

—★ personal
care
support
planning

in education and
children's services

Partnerships for health care and education

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Foreword

Young children routinely require assistance with daily living – or personal care support. Some students will require such support throughout their schooling; others will need support short-term following surgery or because of changes in their health condition. *Personal care support planning* provides advice about how to work collaboratively to maximise students' self management of their personal care, within safe and supportive environments for students and staff.

Personal care support planning was first published in 2001 to assist school and preschool staff to plan safe, reasonable and consistent personal care support for all children and students. It supplements the DECS guidelines: *Health support planning in education and children's services* (updated 2006).

This version contains updated information from therapists. The care plans have been removed and are now published electronically for ease of use on the *child health and education support services (chess)* website www.chess.sa.edu.au.

The 'how to' support guides have also been removed and are provided to staff at training programs. They are also available on the *chess* website.

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



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Disclaimer

The health-related information contained in this book was accurate and up to date at the time of publication. Readers are encouraged to check with their doctor or local health/community service provider for more recent information.

Further information

In South Australia, families and health professionals and community services 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.

The Department of Education and Children's services has a wide range of education professionals who 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)*.

This icon indicates that the information can be accessed from the chess website:

www.chess.sa.edu.au



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Introduction

Personal care support is that daily living support usually provided by parents or guardians and which some children and 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 childcare* (Commonwealth of Australia 2006) and is available from the National Health and Medical Research Council (NHMRC) website: www.nhmrc.gov.au/publications.

1 Personal hygiene support

1.1 Personal hygiene support in schools and preschools

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.

As with all personal hygiene support duties, workers should follow standard precautions (see section 1.4 [*Prevention of the spread of infectious disease*](#)); for example, the worker should routinely:

- cover any personal cuts and abrasions with a waterproof 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 predictably greater exposure to risk of infection, and post-incident medical testing if a needle-stick or other body fluid contamination is suspected.

Hand hygiene

Effective hand hygiene 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

and the only effective method to clean visibly dirty hands. Many lifelong habits, including hand washing, are learned in childhood. Education and care workers have important roles in teaching 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 or 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.

Waterless alcohol-based products, such as gels and rubs, can be useful when soap and water is not available. These are only effective if used on visibly clean hands. Alcohol-based products must be stored safely to ensure children and other vulnerable people do not access them. Care must also be taken in their use, for example avoiding eyesplash from liquid products.



For further information about infection control see [A – Z Health Support Index](#) > [Health support planning](#) on the *chess* website: www.chess.sa.edu.au.

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 [Health support planning guidelines](#) section 6.2 [Contenance 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 management see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Care and learning plans

 A hygiene [care and learning plan](#) can be used to involve children and students in the step-by-step process of hand washing, face washing (for example, after eating) and blowing and wiping their noses. This model encourages teaching and support staff 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.

 The [menstruation care and learning plan](#) can be used in a similar way, as a guide to assist girls to actively participate in these personal care tasks.

Infectious diseases and defences against infection

Infectious diseases

Diseases can be grouped into those that are clearly infectious, those that are clearly non-infectious and those where infection plays a role (but is not wholly responsible for causing the disease), that is, 'mixed'.

Infectious diseases are caused by an interaction between micro-organisms (bacteria, viruses, fungi, parasites etc) and a host (human, animal, plant etc) when the interaction is harmful to the host.

Examples of common infectious diseases in children are school sores (bacterial), gastroenteritis (viral) and tinea (fungal).

Non-infectious conditions include those caused by trauma (broken bones), genetic (haemophilia) and congenital (cerebral palsy) conditions. Examples of diseases where infection plays part of the role (that is, 'mixed') are asthma, inflammatory bowel disease and certain forms of arthritis. In all these diseases, infection may play a role in starting the disease or making it worse, but it is not wholly responsible for causing the disease.

It may seem from the above that every time a micro-organism meets a host, disease will result, but it is not that simple. After contact with a micro-organism, humans may be able to resist infection or 'fight back' successfully so that they do not develop disease.

The human body's defences against infectious diseases

Healthy humans are naturally able to resist infection. The body has a number of important defence mechanisms. These defence mechanisms can be grouped into:

- barriers to micro-organisms (for example, the skin)
- specific 'weapons' developed to fight individual micro-organisms (for example, antibodies). Antibodies are special proteins made by white blood cells after they encounter a specific micro-organism for the first time. These antibodies help the body to fight infection by the micro-organism and prevent disease. Once the body has produced

antibodies to a specific micro-organism, it can make many more identical antibodies very rapidly when the body next encounters the same micro-organism.

Humans are less able to resist infection when their defence mechanisms are not functioning properly.

- barriers can be damaged (for example, a cut or break in the skin).
- antibodies might not be produced effectively. This can be due to age (very young or very old), nutrition, other medical conditions (cancer, diabetes) and certain medications (cancer treatments, steroids).

When human hosts come into contact with a micro-organism, one of three things might, therefore, happen:

- some will not become infected because they are immune (have already encountered the organism before and made specific antibodies) or able to resist infection (for example, the organism comes into contact with only the intact skin surface which it cannot penetrate)
- some will become infected but not develop symptoms of disease. These people are called asymptomatic carriers; they look and feel healthy but are still able to pass on an infectious disease to others
- some will become infected and develop disease.

1.3 Spread of infectious disease

Criteria for the spread of disease

In order for an infectious disease to spread, three things must be present:

- a source of micro-organism such as another person, the person themselves or the environment
- a susceptible host; that is, one who is not immune or who is not able to resist infection due to age, underlying illness or injury
- a means of transmission (for example, via direct contact, airborne or via contaminated food).

This means that a person can have an infectious disease but not pose a risk of infecting others because:

- the source of the organism was the environment (not person-person spread)
- there are not susceptible hosts present (all are immune or resistant to infection)
- the person is no longer capable of transmitting the organism because he or she is no longer in the infectious period. The symptoms of an infectious disease can last far longer than the infectious period. For example, people with chicken pox are infectious from two days before to five days after the appearance of the first blisters, though the blisters themselves can last for weeks.

A person can pose a risk of infecting others but not have symptoms of disease. This is called the asymptomatic or incubation period. For chicken pox, it is the two days before the appearance of blisters. During this time the person might look and feel well but be able to pass the chicken pox virus onto others.

Pathways for the spread of disease

In order to understand the significance of basic hygiene behaviour in preventing the transmission of infection, it is helpful to know the ways in which infectious diseases are spread.

