Workbook to support Module 3

Care Planning – Medical Conditions

Early Years Best Practice Guidance

LINK TO TRAINING BY TEP

The Targeted Support and Personal and Individualised learning sections of the Early Years Best Practice Guidance emphasises:

Systems and whole school planning

- TA/Support staff job descriptions must include the possible need for undertaking personal care.
- SLT must identify members of staff for appropriate training.
- Specialist advice is incorporated into planning for adaptations to the school environment, differentiation of the delivery of the curriculum and format of information
- Ensure health and safety for use of tools/equipment
- Forward planning is undertaken with regard to space and storage requirements for children with additional specialist equipment

Continuing Professional Development

- Practitioners have access to disability awareness training with particular reference to the impact of physical disability e.g. independent access and the safe movement of children, Paediatric moving and handling training, Care Plans and Risk Assessments
- Setting may use pdnet STANDARDS: Children with physical Disability in Early Years Settings, self-evaluation guidance http://pdnet.org.uk/media/pdnet-Standards-for-Early-Years.pdf
- SENCo and key persons follow the advice and modelling of good practice from specialist teachers and qualified health professionals
- Practitioners have access to 'The Prime Importance of Physical Development in the Early Years training
- Practitioners seek training to support the use of equipment to facilitate access to learning or bespoke training to meet the physical and medical needs of individual children e.g. Epi-pen training, use of posture and mobility aids

Provision

- Risk assessments are completed, inside and outside; this may include a personal emergency evacuation plan (PEEP), or banning of certain common foods due to allergies, eg peanuts
- An individual healthcare plan may be in place
- All practitioners are aware of the plans noted above
- Optimum conditions for access to play and learning activities through differentiation, such as additional time for play and exploration of resources for fine and gross motor skills, planned ICT time

- Practitioners actively promote the characteristics of effective learning; careful monitoring of practice enables children to persevere and develop resilience e.g. praise for showing independence
- Practitioners have a good understanding of individual children's needs and appropriate resources are used, including positive role models of disability
- Grouping of children is sensitive to accommodate physical needs e.g. activities are conducted at floor level, or all seated on chairs as appropriate
- Transitions within the setting and to school are planned, including pre-visits to new rooms/schools.

Environment

- Handrails at appropriate height
- The lay-out of the inside and outside areas allow ease of access for those with physical difficulties, including the awareness of slipping/tripping hazards (e.g. spilt drinks, uneven floors) and surface changes, such as carpet to vinyl
- Furniture and storage are accessible or capable of being adapted e.g. storage units are castors can be easily moved and locked in place; water/sand tray leg heights can be changed
- Door handles are at a suitable height to maintain safety but ensure independence
- All children can access washing and toilet facilities independently or with minimal supervision
- The floor is kept free from unnecessary clutter to prevent slips and falls and to allow the use of mobility aids.
- A range of adapted general equipment is available e.g. sink step, loop or spring scissors, non-slip mats
- Lightweight and easy grip toys and resources are available
- A range of computer access devices are used
- Low tech. equipment is available at appropriate heights
- Practitioners are aware of the importance of correct posture and seating and children are positioned appropriately.

Other important documents related to this course can be found here:

- Health and Safety: responsibilities and duties for schools
- The Equality Act 2010 and schools
- Statutory Framework for EYFS
- Supporting pupils at school with medical conditions
- Managing Medicines at Schools and EY Settings
- Guidance on the use of emergency Salbutamol inhalers in school
- Guidance on the use of adrenalin auto-injectors in schools
- E-learning module type 1 diabetes (https://jdrf.org.uk/for-professionals/school-pack/schools-e-learning-module/)

Know your children

Can you list the names of all the children within your setting that have a physical disability or complex medical need?

_____

_____

_____

Are there any health professionals involved with these children?

_____

_____

_____

Establishing prior knowledge:

Read the following symptoms labelled a -e and put the corresponding letter under the correct heading.

Asthma attack	Severe allergic reaction	Epileptic seizure	Diabetic hypo	Gastrostomy feed reaction

a	b	c	d	e
Feeling tired Suddenly feeling either hot or cold for no real reason Feeling very hungry, headache, feeling sick, tingling hands, lips or tongue, inability to think or talk properly, feeling weak, bad mood	Bloating, feeling sick, stomach cramps, new or increased vomiting or diarrhoea	Difficulty talking or walking easily finding it hard to breathe coughing or wheezing a lot Tight or painful chest	Daydreaming, sudden brief muscle jerks, sudden scream/cry – child becomes stiff, falls, moves arms and legs in jerky movements	Sneezing, itchy, runny or blocked nose. itchy, red, watering eyes wheezing, shortness of breath and cough, raised, itchy, red rash, swollen lips, tongue, eyes or face, tummy ache, feeling sick, vomiting or diarrhoea, dry, red and cracked skin

Asthma

Based on what we have discussed, circle all the following that you now consider to be symptoms of an asthma attack?

