Supporting Children with Medical Needs

November 2023

Together we strive for excellence

POLICY CONTROL

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Author	R Bruce
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Headteacher signature	
Chair of Governors signature	

The Governing body of Cubitt Town Primary School ensures that arrangements are in place to support

OUR VISION

Creating the change makers of the future

OUR VALUES

These are the values we teach and instil in our children:

We are **committed**

We are **curious**

We **challenge** ourselves

We **communicate**

We **collaborate**

We **care**

Together we strive for excellence

Tracker to track medications held in school, when medications are given and first aid that has taken place.

The following practices are unacceptable:

- Preventing children from easily accessing their inhalers and medication
- Assuming every child with the same condition requires the same treatment
- Ignore the views of the child or their parents or ignore medical evidence or opinion
- Send children with medical conditions home frequently including lunch unless this is specified in their individual healthcare plans
- If the child becomes ill, send them to the medical room unaccompanied or with someone unsuitable;
- Penalising children for their attendance record if their absences are related to their medical condition
- Requiring parents to attend school to administer medication that are prescribed by a doctor or provide support to their child, including toileting issues.
- Creating unnecessary barriers to any aspect of school life.

During the school day

Any restrictions on a child's ability to participate in PE should be recorded on Medical Tracker and discussed with the Assistant Headteacher. In a small number of cases where a child is not able to participate in PE or swimming die to an ongoing medical need, GP confirmation in writing of a child's inability to participate in any sporting or other activity will be required. Staff supervising sporting activities should consider whether risk assessments are necessary for some children.

Procedure for managing prescription medicines

Medicines prescribed by a doctor, dentist or nurse practitioner, in the original container as dispensed by a pharmacist, should only be taken to school when essential, where it would be detrimental to a child's health if the medicine were not administered during the day. Parents are encouraged to ask the prescriber whether medicines can be prescribed for administration no more than three times a day so that they can be taken outside school hours. Prescribers may also consider providing two prescriptions, one for home and one for school to avoid the need for sending medicines home each evening.

Staff must not give prescription medicines or undertake health care procedures without appropriate training. Any member of staff giving medicines to a child should check:

- That written parental consent has been given (for prescribed or non-prescription medicines.
- The child's name
- Prescribed dose
- That it is in the original container (except insulin)
- Expiry date

- Written instructions provided by the prescriber on the label

Teachers' conditions of employment do not include giving or supervising a pupil taking medicines. Any member of staff who agrees to accept responsibility for administering prescribed medicines should have appropriate training and guidance to do so.

Where children are competent to, and the child's condition warrants it, some children may manage their own health needs and medicines.

All staff have access to protective disposable gloves and aprons, must take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment, in order to avoid infection and must follow hygiene procedures to protect themselves and the children.

Permission

It is important that the school know who has parental responsibility for a child in order to ascertain who may in law give permission for action to be taken or medicines to be administered. In the event of family breakdown both parents will normally retain parental responsibility for the child. In relation to unmarried parents, only the mother will have parental responsibility unless the father has acquired it in accordance with the Children Act 1989. A court residence order confirms parental responsibility for the duration of the Order. A Care Order gives the Local Authority parental responsibility which may be shared day to day with foster parents, residential care workers or guardians.

Cubitt Town Primary school requires prior written agreement from parents before any medicines will be administered. In the event that an alternative care giver wishes to give consent, the office will contact the parent to verbally check details of the medicine to be administered and will ask the parent to confirm these details by email.

If a child refuses to take medicine staff will not force them to do so but will note this in the records and inform parents of the refusal on the same day. If refusal to take medicines results in an emergency, the school's emergency procedures will be followed.

- **Record keeping**

  Cubitt Town Primary School aims to keep written records each time medicines are given, via Medical Tracker in most instances and in an individual asthma book for those pupil taking their asthma medication regularly. Good records help demonstrate that staff have exercised a duty of care and that correct procedures have been followed. In some circumstances it is good practice to have the dosage and administration witnessed by a second adult. Cubitt Town Primary keeps a record of all medicines administered to individual children stating what, how and how much was administered, when and by whom. Any side effects of the medication to be administered at school are also noted. A record must be kept of controlled drugs, the amount held in school and the doses used.