Airborne droplets from nose and throat

Some infections are spread when an infected person sneezes and coughs out tiny airborne droplets. The droplets in the air may be breathed in directly by another person, or indirectly enter another person through contact with surfaces and hands with the droplets on them. Examples are colds and the flu.

Faecal-oral

Some infections are spread when microscopic amounts of faeces from an infected person, with symptoms or without symptoms (carrier), are taken in by another person by mouth. The faeces may be passed directly from soiled hands to mouth or indirectly by way of objects, surfaces, food or water soiled with faeces. Examples are viral gastroenteritis and worms.

Skin or mucous membrane (lining of nose and mouth) contact

Some infections are spread directly when skin or mucous membrane comes into contact with another person's skin or mucous membrane. Infections are spread indirectly when skin or mucous membranes come in contact with contaminated objects or surfaces. Examples are cold sores and conjunctivitis.

Saliva

Some infections are spread by direct contact with saliva (such as in kissing) or indirect contact with contaminated objects (children sucking and sharing toys). An example is glandular fever.

Urine

Some infections are spread when urine is transferred from soiled hands or objects to the mouth. An example is cytomegalovirus (CMV).

Blood or body secretions

Some infections are spread when blood or body secretions from an infected person come into contact with the mucous membranes of an uninfected person or the tissues beneath the skin, such as through a needle-stick injury or a break in the skin. Examples are hepatitis B, hepatitis C and human immunodeficiency virus (HIV).

Sexually transmissible diseases

These are transmitted by sexual contact. Examples are bacterial vaginosis and chlamydia trachomatis.

Diseases where person-to-person spread occurs rarely, if ever

Some infections cannot be spread by direct contact with an infected person. These diseases are spread by contact with an environmental source such as animals, insects or contaminated water. Examples are Ross River virus and legionella.

Prevention of the spread of infectious disease

Preventing disease transmission is not as simple as treating people with actual or perceived infectious disease differently from everybody else. 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. Childcare services staff can refer to the publication [Staying healthy in childcare](#) (Commonwealth of Australia 2006).

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 bodily 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.



For further information about infection control see [A – Z health Support Index > Health support planning](#) on the *chess* website: www.chess.sa.edu.au.

1.5

Risk management

Standard precautions (previously known as universal precautions) form a basic risk minimisation strategy to protect people from the spread of infectious diseases. Universal precautions were initially developed at the Centres for Disease Control in Atlanta for use in health care institutions. They are the work practices required for the basic level of infection control (prevention of spread of infection) and are applied in the treatment of all patients in health care settings.

Standard precautions require that the same work practices are employed regardless of the infection status of the patient (known, unknown or perceived). The purpose of the work practices is to minimise the risk of transmission of infection from patient to staff, staff to patient or patient to patient.

In a negative sense, the use of standard precautions assumes that all patients pose an infectious risk. In a positive sense, the use of standard precautions encourages staff (and patients where possible) to adopt a set of responsible behaviours which will minimise their risk of infecting or being infected by others.

At the heart of standard precautions is the use of basic hygiene behaviour such as hand washing, appropriate disposal of waste and adequate environmental cleaning in every situation. This behaviour is applied in every contact and is not reserved for patients who have been identified or are suspected of being infected.

Besides providing a safe working environment, standard precautions have also helped to remove the stigma associated with certain infections since there is no distinction in the way that patients are treated.

While standard precautions were developed for use in health care settings, their underlying principles have much wider application in the community.

In schools, preschools and childcare settings the emphasis should be on the routine practice of basic hygiene behaviour, in all situations, by every member of the school community. Everyone should be encouraged to view basic hygiene practices as a social responsibility which, if undertaken by every member, will inevitably result in a safer and healthier environment for all.

In order for spread of an infectious disease to occur, three things must be present:

- a source of the micro-organism such as another person, the person themselves or the environment
- a susceptible host; that is, one who is not immune or not able to resist infection due to age, underlying illness or injury
- a means of transmission (for example, direct contact, airborne, contaminated food).

This means there is a number of ways to limit the spread of any infectious disease:

- reducing disease transmission through standard precautions such as hand washing, covering nose and mouth, turning away when coughing and sneezing, and safe waste disposal systems

- removing or reducing risk in relation to potential sources of infection. This includes food, with shared lunches and cooking classes providing opportunities to educate children and students regarding food hygiene, appropriate storage of school lunches and canteen hygiene
- safe environment management. This should include sandpits and gardening and exclusion protocols (children and others diagnosed with an infectious disease should not attend during their infectious period)
- boosting immunity primarily through immunisation.

Immunisation decisions are made by the individual and (in the case of children under 16 years, the age of medical consent) their family, in conjunction with the vaccination provider (general practitioner, local council or other health professional).

Some vaccinations, in line with the Australian Standard Vaccination Schedule, are offered free via school based clinics in South Australia.

Worksites may arrange for immunisation to be offered at their worksite, on a fee for service basis, for employees and others, but any decision about vaccination remains the responsibility of the individual, in consultation with the health service concerned, not the worksite manager.

Immunisation information and schedules are available in ***The Australian immunisation handbook***, 8th edition (NHMRC 2003) and on the website: www.health.gov.au/immhandbook/.

A medical practitioner should be consulted whenever an individual is concerned about his or her possible exposure to an infectious condition. The doctor will advise on treatment as required. If a notifiable disease is diagnosed, the medical practitioner will ensure health authorities are notified. This is not the obligation of the person concerned, nor of education and childcare workers who hear of such a diagnosis.

If someone on the worksite is exposed to blood and/or sustains a needle-stick injury, the following steps, recommended by the National Health and Medical Research Council (***Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting, 2004***) should be taken:

- If blood gets on the skin, irrespective of whether there are cuts or abrasions, wash well with soap and water.

- If the skin is penetrated, wash the affected skin area well with soap and water. If water is not available, alcohol-based hand rinse or foam (60-90 per cent alcohol by weight) should be used.
- If the eyes are contaminated, rinse the area gently but thoroughly with warm water or normal saline, while the eyes are open.
- If blood gets in the mouth, spit it out then rinse the mouth with water several times.

The incident should then be reported immediately to the worksite manager. The person concerned should be assessed by a physician or trained health care worker, preferably one with experience in the management of these situations. Treatment will be offered based on the risk of infection as assessed by the health professional.

