in educating children and students to clean their hands by proper hand washing.

Hands should be washed:

- before eating meals and snacks
- before preparing or serving food
- before smoking
- after using the toilet
- after changing nappies
- after touching animals
- after gardening
- after handling objects soiled with blood, saliva and nasal mucus.

When washing hands, it is important to:

- use soap and running water; warm to hot water is best
- wet hands thoroughly and lather with soap
- rub hands vigorously for at least 10–15 seconds as you wash them
- pay attention to back of hands, wrists, between fingers and under fingernails
- rinse hands well under running water

- dry hands with a disposable paper towel or a clean towel. To minimise chapping (reddening, roughening or cracking of skin) of hands, pat dry rather than rub them. Electric hand-driers may be used. If cloth towels are used select a fresh towel each time or if a roller towel is used, select a fresh portion of towel
- turn off the tap with the used paper towel, if applicable
- use skin lotion, if necessary, to prevent dry cracked skin. If you use skin lotion to prevent dry cracked skin, it should be rinsed off before preparing or handling food.

A bar of soap or liquid soap can be used for hand washing. If reusable containers are used for liquid soap, they should be cleaned and dried before refilling with fresh soap. The type of soap does not particularly matter, provided it is well-tolerated by the user.

Menstruation management

As with all aspects of provision of health and personal care support, menstruation management must be conducted in a manner that maximises the student's safety, comfort, independence, dignity, privacy and learning. Management practices must also reflect occupational health and safety standards for the worksite.

It is anticipated that home, school and child care would have provided relevant information to girls regarding sexuality, sexual health and puberty prior to the onset of menstruation.

Some girls and young women will need reassurance and verbal support to change and manage menstruation aids such as sanitary napkins and tampons.

Where a girl requires assistance with changing menstruation aids, it is recommended that sanitary napkins be used. While a worker could assist with removal of a tampon, insertion of a tampon is an invasive procedure and should not be undertaken by education and childcare workers.

Sometimes a girl who needs assistance with menstruation will require a nappy or other aid for continence management. Disposable nappies are recommended for use in education and care settings (see also section ***6.2 Continence care***). This recommendation is based on the ease of use of disposables, the elimination of the need to use pins, and for comfort and mobility (as relevant) for the child or student.

Some girls and families prefer to use cloth nappies, sometimes for health reasons, and sometimes because of expense. Where this occurs, consideration should be given to providing a nappy collection service to minimise handling.

It is reasonable for staff to request a student who is menstruating to wear a disposable nappy while at school. This helps with containment of blood both routinely and during the changing process, particularly if the student has difficulty keeping still. It also eliminates concerns related to needle stick injury from a blood contaminated nappy pin.

If a student's health and well-being is compromised by wearing a disposable nappy, this should be documented on the individual health care plan provided by the health professional. Where this occurs, families and staff will need to work together to ensure the cloth aid is sufficiently large and absorbent to prevent any leakage. This is true for daily care, not just during menstruation. Additional measures may be needed during menstruation; for example, an extra folded nappy pad and/or a sanitary napkin (for example, with a sphagnum moss barrier) between the folds of the cloth nappy.

For further information about menstruation see Pathways on the *chess* website: www.chess.sa.edu.au.

6.2 Continence care

Incontinence is the lack of control over bowel and/or bladder function.

Incontinence in children and students may be short-term, long-term or intermittent. It can be the result of:

- a medical condition such as gastroenteritis (short-term) or lack of bowel nerve function (long term)
- a medical intervention (for example, as a side effect of medication)
- global development delay and/or physical and intellectual disability
- life experience (for example, a part of behaviour associated with a history of abuse)
- lack of learning opportunity.

Continence care plan

Children and students who require continence care support while at school, preschool or child care (except for young children for whom care is routine and related to age and stage of development) should have a continence care plan completed by a treating medical practitioner or continence specialist. The care plan should include recommendations for:

- the nature and extent of predictable routine or regular support required
- management of unplanned events
- catheter management (if relevant).

In the case of a child or student whose medical condition is not fully determined, or is changing, this assessment should at least recommend whether a timing or training program should be enacted.

Continence support planning

Where staff members agree to provide individualised continence care support, they can document a support plan (see section ***5.1 Management of health records***).