1. cough
2. tummy ache
3. unable to catch a breath
4. too breathless to eat
5. wheezing
6. breathlessness
7. too breathless to sleep
8. tight chest
9. reliever inhaler not helping
10. too breathless to speak

List 5 things that are known triggers for asthma attacks:

1. _____
2. _____
3. _____
4. _____
5. _____

You have a known asthmatic in your setting, name 5 things that you should include in your Healthcare Plan:

1. _____
2. _____
3. _____
4. _____
5. _____

Managing asthma in your setting:

Complete this table for your setting:

Asthma pumps and spacers are stored:	
Who has responsibility for giving the medication?	
Who has responsibility for recording procedures?	
At what age is it appropriate for children to carry their own asthma pumps and medication?	

Know your pumps!

Asthma pumps come in all shapes, colours and sizes; however only one is classified for immediate relief, whilst the others are for long term maintenance. What is the colour and name of the reliever inhaler? 	The reliever inhaler is…

Spacer devices also come in different shapes and sizes.   	The child should be encouraged to hold either the pump or the spacer. True or false?

Allergies

An allergic reaction occurs when the immune system reacts to substances in the environment that are harmless to most people; known as ‘allergens’ and found in foods, insects, pollen, mould, dust mites and some medications. Most allergic reactions are mild and do not involve the airways or circulation. Anaphylaxis is a potentially life threatening, severe allergic reaction and should always be treated as a medical emergency. Not all people with allergies are at risk of anaphylaxis. Anaphylaxis involves the obstruction of oxygen (air) to the airway and lungs and/or the heart, brain and blood vessels. Research shows an increase of 10% per year in hospital admissions for food-induced anaphylaxis between 1997 and 2013, with the majority of food-induced anaphylaxis admissions occurring in children aged under 5, and fatalities as a result occurring between 8 and 35 years of age. Sting-induced anaphylaxis hospital admissions peak between 5 and 9 years of age, with no fatalities within this age group.

What is an allergy?

Please tick or highlight the statements that you think are correct.

a) We talk about an allergy when somebody dislikes a certain food. e.g. many children are allergic to spinach, because they do not like to eat it.
b) We speak of an allergy when the body reacts in an unpleasant or dangerous way after contact with normally harmless substances.
c) Allergic persons are just over-anxious and have a vivid imagination. If you secretly add the substances they claim to be allergic to, nothing happens.
d) The immune system of an allergic person reacts in a "wrong way". A normally harmless substance is perceived by the body's immune system as a threat.
e) Sometimes, allergic reactions can be very dangerous. This is why allergic people must avoid the substances to which they are allergic. People who are allergic to pollen (hay fever) can take special medication to relieve symptoms.

Signs and symptoms of allergic reaction including anaphylaxis

The first symptoms of an allergic reaction are often skin rash or facial swelling, however this is not always the case. Early symptoms to food-based reactions may also include abdominal pain and/or vomiting. Mild to moderate allergic reactions (hives/swelling) may not always occur before anaphylaxis (severe allergic reaction). Anaphylaxis may present with symptoms of breathing difficulty, cough or wheeze. If the same child or young person has asthma then it can be difficult to determine if this is anaphylaxis or asthma.

Signs of a mild to moderate allergic reaction and anaphylaxis (Put the following symptoms under the correct heading)

Mild to moderate allergic reaction	Anaphylaxis (Severe allergic reaction)

Symptoms:

1) Difficult/noisy breathing
2) Wheeze or persistent cough
3) Swelling of lips, face, eyes
4) Persistent dizziness or collapse
5) Pale and floppy appearance (young children)
6) Hives or welts
7) Tingling mouth
8) Swelling of tongue
9) Difficulty talking and/or hoarse voice
10) Swelling/tightness in throat
11) Abdominal pain, vomiting (these are signs of anaphylaxis when the trigger is insect venom)

Specific to your setting

○ How many / which children have a diagnosed allergy?	
○ Where is / would allergy medication be stored in your setting?	
○ Who is responsible for administering allergy medication including emergency adrenalin and recording the process?	