For some treatment, time is critical. People should not delay seeking a medical assessment.

Blood or body secretions on intact healthy skin are virtually never an infectious hazard; nevertheless it is still important to wash well with soap and water.

Further information

www.chess.sa.edu.au

 **A – Z Health Support Index**

2 Continence care support

2.1 Continence care support in schools and preschools

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 [Health support planning guidelines](#) 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
 - manoeuvre 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 [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

2.2 Contenance care planning

 A contenance care plan can be used by health professionals to detail the individual care recommendations for a school student or preschool child.

Care and learning plans have been developed for toileting, intermittent catheterisation and ileostomy, colostomy and urostomy care. They can be used by families and school and preschool staff to assist children and students learn to take appropriate responsibility for these aspects of their personal care.

 For further information about continence see A – Z Health Support Index on the *chess* website: www.chess.sa.edu.au.

2.3 Contenance development

Contenance

Contenance is the ability to pass urine and/or faeces voluntarily at a chosen place and time.

Continent people can:

- **Recognise the need to go to the toilet**

Young children and students, those with certain kinds of nerve damage and some with intellectual disability might not be aware that their bladder needs emptying or be able to consciously control their bowel actions.

- **Identify the correct place to go to the toilet**

Some children and students might have to be explicitly shown and taught how to find and use the toilet at school and preschool.

- **Hold on until they reach the correct place**

For young children and some older students, the interval between recognition of the sensation of needing to go to the toilet and the urgent need to do so is very short. Nearness and accessibility of the toilet is very important for these children and students to maintain continence.

- **Pass urine and/or faeces when they get to the toilet**

Some children and students might have physical and/or psychological difficulty passing urine or having a bowel action. Education and care workers will need advice from health professionals and the family to support children and students with this issue.

The International Continence Society (***The standardisation of terminology of the lower urinary tract function***, London 1984) defines urinary incontinence as ***a condition where involuntary loss of urine is a social or hygienic problem.***

Sometimes children and students have voluntary control (and are therefore continent) but pass urine or faeces in the wrong place. This situation requires a learning and behaviour plan to address the choice of an inappropriate location. Some children and students misunderstand or are confused about what is socially acceptable; for example, many people would consider it acceptable to urinate behind a bush on a country road but would consider it inappropriate to do so behind a bush at school. For other children and students, choosing an inappropriate place is a purposeful action to communicate a psychological need.

In many Australian families and communities, toilet training for continence starts at about 18 months of age, following indicators of readiness such as a dry nappy after a significant period of time, or interest expressed by the child in using the toilet or potty. Some children are not developmentally ready for this step until the preschool or school years.



Children and students who are incontinent at school and preschool require a [health support plan](#) based on a [continence care plan](#) from a health professional.

Urinary continence

The urinary tract system has four parts: two kidneys, two ureters, a bladder and a urethra.

The kidneys filter and remove waste from the blood. After this filtering process has occurred, urine is formed. The kidneys are the most important organs for maintaining the body's fluid balance.

The ureter is the tube from each kidney that carries urine to the bladder. Urine enters the bladder at a rate of two to five drops per second.

The bladder is a muscular sac, which stretches to accommodate urine until it reaches a point of discomfort, indicating it is full. A message is then sent then to the brain to empty the full bladder. This process cannot occur unless the child's brain is sufficiently developed (typically from about 18 months) and all the nerve pathways are in tact and functioning.

The bladder holds approximately 30–45mls of urine for each year of the child's age. Generally fluid intake reflects fluid output although problems do develop from inadequate fluid intake. Generally, a healthy bladder needs to be emptied four to six times during the day and once or not at all at night. Schools and preschools can support healthy behaviour in this area by ensuring children and students can access the toilet as needed and by not encouraging going to the toilet 'just in case' they might need to later.

Faecal continence

Faecal continence involves the small and large intestines, the rectum and the anal canal.

Digestion starts in the mouth with chewing and the production of saliva. The exception is where people receive nutrition directly into the stomach, via a nasogastric tube (via the nose) or gastrostomy tube (via a 'button' inserted over a surgically created hole into the stomach).

Gastric juices in the stomach continue to break down the food and this is continued in the small and large intestine.

The large intestine, or colon, is a muscular tube lined with a mucous membrane. It is where water and nutrients are absorbed for use by the body, and waste is moved forward to be eliminated. Most waste is eliminated within 48 hours.

The anal canal has an internal and external sphincter (band of muscle fibres). The internal sphincter is an involuntary muscle that can stop the sphincter from closing. The external sphincter is usually voluntarily controlled so the person can choose when to use his or her bowels.

Every individual's bowel pattern varies. For example, for some people a bowel action three times a day is normal, for others, three times a week is routine. Some people with functional disability need to monitor their bowel patterns closely as part of their routine care. In schools and preschools, staff would not routinely monitor the time and nature of bowel actions. The exception might be where staff routinely change a child or student with a disability and are asked to record bowel actions, for a short period of time, to advise a medical review. Any such role undertaken by staff would be part of an agreed health support plan.

2.4 A supportive environment for continence

Teaching the skills of continence is primarily the responsibility of the family. Education and care workers have a responsibility to ensure the environment supports healthy bladder and bowel function and enables a consistent approach with the family in supporting developing continence.

In a supportive environment for continence, staff promote eating, drinking and going to the toilet as important routines in everyone's day. The program:

- enables adequate fluid intake
- is structured for regular food intake
- provides a balance of physical activity and rest
- facilitates use of equipment and aids for occupational health and safety
- provides facilities which respect privacy, dignity and safe and hygienic practice.

Fluid intake

Recommended fluid intake varies with age and stage of development, climate and current health circumstance. As a general guide:

- a 3-year-old who weighs 15kg requires 5–7 glasses (200ml per glass) of fluid daily
- a 14-year-old who weighs 50kg requires 8–10 glasses of fluid daily
- adults require 8–10 glasses of fluid daily.

Water, juice and milk are recommended for bladder health. Drinks should be spaced throughout the day with consideration given to toileting and other personal needs. This means that children and students should have access to fresh water and the toilet throughout the day.

Food intake

People also require regular intake of high fibre foods such as breads, cereals, vegetables and fruit. In most services, foods are provided from home. When food is supplied at school or preschool, Commonwealth and State [Healthy Eating Guidelines](#) should be followed (see section 3.1 [Eating and drinking](#)).