The health support plan will reflect the limited skills and responsibilities of education and care workers in this regard. For example, staff might agree to support a toilet training program for a limited period as part of a full-time intervention plan recommended by a health professional, but they cannot take full responsibility for toilet training: this is generally a family responsibility. Similarly, workers cannot agree, for example, to a parent's or guardian's request that a child or student be toileted every 20 minutes to keep them 'clean and dry' since this is not allowing the child or student to learn the signs of needing to use the toilet and so to increase his or her independence. A health professional needs to recommend training and timing strategies.

Continence aids and equipment

The support plan should also detail family roles and responsibilities. Provision of continence management aids and changes of clothing is the responsibility of the parent, guardian or adult student unless specifically agreed by the service. The employer should provide equipment such as slings, hoists and hydraulic lifts, for employee use, to support continence

care. Home-based carers can negotiate with families to obtain this equipment.

Where nappies are part of a child's or student's personal care requirements, parents and guardians should be requested to provide disposable nappies to minimise handling and risks to staff. Disposables are also preferable for ambulatory children and students to support freedom of mobility. Parents, guardians or adult students may, in limited situations, indicate that disposable nappies cannot be used; for example, where there is an allergic reaction to these items. If this occurs, the provision of a cloth nappy collection service should be considered to minimise handling of waste.

Workers should not be expected to sluice and otherwise handle used nappies more than is absolutely necessary. Similarly, workers should not be expected to use 'sharps', including metal nappy pins, where a safer alternative of comparable cost is available.

Where provision of aids that meet occupational health and safety requirements present financial hardship for the family, the education or care service can assist the family to contact local health and disability services to assist with costs.

Continence support facilities

All schools, preschools and childcare centres should incorporate in development and redevelopment projects facilities to assist with continence management. These facilities should incorporate at a minimum:

- space to
  - maneuver equipment such as hoists
  - house equipment such as hydraulic lift change tables
  - store such equipment when not needed
  - enable wheelchair access and two-person lifts onto the toilet
- location to maximise
  - safety for children, students and workers
  - dignity for all.

Such facilities are a priority where a health support plan for a child or student anticipates long-term assistance (for example, greater than three

months). While waiting for necessary facilities, staff should develop interim plans. These plans might incorporate interim attendance at another setting.

Home-based carers and some centres do not have the space to accommodate a nappy change table and other equipment. The worksite manager should seek advice from a health professional, such as a physiotherapist or occupational therapist, to ensure support is provided in a manner which is safe for the child or student and workers. Often such sites undertake many activities at floor level—it might be possible to have a floor-changing method which is not only safe, but which also removes the need for transfers and positioning.

For further information about continence see Pathways on the *chess* website: www.chess.sa.edu.au.

6.3 Eating and drinking

All people need access to fluid and food. In schools, preschools and childcare services, this will generally involve having access to fresh water at all times (for example, for school students, a capped container at their desk) and food at break times. Provision and preparation of food, and drink other than water, is the responsibility of the parent, guardian or adult student unless otherwise specifically negotiated.

For further information about eating and drinking see Pathways on the *chess* website: www.chess.sa.edu.au.

Dietary guidelines for children and adolescents

Learning and care programs must support safe and healthy eating and drinking, in line with healthy eating guidelines. The South Australian *Healthy eating guidelines*, and related health policies, can be downloaded from the eatwell sa website (see Information on the *chess* website: www.chess.sa.edu.au). At the same time, education and childcare workers need to respect the primary responsibility of parents and guardians to manage their child's eating and drinking, and for older students to make their own food choices.

Supervision of eating and drinking in schools, preschools and childcare services

Most school students and preschool children manage their own eating and drinking. Childcare services have separate and detailed guidelines for the provision of healthy eating and drinking programs for infants and toddlers. Some children and students will require supervision of eating and drinking for their safety and well-being.

Some children and students have modified diets. Management of cystic fibrosis, for example, requires that a balanced diet be supplemented by a high intake of fat, salts and measured enzymes with each meal. Diabetes management requires dietary modifications to ensure a healthy balance of food, physical activity and hence blood sugar levels. If children and students have special dietary requirements, the doctor should document these, with the family, in a health care plan.

Some children and students have difficulty with oral intake of food and drink and need assistance with the procedure. Others need assistance to enable them to manage the volume of intake necessary for their health and well-being. They will require an oral eating and drinking care plan, generally documented by a speech pathologist working within community or hospital health services.

Some children and students take nothing orally. They receive food and drink via a tube. Assistance for these children and students will need the involvement of a registered nurse.