Mild to moderate:7, 3, 6, 11 Anaphylaxis: 1, 8, 10, 9, 2, 4, 5

Epilepsy

1. Epilepsy is caused by a problem in the ..... that can sometimes stop the body from working the way it should.

a) Arms and legs
b) Brain
c) Eyes

2. You can catch epilepsy from someone if they cough or sneeze on you.

a) True
b) False

3. A seizure is...

a) A sudden, uncontrolled burst of electricity in the brain that causes it to become muddled for a short time
b) When the brain of somebody with epilepsy shuts down for a short time

4. A seizure that suddenly makes the person stop what they are doing and look as though they are daydreaming for a few seconds is called:

a) A tonic clonic seizure
b) An absence seizure
c) An atonic seizure

5.The person can stop how their body is behaving during a seizure if they concentrate very hard.

a) True
b) False

6. Seizures that only make part of the brain become muddled are called:

a) Generalised seizures
b) Focal seizures

7. After how many minutes should you call an ambulance if a tonic clonic seizure (when someone's body suddenly stiffens and then begins to shake or jerk) has not stopped?

a) 3 minutes
b) 5 minutes
c) 10 minutes

8. Which of the following should you NOT do during a seizure to help someone?

a) Cushion their head
b) Time how long the seizure lasts for
c) Hold them down
d) Speak to them during the seizure

9. Which of the following is a good way to behave if someone is having a seizure and already being helped by other people?

a) Crowd around and watch
b) Point and stare
c) Keep back and give them some space
d) Cry

10. A disadvantage of taking epilepsy medicine is:

a) They increase the number of seizures a person has
b) They make the person's tongue go blue
c) They can make the person feel dizzy, sick, and tired

11. It is against the law to discriminate against somebody because of their epilepsy.

a) True
b) False

Who in my setting has epilepsy?		Date
What seizure type do they have?		
If they use emergency seizure medication, what is it called and what is the expiry date?		
Have I and other relevant staff members been trained in administering emergency medication by health?		
If I am yet to be trained in administering emergency medication, this will be organised by what date and by whom?		
Emergency medication is kept where?		
Who is responsible for administering medication and recording seizure activity		

1.b, 2.b, 3.a, 4.b, 5.b, 6.b, 7.b, 8.c, 9.c, 10.c, 11. a

Epilepsy

Epilepsy seizure first aid

DO or DON'T and why?

LOTTERY FUNDED

Look at the pictures below and decide if each one shows something you **DO** or **DON'T** do to help someone who is having a seizure. Try to give a reason for each of your answers.

Action	Picture	DO or DON'T?	Reason
Call an ambulance immediately			
Panic			
Put something soft under the person's head			
Try to bring the person around			
Send for help			

Epilepsy seizure first aid

Action	Picture	DO or DON'T?	Reason
Hold the person down to stop them hurting themselves			
Immediately put the person on their side			
Move the person away from the chair to avoid harm			
Time how long the seizure lasts			
Stay with the person until they are fully recovered and reassure them			

Diabetes

Type 1 diabetes develops when the insulin producing cells in the body have been destroyed and the body is unable to produce any insulin. Insulin is the key that unlocks the door to the body's cells. Once the door is unlocked glucose can enter the cells where it is used as fuel. In type 1 diabetes the body stops producing any insulin so there is no key to unlock the door and the glucose builds up in the blood. There are several theories' why these insulin producing cells have been destroyed but the most likely cause is the body having an abnormal reaction to the cells. This may be triggered by a virus or other infection. Type 1 diabetes accounts for between 5 and 15 per cent of all people with diabetes and is treated by daily insulin injections, a healthy diet and regular physical activity.

There are currently around 1,320 children with Type 1 diabetes under the age of five in the UK. This number has increased five-fold in 20 years.

What symptoms would you expect to see in someone who may have diabetes?

How much do you know about type 1 diabetes?