Physical activity

Physical activity supports overall health and well-being. It also supports healthy bowel and bladder function, strengthening key muscle groups and assisting digestion and elimination.

Equipment and aids

Families are responsible for providing the aids and equipment needed by children and students as part of their continence care. This can be recorded on a [care and learning plan](#). Personal kits can include a change of clothes and personal hygiene products. Consideration can be given to sending clothes, which maximise independence and minimise the time spent in changing.



Some children will have a care plan that recommends the wearing of nappies and/or absorbent pads and pants.

Other children will have equipment related to invasive continence care, for example catheter tubes and/or ileostomy and colostomy bags. The worksite should provide a safe, private and convenient location for storage of these products.

The employer is responsible for the provision of equipment to enable staff to safely undertake continence care support (see section 1 [Personal hygiene support](#) and section 4 [Transfers and positioning support](#)).

Facilities

Toilet facilities should be accessible, hygienic and safe. Families and health services have reported that some children and students delay using the toilet at school and preschool citing the smell, lack of soap and toilet paper and lack of privacy as their major concerns. Managing toilet facilities can require considerable time, cost and effort, particularly in large school sites. The importance of this work is highlighted by medical evidence which indicates that extended postponement of using the toilet can cause physical as well as psychological issues for children and students, with the potential for development of chronic bladder and bowel problems.

Some children and students will require disabled toilet facilities to enable nursing support (for example, for changing catheters and stoma bags), wheelchair access and transfer and positioning support. Individual needs vary and any new development or redevelopment of a worksite should consider including toilet access for all potential users of the site. Employers can refer to the ***Australian standards*** to develop inclusive facility provisions.

2.5 Managing incontinence

Incontinence can be short or long-term. One in four women and one in 10 men experience incontinence at some time in their lives. People with physical disabilities are more likely to have continence issues either as a direct result of their medical condition or because of their impaired mobility. For many young children incontinence is a developmental issue that will, with understanding, patience and support, be resolved over time. For older students, incontinence can be associated with a physical illness, psychosocial issues or functional disability. Whatever the cause or nature of a child's or student's incontinence, it needs to be managed efficiently and effectively within school and preschool to maintain the child's or student's dignity and self-esteem.

Urinary incontinence

Over the life span, urinary incontinence (enuresis) is routinely experienced by:

- 15–20 percent, or 1 in 6 five-year-olds
- 7 percent, or 1 in 14 seven-year-olds
- 5–6 percent, or 1 in 20 ten-year-olds
- 2–3 percent, or 1 in 30 adolescents
- 1–2 percent, or 1 in 50 or 1 in 100 adults.

Males are twice as likely as females to experience urinary incontinence.

Night-time bed-wetting (nocturnal enuresis) is more common. Nocturnal enuresis is defined as bedwetting after the age of five years or when a younger child has been dry for a period of three months and begins to wet again. It is common until the age of six or seven when the incidence drops significantly. It is estimated that more than 100 000 Australian children between the ages of five and 15 are affected by nocturnal enuresis. Often children and students choose not to participate in overnight activities because of this issue. Educators and support staff can indicate their willingness to be approached in confidence to ensure this health issue can be supported sensitively and enable the child or student to participate with his or her peers.

The Continence Foundation of Australia (www.confound.org.au) in **Good bladder habits for everyone** (2000) recommends that medical or continence advice be sought if a child experiences the following:

- involuntary leakage of urine
- loss of urine when coughing, sneezing, laughing, standing up, lifting or during physical activity or sport
- an urgent need to pass urine, not being able to hold on or not getting to the toilet in time
- passing small amounts of urine frequently and consistently, for example more than eight times per day and in amounts less than 200mls (approximately a tea cup)
- bed-wetting over the age of five years.

There are others listed and it is recommended that parents and guardians contact a doctor or continence advisor if the child has any changes or irregularities in his or her bladder habits.

Involuntary soiling (encopresis) and other bowel problems

Incontinence of faeces is less common than incontinence of urine. It is estimated that about 1 in 200 adults experiences regular faecal incontinence, with the percentage rising in older people. Lack of voluntary bowel control in a child or student should always be investigated by a health professional so that staff have clear advice about the child's or student's support requirements. Faecal incontinence at school or preschool has the potential to impact significantly on the child's or student's relationships, self-perception and behaviour. Discreet and sensitive management is critical.

Constipation is one of the most common bowel problems. It can be caused by lifestyle (for example, reduced fluid and food intake, low fibre diet and lack of exercise), physical impairment, medications and environmental factors (for example, lack of adequate toilet facilities and privacy). Constipation requires proper medical assessment. Untreated it can become chronic and cause the faecal matter to become impacted in the bowel. This causes overflow faecal incontinence, with frequent small amounts of faecal matter being passed throughout the day and night. Sometimes medication is prescribed to treat constipation and other bowel problems. This should always be undertaken only with medical advice and managed to minimise disruption to the child's or student's participation in school and preschool.

Soiling at school or preschool should also be investigated by a health professional. Schools and preschools should request a continence care plan from the doctor or continence nurse to ensure care and learning support within the education setting is appropriate.

Hygiene after a bladder or bowel episode

Standard precautions should be followed in providing continence care support (see section 1 [Personal hygiene support](#)). Standard precautions minimise transmission of infection by contact with urine, faeces or blood. They are used in all cases, on the assumption that any body fluid should be considered potentially infectious. Standard precautions in the provision of continence support include the following:

- wear gloves (check that the child or student does not have an allergy to the glove: allergy to latex is not uncommon with some medical conditions)
- wash hands before and after using gloves
- wear a protective apron if soiling of clothing by urine, faeces or blood is likely
- use gloves (such as household rubber gloves) for general cleaning. Rubber gloves can be disinfected and reused, but should be discarded if they are peeling, cracked or discoloured. They should also be replaced if they have punctures, tears or other evidence of deterioration.

Hygienic cleaning of an area affected by urine or faecal matter includes the following:

- remove any excess faeces with paper, then wash the area with cold water
- follow with warm soapy water and rinse with cold water
- try to leave the area as dry as possible.

Cleaning up quickly will mean there is less chance of any odour or staining occurring.