In South Australia, involvement of a registered nurse is negotiated through the *Access Assistant Program.*

For further information see Pathways on the *chess* website: www.chess.sa.edu.au.

Nature of support

Support for oral eating and drinking in schools, preschools and child care can be considered in three categories:

- Supervision and guidance where there is no physical impediment to safe eating and drinking

These children and students can manage their own eating and drinking but may need to be supervised to ensure they eat safely (for example, seated, calm, chewing hard foods), learn to eat socially, or to eat and drink at all. School, preschool and childcare workers routinely provide assistance of this nature.

- Supervision and assistance where children and students have difficulty with oral eating and drinking

  Some children and students have individual safety and learning requirements for oral eating and drinking and should have an oral eating and drinking care plan documented by a speech pathologist or other relevant health professional. This care plan will be used to develop an education or childcare health support plan.

- Supervision and assistance with nasal or gastric tube feeding and/or suctioning during intake

  Some children and students take food or fluid via a tube through their nose or directly into their stomach. Others have an identified risk of aspiration (inhaling food or fluid into the lung) and require suctioning. Planning support for tube feeding and suctioning should involve a registered nurse.

Care plan for oral eating and drinking

School, preschool and childcare workers can be asked to assist with supervision of oral eating and drinking where no invasive procedure (such as suctioning) is required. Any such request must be documented in a care plan, completed by a speech pathologist or other relevant health professional (such as an occupational therapist or a psychologist) and signed and released by the parent, guardian or adult student. This care plan will form the basis of an individual child or student health support plan. The speech pathologist should be available to provide additional information, clarification or demonstration as requested. Generally, educational speech pathologists will not write a care plan for eating and drinking, although they may be consulted by the health sector speech pathologist that is developing the plan.

A suitable oral eating and drinking care plan for education settings will include, as relevant to the student and the setting, recommendations regarding:

- level of support required (time and degree of supervision)

- type of support needed (preparation, equipment, environmental management, positioning and care after mealtime)
- communication (by supervisor and student)
- preparation and presentation of food and drink (consistency, size of bites or sips, rate and order of intake, specific strategies for spoon and finger food and drinking)
- learning targets (for example, increasing independence, behaviour management, increasing intake)
- individual, predictable first aid support
- any requests for documentation or observations from staff
- any additional information to enable staff members to maximise the effectiveness of their support to the student.

The recommendations in a care plan provided by the relevant health professional should be followed by the worker unless changes are negotiated, through the family, with the health professional who wrote the care plan.

Support plan for the supervision of oral eating and drinking

Duties which workers agree to undertake to support a care plan should be negotiated with the family and documented and agreed via a health support plan (see section ***5.1 Management of health records***). The support plan should address routine and special events including parties, camps and excursions. In negotiating a support plan, priority will be given to child and student safety and well-being. Care and education workers will not generally take sole responsibility for introduction of new foods or related therapies. They may agree to support learning targets that complement the overall education and care program.

Emergency and critical incident management

Choking means that the airway is occluded (blocked) and the air supply threatened. This should not be confused with coughing. If a person is choking, there is likely to be significant distress and very little noise or movement. The person may not be able to indicate that he or she needs help. If a worker observes a choking incident he or she should commence first aid, firstly by calling an ambulance if necessary.

If a worker is concerned at any time about the safety of a child or student, this should take first priority. Education and childcare staff members are

advised to seek parental or guardian permission to contact the speech pathologist who documented the child's or student's care plan if they have concerns about observations made of a child's or student's eating or drinking.

If a worker is concerned about the immediate safety of a child or student the worker should stop the meal and ensure his or her concerns are communicated to the family and, as agreed with the family, to the relevant health professional. Workers should be concerned if, during oral eating and drinking, a child or student reports distress or shows other signs of distress, tires and is unable to manage, gags or coughs with unusual frequency, becomes pale or sweaty while eating, begins to sound 'gurgly', or undergoes a change in voice. If the child or student begins to choke, emergency first aid should be instigated.

Any incident of choking should be recorded in the first aid log; an oral eating and drinking observation log (to be forwarded to the family and health professional as negotiated in the health support plan); an accident and emergency report, as relevant; and a critical incident report, as relevant.

Reviewing the plans

Care plans should be reviewed at least every six months. The proforma oral eating and drinking care plan has a review date on the front page.

This review will be initiated by the speech pathologist involved. Education and childcare workers should request a review if they:

- notice a change in the child's or student's ability to chew, swallow or manage food and drink overall (see also Emergency and critical incident management)
- feel concerned about gagging, near-choking, or distress in the child or student at or soon after meals.