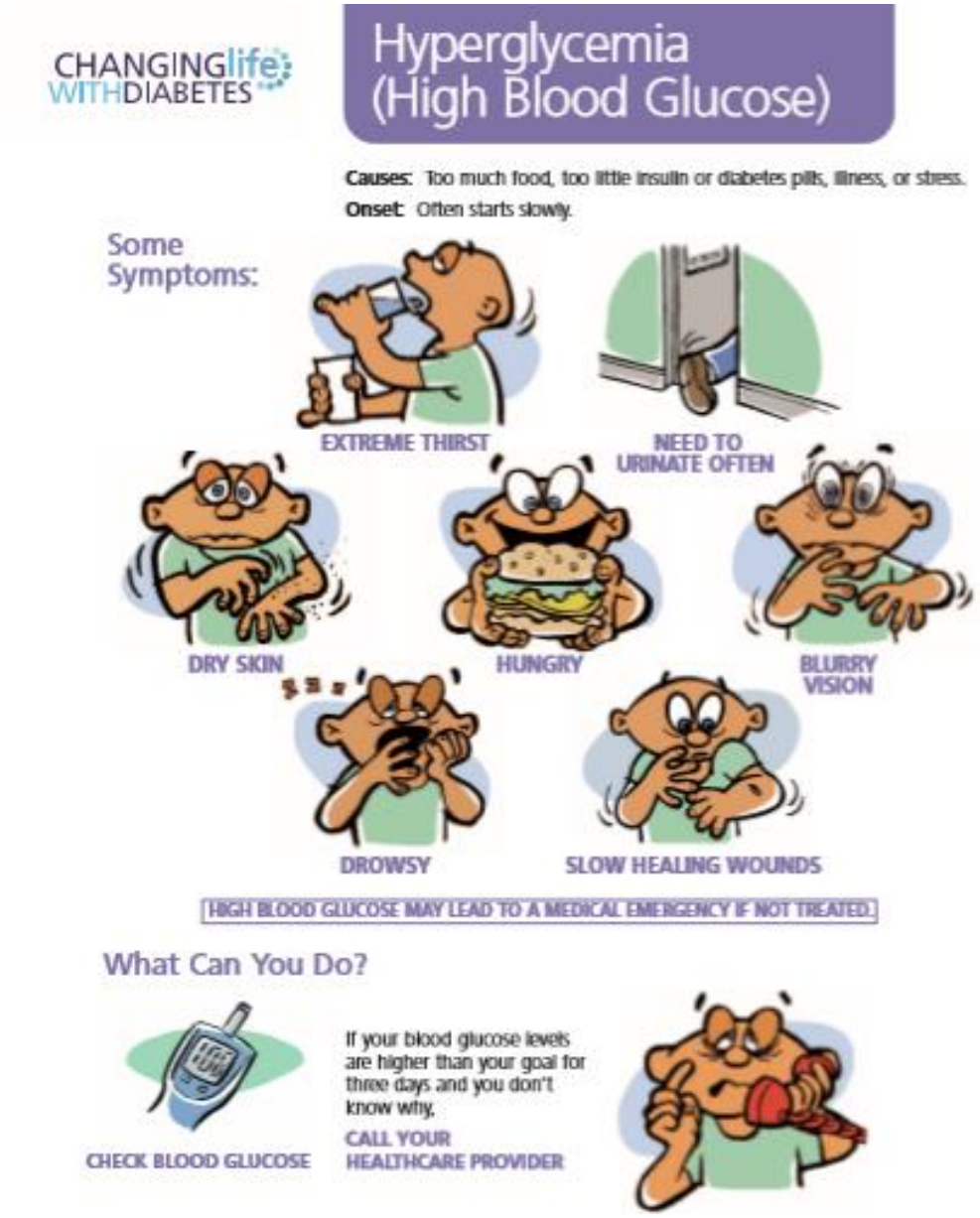
Decide which of the following statements are Fact and which are Fiction and enter the statement number under the correct heading in the table.

Fact	Fiction

1. Type 1 diabetes is contagious
2. Type 1 diabetes is caused by eating too many sweets and sugary products
3. Insulin is a cure
4. People with type 1 diabetes can eat cakes and ice cream
5. You can tell by looking at a child that they have type 1 diabetes
6. People with type 1 diabetes cannot be as successful in later life as people without type 1 diabetes

Fact: 4 Fiction: 1, 2, 3, 5, 6

Managing Hypoglycaemia	
Recognising a young child is having a hypo, what steps do you take?	
Things are not improving, what is your next step?	
What recording measures do you take?	



When do you?	Managing Hyperglycaemia
	• Give plenty of sugar free fluids • Monitor bloods • Refer to care plan and adjust insulin if required
	• feeling or being sick • tummy (abdominal) pain and diarrhoea • rapid, deep breathing • a fever (38C or above) for more than 24 hours • signs of dehydration, such as a headache, dry skin and a weak, rapid heartbeat • difficulty staying awake
a) Seek urgent medical attention because this could be a sign of more serious complications	b) Monitor, record and advise parents

Gastrostomy

The feeding tube can be used for which of the following reasons: (tick all that apply)

- to give the child liquid food for nutrition
- to give the child water for hydration
- to give the child medicines
- to remove excess air and fluid from the child's stomach (this is called venting)

If you have a child in your setting with a gastrostomy, are you aware of why they have it?