- Collect any solid waste on paper and dispose of it by either double bagging (placing one bag inside the other) or placing the excreta in the toilet. If placing the excreta in the toilet, the paper can be flushed down the toilet if a fairly small amount of toilet paper is used without causing a sewer blockage. If a larger amount of paper was used, double bagging and disposal in biological waste systems is required.
- Always wear gloves when handling any waste products. It is best to wash hands before and after attending to a child or student as well as wearing disposable gloves. This is double protection for the child or student and the care provider.

- Soiled clothing can be rinsed through in cold water, and placed in a plastic bag for the child or student to take home.
- Parents and guardians need to be advised of what has happened and encouraged to seek medical advice if this is not a typical event for the child or student.

Catheterisation

Some people (for example, those with poor or no bladder or sphincter muscle or nerve function) can achieve independent urinary continence by intermittent catheterisation. This allows the person to avoid the build-up of residual urine that can cause overflow incontinence and infection.

Clean intermittent catheterisation involves passing a small catheter, or tube, via the urethra several times a day. For the student, this is typically once during the six-hour school day. Catheterisation is an invasive procedure that would not be undertaken by school or preschool staff. Typically a visiting nursing or care worker service would undertake this level of care.

Upper primary students can often manage to self-catheterise at school and require only an appropriate facility with an adult nearby for reassurance. There is no need for sterile techniques as standard precautions are adequate. This is because most people have resistance to their own bacteria, and because the regular drainage of the bladder removes bacteria before they get a chance to take hold and multiply.

Stoma bags: ileostomy, urostomy and colostomy

A stoma is a surgically created opening in the bowel or urinary tract, on the abdomen, that provides an exit point for urine or faeces. The word 'stoma' is derived from the Greek word for mouth or opening.

There are many reasons that a child or student may have a stoma. The name given to each stoma relates to the part of the bowel or urinary tract that has been diverted to the abdomen (for example, small bowel—ileostomy; large bowel—colostomy; bladder—vesicostomy; and urinary tract—urostomy).

The output from these openings cannot be controlled and is therefore collected in an appliance (pouch) that sticks on the abdomen.

Children and students may need to empty the appliance once or twice, during the day. They will require an appropriate private facility, and may need an adult nearby for reassurance. The family will provide all stomal equipment. Strategies for occasional leakage episodes should be planned.



For further information about continence see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Further information

www.chess.sa.edu.au



[A – Z Health Support Index](#)

3 Oral eating and drinking support

3.1 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 [A – Z Health Support Index](#) 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, within the context of the ***Dietary guidelines for all Australians***: www.nhmrc.gov.au/publications/synopses/dietsyn.htm.



In South Australia, services should refer to the ***Healthy eating guidelines for schools and preschools*** (DECS, 2004). At the same time, staff 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

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](#) or other health professional with specialist skills in eating, drinking and swallowing management.

Some children and students take nothing orally ('nil by mouth'). They receive food and drink via a tube. Assistance for these children and students will need the involvement of a registered nurse. Some students may have tube feedings but also take food or fluid orally to supplement this and for enjoyment. Should these students require assistance with oral feeds (eg restricted intake, small portions or tastes) they will also require an [oral eating and drinking care plan](#).

In South Australia, involvement of a registered nurse is negotiated through the *Access Assistant Program* (see [A – Z Health Support Index](#) 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:

Category 1

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. Education and childcare workers routinely provide assistance of this nature.

Category 2 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 with specialist skills in eating, drinking and swallowing management. This care plan will be used to develop an education or childcare health support plan.

Category 3 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. In South Australia, involvement of a registered nurse is negotiated through the [A – Z Health Support Index](#) > [Access Assistant Program](#).

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 health professional should be available to provide training, 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 who 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 (degree of supervision/assistance)
- type of support needed (preparation, equipment, environmental management, positioning, feeding strategies and after mealtime care)
- communication (by supervisor and student)
- preparation and presentation of food and drink (texture, 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.
- time required
- recommended [training](#)
- clear expiry and review date.

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](#). 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 and spluttering. 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 are advised to seek parental or guardian permission to contact the health professional 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
- shows signs of distress (eg difficulties breathing)
- has seizures or loses consciousness
- tires and is unable to manage
- frequently and or repeatedly gags, coughs or splutters at mealtimes
- becomes pale or sweaty while eating or drinking
- sounds 'gurgly' when eating and drinking, or undergoes a change in vocal quality.

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 have a suggested review date on the front page.

Care plans should be reviewed routinely (usually every 12–18 months) or more frequently for students whose skills may be developing or deteriorating. The oral eating and drinking care plan proforma has a review date boxes on the front page.



This review will be initiated by the family in conjunction with the education, childcare and or community support service. Families, education childcare and community support 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)
- frequent and repeated coughing, spluttering, gagging, near-choking, or distress in the child or student during or soon after meals
- weight loss
- frequent and repeated chest infections and or hospitalizations
- the review date is approaching.



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



For further information about eating and drinking see A – Z Health Support Index on the *chess* website: www.chess.sa.edu.au.

3.2 Swallowing

Swallowing is a highly complex skill which requires good sensation, precise muscle control, a prompt and effective swallow reflex and a highly coordinated process between manipulating and controlling the bolus, breathing and swallowing. The swallowing action occurs very rapidly and food and liquids are moved from the back of the mouth to the stomach in only a few seconds.

Normal swallowing

Swallowing requires good sensation, muscle strength, healthy teeth and gums, precision and smooth coordination of the lips, teeth, tongue and cheeks and other oral structures to form food and fluid into a manageable mass called a bolus. Strong, well coordinated movements and good sensation to feel food and fluid in the mouth are necessary to bite, chew, move and form food and liquids ready for swallowing. All of this happens in the mouth, before swallowing takes place. This part of the swallowing process is under our voluntary control.

The actual swallowing action then occurs very quickly. Swallowing itself is a reflex activity, and is not under our voluntary control. Once food and liquids have been formed into a bolus this is pushed to the back of the mouth using the tongue. When the bolus reaches the back of the mouth, the swallow reflex is triggered and the bolus moves through the throat, down into the food pipe and into the stomach within seconds. Once the bolus has reached the stomach, a small muscular valve prevents any food or drink from refluxing (that is, going back up) into the oesophagus, or towards the lungs. As swallowing occurs, the open airway is closed completely, automatically preventing food or liquid from entering the lungs. If any food or drink does accidentally enter the airway (that is, aspiration), a cough reflex is immediately ‘triggered’ to expel the ‘foreign matter’.