The support plan should be reviewed whenever an updated care plan is requested or received.

For further information about planning eating and drinking support see Pathways on the *chess* website: www.chess.sa.edu.au.

6.4 Transfers and positioning including the use of therapeutic equipment

Children and students may require assistance to be transferred (for example, chair to toilet, chair to vehicle) or to be positioned for comfort, safety and curriculum access. Such needs may be short-term (for example, while in plaster) or long-term. The level of assistance required will also vary. Some children and students may require supervision for safety and some guidance; others may be able to participate in cooperative transfers and positioning with staff; while others may be totally dependent and, because of their size and weight or the circumstances of the movement, require the support of two or three staff.

Care plan for transfers and positioning

Education and childcare workers may be requested to assist with transfers and positioning. They will need a written care plan to be completed by a physiotherapist (or other relevant health professional) and signed and released by the parent, guardian or adult student.

The care plan is the basis for an individual education or childcare support plan. The physiotherapist should be available to provide additional information, clarification or demonstration as requested in relation to the clients for whom they have developed care plans.

A suitable plan for transfers and positioning in care and education settings will include, as relevant to the child or student, recommendations regarding:

- situations in which assistance is required
- level of assistance required (such as standby assistance, cooperative assistance, total dependence)
- type of transfer or positioning
- equipment specifications and use
- situational advice (mobility indoors and outdoors, use of special equipment such as sticks and walking frames, repositioning for comfort)
- communication between the worker and the child or student
- learning targets
- any documentation requested from school, preschool and childcare workers (for example, an observation log).

Workers should follow the care plan unless changes are negotiated, through the family, with the health professional who wrote the plan. If there is some disagreement between the physiotherapist and education or care staff, the professional expertise of the physiotherapist should be respected.

Support plan for transfers and positioning

Duties which education and childcare workers agree to undertake to support an individual care plan should be negotiated with the family and documented and agreed via a health support plan. The support plan should address routine and special events including excursions.

In negotiating a support plan, the worker will describe and allocate duties in a way which supports the safety and well-being of the child or student and upholds occupational health and safety principles. In schools, preschools and centres where there is more than one worker, the support plan will encompass an equitable allocation of duties, including arrangements to cover staff illness, injury or absence.

Workers should be able to access training, as required, encompassing the use of equipment as specified in the care plan. They must act to take responsibility for their own health, safety and well-being. This includes an obligation to use mechanical lifting assistance as specified in the support plan. While at times a manual lift may appear quicker and easier, mechanical assistance is provided to prevent injury that can occur as a result of chronic exposure to unsafe lifting. While a worker may not appear to be injured at the time, harm may be incurred over time.

Sometimes facilities cannot accommodate equipment available to assist the worker. For example, many early childhood centres do not have room to accommodate a nappy change table. This situation can be discussed with a continence specialist to minimise the need for changing to occur at the centre. Where changing is required, a physiotherapist can be asked for advice about how to do this work safely. It can be safer, for example, to change a child on the floor, especially where this avoids the need to lift a child onto a change table. Workers can access training to assist them to safely do this and other floor-level work.

Generally, education and childcare workers cannot take responsibility for provision of therapy. They may, however, negotiate with families and

therapists to identify ways in which routine care and curriculum activities can also support therapy outcomes.

Reviewing the plans

Care plans should be reviewed at least annually.

The support plan should be reviewed whenever an updated care plan is requested or received.

Further information

www.chess.sa.edu.au

Information

Personal care support

7 Web based materials

- Guidelines for education and children's services
- Planning and support guides for education and children's services
- Health care proformas for health professionals
- General forms for physical and mental health care
- Condition-specific care plans
- Planning forms for education and children's services
- Information for education and children's services
- Information for families
- Information for Occupational Health and Safety Committees
- Articles and newsletters

www.chess.sa.edu.au

Health

chess Overview
child health and education services

Information–Support
Guidelines and worksite examples

Information–Promotion
Health promotion, special initiatives, projects and programs

chess Training
Health training, including first aid, health support planning and worksite health information modules (WHIMS)

chess Research
Details of the research partnerships

chess Pathways
Information and forms for health support planning. Care plans, resources and support related to conditions and care needs

Education Services
Hospital (and other health) education services

Resource Index
child health and education support services resources and forms

eatwell sa
Healthy eating guidelines