- **During trips and outings**

The governing body ensures that arrangements are clear and unambiguous about the need to support pupils with medical conditions to participate in school trips, visits, sporting activities and not prevent them from doing so. Reasonable adjustments will be made to enable children with medical needs to participate fully and safely on visits planning the necessary steps to include everyone. A risk assessment may be necessary. Risks of severe allergic reactions can be minimised by not allowing anyone to eat on vehicles. Sometimes additional volunteers may be needed – a copy of any health care plan should be taken on visits in the event of information being needed in an emergency.

- **Emergency situation**

Where a child has an individual health care plan, this will define what constitutes an emergency and explain what to do. Other pupils in the school should know what do in general terms, such as informing a teacher immediately.

If a child needs to be taken to hospital, staff should stay with the child until the parent arrives, or accompany a child taken to hospital by ambulance. It is sometimes appropriate for a member of staff to accompany a parent to their home (in their own or staff member's car where public liability insurance is in place).

- **Safe storage of medicines**

Medicines are stored in a secure child-proof cupboard in the office in order to control the risks to the health of others. Emergency medicines such as adrenaline pens and asthma inhalers are kept in the child's classroom, and taken to PE sessions. Access to a refrigerator holding medicines is restricted. Children with medical needs must be told and shown where their medicines are kept. The school holds back-up asthmas inhalers and back-up EpiPen. When a child gets a new diagnosis needing one of these medications, parents are asked to sign a form giving consent to the medication being administered, as well as permission for the school's back-up devices being used should the situation permit.

Children may not, under any circumstances, take or carry medicines without staff supervision. If children can take their controlled drugs or medicines themselves, staff may only need to supervise self-medication.

Assisting children with long-term or complex medical needs

An individual health care plan for a child with long term or complex medical needs helps to identify the level of support that is needed. It clarifies for everyone the help that can be provided. The plan should be produced in consultation with the parent or carer, GP or other health care

professionals, with staff trained to administer medicines and staff trained in emergency procedures. Coordinating and sharing this information is important. In Cubitt Town Primary School individual health care plans are securely stored on Medical Tracker and paper copies given to the class teacher and kept with the child's medication.

ASTHMA

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have 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.

However, 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 know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

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 day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are 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 use their inhaler from an early age, and many do.

Staff ensure 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.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting, which could be carried with the child around the school by an adult.

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 speak**
●	**the child is becoming exhausted**
●	**the child looks blue**

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. Pupils with Severe Asthma may have an Asthma Care Plan which is stored with their asthma pump.

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents 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 with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

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

Children 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 or attendance officers as appropriate.

The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff either have training or are provided with information about asthma once a year. 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.

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 have 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 does experience 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. Instructions for use **must** come from the prescribing doctor.

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. If arrangements can be made for two adults, 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 8s day care requires 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 (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. 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. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. 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 administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

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 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 hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- the child does not recover after repeating point 41 above three times.
- the child becomes unconscious

Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

ANAPHYLAXIS

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 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. Usually at WLIS they are stored in the Medical Room.

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 practise 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. Red cards carrying allergy information are carried in the Dining Hall. Responsibility for ensuring children carry their red cards lie with the Midday Supervisor for the class. 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. Lists (with photographs) of children at risk of anaphylaxis are passed onto the Kitchen and updated when necessary.

Parents are asked to exclude nuts from the premises (in the form of peanut butter, chocolate or yoghurt covered nuts and Nutella spread). This is not always feasible, and sometimes parents are uncooperative, although appropriate steps to minimise any risks to allergic children are 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.

Intimate Care

Members of staff must be given the choice as to whether they are prepared to provide intimate care to pupils.

All staff undertaking intimate care must be given appropriate guidance.

This Intimate Care guidance has been developed to safeguard children and staff. It applies to everyone involved in the intimate care of children.

Child Focused Principles of Intimate Care

The following are the fundamental principles upon which this Policy and Guidelines are based:

- Every child has the right to be safe.
- Every child has the right to personal privacy.
- Every child has the right to be valued as an individual.
- Every child has the right to be treated with dignity and respect.

- Every child has the right to be involved and consulted in their own intimate care to the best of their abilities.
- Every child has the right to express their views on their own intimate care and to have such views taken into account.
- Every child has the right to have levels of intimate care that are as consistent as possible.