For further information about the swallowing process see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Swallowing disorders

A swallowing disorder or the technical term **dysphagia**, occurs when there is a problem with the normal ability to swallow food and or liquids. Swallowing problems or dysphagia can occur for many reasons and may be temporary, permanent or degenerative, where the difficulties become progressively worse. Swallowing disorders can occur suddenly as a result of an injury, accident, stroke or disease. Some people may be born with difficulties such as cerebral palsy, malformations of the face and oral structures or developmental disabilities which may affect eating, drinking and swallowing skills.

Any disease or injury which directly affects the oral musculature or damage to the brain which causes impairment to the swallowing mechanism may result in a swallowing disorder. Swallowing difficulties

can be quite mild or even so severe that food and fluid cannot be taken by mouth and the individual must be fed via other means either temporarily, partially or permanently.

Swallowing difficulties can pose significant dangers as food or fluid may enter the lungs rather than the stomach. Inhalation of foreign particles such as food, and liquid is called aspiration and this in turn can lead to serious medical complications such as lung infections.

Swallowing difficulties can occur at any stage of the swallowing process. Problems with strength, movement, coordination, and sensation of the oral muscles may cause difficulties with chewing, moving and collecting food; managing liquids and effectively clearing the mouth. Similar problems with the pharyngeal musculature or difficulties with triggering the swallow and cough reflexes may cause food to be trapped in the throat; pushed into the nasal passageways or into the airway and lungs causing aspiration or nasal regurgitation. Problems with the muscles of the oesophagus may result in narrowing or pocketing of food interrupting a smooth passage of food into the stomach or reflux of stomach contents.

As difficulties can be due to a variety of reasons, these need to be carefully investigated, usually by a speech pathologist with specialist skills in eating, drinking and swallowing in the first instance. If necessary a medical doctor, or specialist (eg paediatrician ear, nose and throat specialist, gastroenterologist, respiratory physician) may also be consulted for specialised investigation and/or treatment.

An awareness of the signs of swallowing problems is necessary for safe mealtime management of children and students who have swallowing disorders.

Signs of swallowing problems

- lengthy mealtimes (longer than 30mins)
- refusal to eat or drink
- taking a long time to open the mouth before beginning to eat/drink
- difficulties biting, chewing and manipulating food in the mouth
- weak and or poor control of the muscles of the face, mouth and tongue
- unusual oral skills (eg tongue thrust or bite reflex)

- drooling or poor saliva control
- poor sensation of the face, oral or throat musculature
- spitting or spillage of food/drink
- slow or absent chewing
- slow movement of food around the mouth
- pocketing of food at the sides of the mouth
- food remaining in the cheeks or mouth after swallowing
- difficulties coping with certain types of food/liquids
- difficulty initiating a swallow
- delayed or slow swallow trigger
- multiple swallows to clear food and fluid
- difficulty coordinating breathing and swallowing
- coughing, spluttering, gagging at mealtimes
- discomfort swallowing whilst eating or drinking
- inability to cough, or a weak cough
- wet, gurgly voice during or immediately after swallowing or at mealtimes
- nasal regurgitation (ie food or liquids in the nasal passageways) or frequent sneezing during a meal
- gastric reflux and vomiting
- sweating, pallor or glassy eyes during meals
- weight loss and/or failure to thrive (grow well)
- recurrent chest infections/temperature changes.

Difficulties with swallowing should be treated immediately as they can have serious consequences. There are many treatment options available to develop eating, drinking and swallowing skills. People with swallowing difficulties need to have specific intervention designed to meet their individual problems to ensure swallowing is safe. Specific treatments and mealtime management plans should be followed carefully to ensure safe swallowing.

Just before swallowing occurs, the open airway rapidly and completely closes, preventing food or drink or foreign items from entering the airway and possibly the lungs. However, if any foreign matter, food or drink does accidentally enter the airway (that is, aspiration), a cough reflex is immediately 'triggered' to expel the 'foreign matter'. Aspiration, partial airway obstruction and choking can be very significant safety issues for people with swallowing disorders.

Coughing

Coughing, spluttering and gagging are part of the body's defence mechanism to prevent food, fluids and foreign objects entering the airway. These defences however rely on very good sensation and strong muscular action and may not work effectively in people who have physical and or sensory impairments to the muscles involved in swallowing.

By coughing the body moves the foreign material up out of the airway back into the throat where it can be swallowed or spat out.

Coughing, spluttering, gurgliness, gagging and choking rarely occur during the normal swallowing process. Regular occurrence of these symptoms at mealtimes can indicate swallowing difficulties.

Aspiration

Aspiration occurs when any foreign material (eg food, fluid, saliva) enters the airway (lungs) beyond the level of the vocal folds (voice box). Aspiration is the feeling that 'something' has 'gone the wrong way', as though you have inhaled rather than swallowed.

This can result in partial airway obstruction.

The body's normal reaction to this is to immediately attempt to clear this by throat clearing, coughing, gagging or even vomiting.

Some people may have poor sensation or weak muscle action and may not notice food or fluid entering the airway or be unable to cough or clear their airway effectively so are at much greater risk of aspiration and choking.

Silent Aspiration

Silent aspiration occurs when food or fluid enters the airway below the level of the vocal folds with no observable outward signs such as coughing or throat clearing. So to an observer, the person has simply swallowed, when in fact food or fluid has entered the airway.

Silent aspiration is of concern if the amount and or type of food or fluid entering the airway and lungs leads to distress at mealtimes, respiratory illness and over time possibly lung damage.

Airway Obstruction

Partial or total airway obstructions or blockages can occur due to foreign objects becoming lodged in the airway (eg solid food), inflammation of the airway itself causing it to swell up and close off (eg anaphylaxis due to food allergy such as peanuts or shellfish) or compression on the airway.

Mealtime factors that can contribute to *partial or total airway obstruction* placing a person, particularly children, at risk of choking to death include:

- poor positioning
- inappropriate foods (eg giving solid foods to a person who cannot chew)
- inadequate chewing of food
- breathing in while eating
- sudden laughing or crying with an object or food in the mouth
- running and falling with an object or food in the mouth
- placing small objects in the mouth (eg toddlers and young children)
- food allergies (eg peanut, shellfish, egg)
- medications (eg that may affect the ability to swallow, or allergies)
- level of consciousness (eg seizures)
- swallowing disorders.