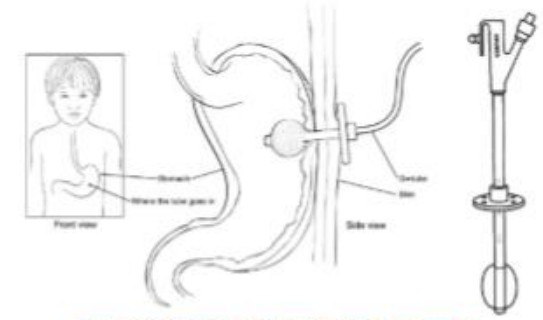
_____ needs a feeding tube because:

What is a feeding tube?

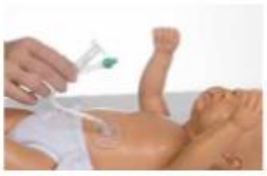
A feeding tube is a thin, flexible tube that goes through the skin and muscle into the stomach. Liquids go through the tube directly into the child's stomach or intestine.

There are different kinds of feeding tubes (see pictures 1-7). The child's doctor has chosen the one that best meets their needs at this time. As their needs change, the doctor may recommend a different type of feeding tube.

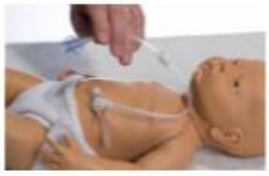
Look at the images below. Find out the name of the feeding tube the child in your setting has and write it here:



Picture 1. Gastrostomy feeding tube inside the stomach



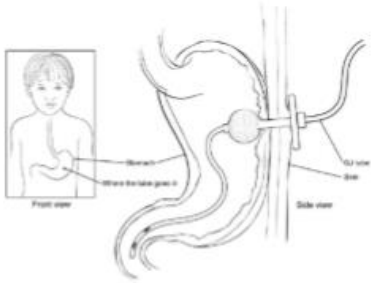
Picture 2. Gastrostomy feeding tube



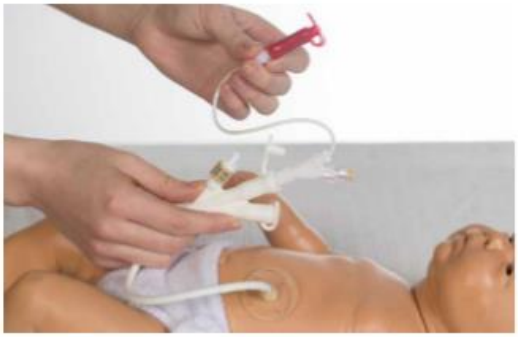
Picture 3. Low profile gastrostomy feeding tube

Picture 4. PEG feeding tube

Picture 5. Foley feeding tube



Picture 6. Gastrojejunostomy feeding tube inside the stomach and intestine.

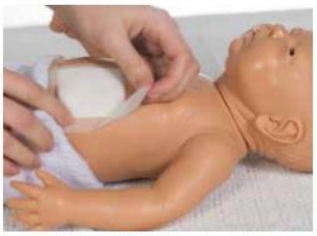


Picture 7. Two piece gastrojejunostomy (GJ) feeding tube

What do you do if the tube is accidentally removed?

If it has been less than 3 months since the tube was placed (any tube type)

- Cover the opening with gauze (see Picture 10) or a clean cloth.
- If the feeding tube is new or has not yet been replaced by a clinician and comes out accidentally, call parents immediately so that they can come and insert a new tube.
- Staff will need to have emergency training on what to do in the event a gastrostomy is accidentally removed. Under no circumstances should an attempt at reinserting/inserting a new tube be made without previous competency training from Health.
- The Child's Health Care Plan and Risk Assessment must reflect the appropriate action to take in the event of a gastrostomy coming out.



Picture 10. Covering the stoma with a gauze.

Managing a gastrostomy in your setting.

Which children have a gastrostomy?	
Have identified members of staff received training from a registered Health professional?	
List the dates training has been undertaken or is expected. Include review/ follow up training expectations	
Where and how is the child's equipment kept?	
Does your Health Care Plan and Risk Assessment fully reflect the needs of the child?	
What information needs to be recorded following any physical interaction with the child with a gastrostomy?	
How important are hygiene procedures when supporting a child with a gastrostomy?	
What equipment should you have ready when conducting a feed or administering fluids or medication?	
Who is responsible for gastrostomy care in your setting?	