Definition of Intimate Care

Intimate care can be defined as any care which involves washing, touching or carrying out a procedure to intimate personal areas which most people usually carry out themselves but some pupils are unable to do because of their young age, physical difficulties or other special needs. Examples include care associated with continence as well as more ordinary tasks such as help with washing, toileting or dressing.

Definition of Personal Care

'Personal Care' generally carries more positive perceptions than intimate care. Although it may often involve touching another person, the nature of this touching is more socially acceptable, as it is less intimate and usually has the function of helping personal presentation and hence is regarded as social functioning. These tasks do not invade conventional personal, private or social space to the same extent as intimate care and are certainly more valued as they can lead to positive social outcomes for people.

Those personal care tasks specifically identified as relevant here include:

* Skin care/applying external medication
* Feeding
* Administering oral medication
* Hair Care
* Dressing and undressing (clothing)
* Washing non-intimate body parts
* Prompting to go to the toilet

Personal care encompasses those areas of physical and medical are that most people carry out for themselves but which some are unable to do because of age, disability or medical need. Children and young people may require help with eating, drinking, washing, dressing and toileting. Children may require help applying sunscreen in exceptional circumstances.

This guidance is not prescriptive but is based on the good practice and practical experience of those dealing with children in our school.

Links with Other Agencies

Wherever required other agencies will be consulted to support a child with specific intimate care needs such as the school nurse, the enuresis clinic. The school nurse should always be informed when a need for regular intimate care is required.

It also includes supervision of pupils involved in intimate self-care.

Best Practice

Pupils who require regular assistance with intimate care have written health care plans or intimate care plans agreed by staff, parents/carers and any other professionals actively involved, such as school nurses or physiotherapists. Ideally the plan should be agreed at a meeting at which all key staff and the pupil should also be present wherever possible/appropriate. Any historical concerns (such as past abuse) should be taken into account. The plan should be reviewed as necessary, but at least annually, and at any time of change of circumstances, e.g. for residential trips or staff changes (where the staff member concerned is providing intimate care). They should also take into account procedures for educational visits/day trips.

Where relevant, it is good practice to agree with the pupil and parents/carers appropriate terminology for private parts of the body and functions and this should be noted in the plan.

Where a care plan is not in place, parents/carers will be informed the same day if their child has needed help with meeting intimate care needs (eg has had an 'accident' and wet or soiled him/herself). It is recommended practice that information on intimate care should be treated as confidential and communicated in person by telephone (severe incidents) or by separate slip home for non-serious accidents, not through the home/school diary.

In relation to record keeping, a written record should be kept in a format agreed by parents and staff every time a child has an invasive medical procedure, e.g. support with catheter usage (see afore-mentioned multi-agency guidance for the management of long term health conditions for children and young people).

Accurate records should also be kept when a child requires assistance with intimate care; these can be brief but should, as a minimum, include full date, times and any comments such as changes in the child's behaviour. It should be clear who was present in every case. These records will be kept in the child's file and available to parents/carers on request. (Appendix 2)

All pupils will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each individual pupil to do as much for his/herself as possible.

Staff should make sure that there is always a second member of staff close by when any intimate care is given. It is recommended that any invasive intimate care procedures are carried out with 2 adults present unless agreed with parents in an Intimate Care Plan.

In Foundation Stage a child requiring intimate care will be offered that care within the FS bathrooms, if maintaining privacy is possible. If not, then the Disabled Toilet in the year 1 corridor is equipped with aprons, gloves and bags to protect the individual, other users and staff supporting the care. All children should be taken by the adult/s to this area. The Acting Deputy should be contacted whenever

practical to offer support and to contact the parent if required. If the child is distressed then the parent should be contacted and asked to come and provide the intimate care required. The parent should then be offered the use of the resources in the Disabled Toilet. Clean clothes will be provided for the child. Soiled clothing will be bagged up for collection by the parent/carer.

A record should be kept and discussed with a parent/carer of a child who requires weekly support for such care. This record should be discussed with the Head of Incusion. School Nurse support should be offered in such cases. Staff who provide intimate care are trained in personal care (e.g. health and safety training in moving and handling) according to the needs of the pupil. Staff should be fully aware of best practice regarding infection control, including the requirement to wear disposable gloves and aprons where appropriate.