Partial Airway Obstruction

Occurs when part of the airway is blocked, but some air can still move in and out. The blockage could be due to food (eg partially chewed or whole pieces) or objects or inflammation of the airway itself (eg anaphylaxis, asthma).

Coughing is the body's natural and most effective way of clearing a partial obstruction from the airway. If the child or student is able to cough, then he or she is not in a life-threatening choking situation. If a child or student is coughing because of a partial obstruction:

- do not leave the person
- stop eating
- offer reassurance
- encourage the person to cough, clear their throat, vocalise.

If the person is wheezing or breathing is noisy and laboured, call an ambulance.

- continue to reassure
- DO NOT give back blows as this may cause total obstruction as the person may suddenly inhale.

Choking

Choking is **total** blockage of the airway. This is usually due to foreign objects or hard, dry, stringy or fibrous foods which have not been effectively chewed and swallowed. They become stuck and this obstructs the passage of air. Choking symptoms can also be caused by an allergic reaction. As air can no longer flow in and out freely, breathing stops, which means that a person is without oxygen unless the airway can be rapidly cleared. Total lack of oxygen results in death.

First aid for **partial and total airway obstruction** is taught in standard First Aid courses (eg Red Cross, St Johns). In South Australia, teachers and caregivers can request additional training in first aid for choking, including situations involving students and children with poor upper body control.

Any carers or support workers assisting children and students at mealtimes should ensure they have up to date first aid training including resuscitation and choking management.

Children and students with physical disabilities may require a modified choking management plan if they are in supported seating (eg wheelchair) at mealtimes. Staff and carers may need to be familiar and ready to remove the student from equipment quickly if the student requires first aid and know how to administer this.



For further information, including *choking on an object/food* and *modified choking* first aid guides, see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

3.4 Mealtime management

Everyone needs a well-balanced diet. What people eat and drink provides the nourishment and energy for growth and development. Poor intake of fluids and foods directly affects physical development and general well-being.

People with disabilities can have mealtime difficulties which affect their eating and/or drinking skills, their body's ability to use nutrients and, overall, their general health, energy level and participation in daily activities.

Team approach

Mealtime difficulties often require a team approach to accurately assess the problem and to provide a management plan. The team working with the family and education and care staff can include:

- general medical practitioners (GPs) and medical specialists
- nutritionist
- nurse
- speech pathologist
- occupational therapist
- physiotherapist
- psychologist.



Generally the speech pathologist will be the professional who completes the [oral eating and drinking care plan](#), and who provides information and advice to workers who use the plan. Speech pathologists have specialist skills in the areas of eating, drinking and swallowing.

Management of mealtime issues can include:

- specialised diets (eg high energy intake, high fibre)
- additional nutrition by means of special foods and drinks (eg Sustagen, polyjoule)
- particular body positioning during and after meals
- changes in food and/or fluid textures
- adapted eating/drinking equipment
- specific swallowing methods
- medications (eg for reflux)
- surgery, for example to prevent gastric reflux (astro-oesophageal reflux)
- a care and support plan for education and childcare so that the child's or student's mealtime needs are understood and safely met
- ongoing monitoring by the team.

Assisting at Mealtimes

This is a very personal area of care and can be uncomfortable and even frightening for the student and challenging for workers. Communication is essential to ensure everyone is feeling comfortable, assured and able to trust one another. It is important to be very aware of all the steps involved with eating, drinking and swallowing, to pay attention and to encourage the student to do so also.

Assisting someone to eat can take considerable time, energy and effort. Mealtimes are usually about socialising and sharing everyday information with others. The aim is to keep mealtimes a pleasant positive and personal experience, for the individual, the person giving assistance and any others in the group. Mealtimes are very often (but not always) social occasions, so where possible encourage two way communication. Conversation at meals is rarely about the food alone: taking time to share everyday information as well often brings the sense of enjoyment in sharing time with others. When people eat alone they often do other activities such as reading, watching TV, observing their surroundings or listening to music: eating and drinking are generally background activities. Two-way communication creates a pleasant, positive and personal experience for the person being assisted as well as for the carer.

Level of Assistance

Many people with eating difficulties are independent or semi independent at mealtimes but may require close supervision, coaching and guidance. Others need individual help. This may involve assistance with:

- preparation of food/drinks (eg opening/unwrapping, ensuring solids and liquids are of the appropriate consistency or texture, placing in suitable equipment)
- positioning
- use of modified mealtime equipment (eg a Manoy scooper plate, flexi-cup, built-up handle spoon etc)
- special techniques to assist eating, drinking and swallowing.

Without assistance, some people may be unable to eat or drink at all or experience additional swallowing problems and complications from dysphagia. Some students may require more or less assistance at varying times due to physical skills, fatigue and health issues.

The student's care plan should detail the assistance required; their health support plan will identify who provides this in the education setting.

Mealtime Routines

Generally if you are healthy and well you are likely to be having a reasonably well balanced diet overall. It is important to focus upon this rather than the total amounts or types of foods eaten at particular meals. Usually if a nutritious diet is offered things will balance out. There are many instances which can affect a person's appetite on a given day. Mealtimes can pose many difficulties if they become a battle of wills rather than being an enjoyable social time.

Creating good mealtime routines is a way to facilitate an interest in eating, appetite and cooperation so that mealtimes remain enjoyable social occasions. Developing simple guidelines and routines at mealtimes can assist both the carer and the person with the eating difficulty to approach mealtimes positively.

As much as possible mealtime routines should follow the same predictable or regular pattern, but still allow some scope for variation. Routines can assist people who have eating difficulties to become comfortable and familiar with what is expected of them and what to

expect from people assisting them. Mealtimes routines should include regular signals, familiar people and surroundings where possible but allow for changes. Routines then provide a basis for introducing changes such as a new food or drink, a new staff member or new location. These changes can be introduced gradually by making modifications to one area at a time, while keeping other aspects the same.

Routines allow everyone involved to:

- prepare for the occasion
- understand expectation and procedures
- be aware of physical outcomes
- manage difficulties
- participate as fully as possible in the social aspects of the event.

Routines can involve regular meal and snack times. Workers should not be overly concerned if food or drink is refused unless this becomes a routine occurrence or is associated with other signs of swallowing difficulties (eg always refusing thin liquids). If possible, offer an alternative and be mindful of food and fluid preferences as refusal may be the child's means of indicating they don't like the item's taste, texture or temperature.