There must be careful communication with each pupil who needs help to discuss their needs and preferences. Where the pupil is of an appropriate age and level of understanding permission should be sought before starting an intimate procedure.

Staff who provide intimate care should speak to the pupil personally by name, explain what they are doing and communicate with all children in a way that reflects their ages.

Every child's right to privacy and modesty will be respected. Careful consideration will be given to each pupil's situation to determine who and how many carers might need to be present when s/he needs help with intimate care. SEND advice suggests that reducing the numbers of staff involved goes some way to preserving the child's privacy and dignity. Wherever possible, the pupil's wishes and feelings should be sought and taken into account.

The religious views, beliefs and cultural values of children and their families should be taken into account, particularly as they might affect certain practices or determine the gender of the carer.

Adults who assist pupils with intimate care should be employees of the school, not students or volunteers, and therefore have the usual range of safer recruitment checks, including enhanced DBS checks.

All staff should be aware of the school's confidentiality policy. Sensitive information will be shared only with those who need to know.

Health & Safety guidelines should be adhered to regarding waste products, if necessary, advice should be taken from the DCC Procurement Department regarding disposal of large amounts of waste products or any quantity of products that come under the heading of clinical waste.

No member of staff will carry a mobile phone, camera or similar device whilst providing intimate care.

Child Protection

The Governors and staff at this school recognise that pupils with special / medical needs, and who are disabled are particularly vulnerable to all types of abuse.

The school's child protection procedures will be adhered to.

From a child protection perspective it is acknowledged that intimate care involves risks for children and adults as it may involve staff touching private parts of a pupil's body. In this school best practice will be promoted and all adults (including those who are involved in intimate care and others in the vicinity) will be encouraged to be vigilant at all times, to seek advice where relevant and take account of safer working practice.

Where appropriate, pupils will be taught personal safety skills carefully matched to their level of development and understanding.

If a member of staff has any concerns about physical changes in a pupil's presentation, e.g. unexplained marks, bruises, etc s/he will immediately report concerns to the Designated Safeguarding Lead or Headteacher. A clear written record of the concern will be completed and a referral made to Children's Services Social Care if appropriate, in accordance with the school's child protection procedures. Parents/carers will be asked for their consent or informed that a referral is necessary prior to it being made but this should only be done where such discussion and agreement-seeking will not place the child at increased risk of suffering significant harm.

If a pupil becomes unusually distressed or very unhappy about being cared for by a particular member of staff, this should be reported to the class teacher or Headteacher. The matter will be investigated at an appropriate level (usually the Headteacher) and outcomes recorded. Parents/carers will be contacted as soon as possible in order to reach a resolution. Staffing schedules will be altered until the issue/s is/are resolved so that the child's needs remain paramount. Further advice will be taken from outside agencies if necessary.

If a pupil, or any other person, makes an allegation against an adult working at the school this should be reported to the Headteacher (or to the Chair of Governors if the concern is about the Headteacher) who will consult the Local Authority Designated Officer in accordance with the school's policy: Dealing with Allegations of Abuse against Members of Staff and Volunteers. It should not be discussed with any other members of staff or the member of staff the allegation relates to.

Similarly, any adult who has concerns about the conduct of a colleague at the school or about any improper practice will report this to the Headteacher or to the Chair of Governors, in accordance with the child protection procedures and 'whistle-blowing' policy.

Physiotherapy

Pupils who require physiotherapy whilst at school should have this carried out by a trained physiotherapist. If it is agreed in the care plan that a member of the school staff should undertake part of the physiotherapy regime (such as assisting children with exercises), then the required

technique must be demonstrated by the physiotherapist personally, written guidance given and updated regularly. The physiotherapist should observe the member of staff applying the technique.

Under no circumstances should school staff devise and carry out their own exercises or physiotherapy programmes.

Medical Procedures

Pupils who are disabled might require assistance with invasive or non-invasive medical procedures such as the administration of rectal medication, managing catheters or colostomy bags. These procedures will be discussed with parents/carers, documented in the health care plan and will only be carried out by staff who have been trained to do so.

It is particularly important that these staff should follow appropriate infection control guidelines and ensure that any medical items are disposed of correctly.

Any members of staff who administer first aid should be appropriately trained in accordance with LA guidance. If an examination of a child is required in an emergency aid situation it is advisable to have another adult present, with due regard to the child's privacy and dignity.

Massage

Massage is now commonly used with pupils in order to develop sensory awareness, tolerance to touch and as a means of relaxation.

It is recommended that massage undertaken by school staff should be confined to parts of the body such as the hands, feet and face in order to safeguard the interest of both adults and pupils.

Any adult undertaking massage for pupils must be suitably qualified and/or demonstrate an appropriate level of competence.

Children unable to attend school for medical reasons

Cubitt Town Primary School children should be able to access education without stigma or exclusion. The designated teacher for the education of children with medical needs is Angie Drew, Assistant Headteacher for Inclusion, whose role it is to facilitate communication with all parties and attend reviews. Children (of compulsory school age) who will be absent from school for 15 working days, trigger intervention. The school should hold, chair and document a planning meeting to which the Co-ordinator of the Tuition Service and parents/carers are invited.

The designated teacher will be responsible for collecting half termly plans of work, curriculum assessment information, work, resources and the compiling of a personal education plan. This information will be collected by the tutor, as soon as is reasonably possible after the outset of tuition. Copies of all information will be kept by the class teacher.

The designated teacher (SENCo) will liaise with the tutor to pass on details of the child's special educational needs and a copy of the current EHCP The child will remain on the school roll during the period of alternative education. The LA Attendance Officer will be informed of the child's absence, at the commencement of tuition, by the school. The absence will be recorded on register using the appropriate symbol, B, as specified in registration guidelines, from the date of commencement of tuition.

The school will be responsible for requesting special arrangements in advance of any assessments. The designated teacher will contact the tutor and make clear the arrangements for the assessments, giving teacher assessment where possible. The designated teacher and the Service Co-ordinator will be responsible for liaison at regular intervals (usually half-termly) to discuss progress and set future targets. Work folders will be passed on to the school from the tutor. All newsletters will be sent to parents/carers when issued and e-mail contact will be encouraged where possible. It is vital that contact between the school and the child is maintained throughout the period of absence.

The child's views will initially be recorded in the personal education plan and updated/modified when necessary, by liaison between the tutor and the designated teacher. Parents/carers must be fully informed of any initiatives undertaken by the school (designated teacher) or Tuition Service. At all times parents/carers will be informed of actions being taken.
The school, child, parent/carer, tutor and any other professionals involved, will jointly plan an individual reintegration programme for the child. Re-integration will be successful if parents/carers, staff and the child are fully involved in the process. Peer support is vital throughout the re-integration period. If necessary, the tutor will continue support during this transitional period. Following the child's re-integration into school, it would be helpful if the designated member of the school staff could complete a brief evaluation form to inform the future development of the service providers in relation to schools, children and the service they receive.

Staff Training

Cubitt Town Primary School is responsible for making sure that staff have appropriate training to support children with medical needs. This should give staff sufficient understanding, confidence and expertise to support children and families. Staff with children with medical needs in their class or group should be informed about the nature of the child's condition. Staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. It is important that lunchtime supervisors and supply staff are also aware of the child's condition and procedures for supporting that child. Staff should be aware that a) some conditions and some medicines may affect learning, leading to poor concentration or difficulties in remembering; b) access to education can be disrupted through unwanted effects of treatments or through the psychological effects serious or chronic illness or disability. For a child with medical needs the head will need to agree with the parent exactly what support can be provided and should seek advice from the school nurse or other medical advisers as to how to achieve appropriate support. The person with responsibility for Children with Medical Needs will ensure that any member of school staff providing support to a pupil with medical needs has received suitable training. The Healthcare professionals will agree the type and level of training required.

Complaints

Complaints about the support provided to pupils with medical conditions should be made to Headteacher. Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If for whatever reason this does not resolve the issue, they may make a formal complaint via the school's complaints procedure. Making a formal complaint to the Department for Education should only occur if it comes within scope of section 496/7 of the Education Act 1996 and other attempts at resolution have been exhausted.

This policy will form part of the SEND policy.

It will be reviewed three yearly.