For many children and students with disabilities, mealtimes can be one of the few areas of life in which they have some control. An individual's likes, dislikes and mealtimes preferences should be respected as much as possible by carers, while still being mindful of good nutrition and a well-balanced diet.

Before the Meal

- Tell the person what is going to happen, use language the child understands and visual cues such as signing, pictures or photos to help the person prepare for eating and drinking – as per the child or student's plan.
- Include the child or student in the preparation of the meal where possible, this may be as simple as looking inside his or her lunchbox and or taking the contents out, unwrapping or placing it in a bowl or cup. Or it may be more involved such as actual food preparation, organisation of foods and drinks or setting up the meal area. Simple opportunities to see, smell, hear and possibly touch containers and

food items can help stimulate the appetite as well as prepare the body for eating.

- Incorporate preparation for eating the meal into the routine, for example putting on a clothes protector or napkin and positioning at the table. Physical cues such as these can assist the child or student to anticipate meals and learn what is expected of him or her.
- Use placemats or trays with outlines for the plate, cup and utensils or photos or pictures contacted onto table tops can provide visual cues and assistance with organisation and pacing at mealtimes.
- Be aware of the total environment in which meals occur. Comfortable, calm, enjoyable, distraction free environments can assist both the person and the staff member. It is difficult for children to focus on eating when workers are continually getting up and down or moving around or doing other tasks.

During the Meal

- Take time when feeding or assisting people to eat.
- Allow children and students to pace their own meal, as much as possible. People who have swallowing difficulties need more time to chew, to swallow and fully clear their mouth before the next mouthful. If a person is experiencing difficulties, then he or she can become anxious and require even more time to eat or drink safely.
- Encourage further swallows for the student to clear their mouth, if necessary, before presenting the next bite or sip.
- Where possible, offer choices around the types of food and drink available, rather than continually presenting the same items.
- If the support plan includes the introduction of new foods, do this when the child or student is calm, alert and hungry.
- Keep foods at serving temperature (especially for slow eaters). Some food can be unpleasant or unsuitable when cold or warm.
- Do not become angry or upset if food is refused; remove it and try something else; reintroduce it at a later time.
- Try keeping mealtimes enjoyable for everyone involved. Where possible, use mealtimes to share information or have low key social activities around to focus on and perhaps talk about and share.

After the Meal

- Mealtimes should finish with a signal to clearly indicate their conclusion particularly for children and students who may have difficulties understanding or those with visual, hearing or sensory impairments. (eg using the sign for finish or stop, wiping the person's face, packing up utensils or helping to clean up). Involve students in these routines where possible.



Refer to the [oral eating and drinking care plan](#) for specific information documenting individual care needs.

3.5

General guidelines for mealtime assistance

Communication

- Always inform the person about what you will do prior to doing it.
- Provide ongoing verbal coaching to remind students about good positioning, oral movements (eg bottom lip under the cup; suck in the liquid, lips together, strong swallow).
- Be aware of students with visual and or hearing impairments, they may need a physical cue to signal the approach of a spoon or cup.
- Offer choices, often just the use of the food items themselves can assist this.
- Remember communication at mealtimes is often about other topics and is a social occasion, offer opportunities for positive interaction.
- Signing is often a useful tool as it can provide an additional visual cue and some of the mealtime signs are very easy to incorporate at mealtimes (eg eat, drink, more, finish).
- Use the student's own communication system where possible (eg photos, pictures, communication device).

Signing at Mealtimes

Remember when using signing to always say the words to assist communication and understanding. Some children with physical impairments may use slightly modified signs depending upon their

physical skills. The following illustrations show the more common signs that can be used at mealtimes.

Mealtime Preparation

- Be aware of loose clothing and hair and ensure it does not drape or fall over the student or food.
- Wash your hands thoroughly before preparing foods and utensils.
- Wear gloves when directly assisting an individual to protect both yourself and the person from cross infection.
- Involve the person in the preparation where possible.
- Remember optimal positioning for the student is essential.
- Sit in front or to the side of the person you are assisting so you are at eye level, this encourages a forward head and chin position for safe eating and swallowing.
- Ensure you are comfortable and stable.
- Have equipment and utensils positioned within easy reach.

Positioning

Good posture while eating and drinking is essential. A comfortable, stable upright body position encourages better coordination of the muscles used to breathe, bite, chew and swallow. Good positioning is essential for safe eating, drinking and swallowing.

A stable upright and well aligned position allows more energy and effort to be concentrated upon the actual process of eating, drinking and swallowing. Anyone who eats or drinks in an awkward position can become at risk of *inhaling* food and/or fluid, or even choking.

Some people with eating, drinking and swallowing difficulties may have physical impairments which interfere with their ability to maintain a stable position. They may have problems with muscle tone, difficulty controlling and coordinating movements and possible muscle weakness. These difficulties can directly interfere with the ability to eat and drink safely and efficiently.

Attention to positioning and possibly the need for specialised equipment or adapted utensils may be required. Adequate time should be taken to ensure individuals are positioned optimally and that recommended equipment is used correctly.

Guidelines for optimal positioning at mealtimes:

- upright, straight body alignment
- some students may require a slight recline to provide additional support for both trunk and head (where advised)
- bottom and hips well back into the chair to provide a stable base for the trunk (eg use of pelvic strap)
- knees at around 90 degrees and comfortably apart (eg a pommel or padded wedge or block may be needed to help separate the knees)
- feet comfortably apart and resting on the floor or a support where possible (eg footstool or footplates on a wheelchair or highchair, AFO's and foot straps may be needed)
- head centred over the shoulders with an elongated neck, in a relaxed, upright and slightly chin-tuck position (remember head back will open the airway and swallowing is extremely difficult and unsafe)
- head on neck positioning can be assisted by a well-positioned head rest or even the use of a rolled towel, small cushion or even a neck brace or halo (where advised)
- shoulder straps, chest harness may provide added support where advised
- generally arms forward on the table or tray
- where possible, students should be encouraged to actively move slightly forward towards the food, spoon, or drink (this is part of the normal active process for eating or drinking)
- a small wedge cushion or angled seat base can assist this for students who have better trunk control and more active movement
- for students who are unable to do this, ensure positioning is optimal and head on neck alignment is suitable for swallowing (ie elongated neck and slight chin-tuck).



Refer to the [oral eating and drinking care plan](#) for documenting individual needs.

Assisted eating

Many people with eating difficulties are independent at mealtimes. Others need individual assistance, which can involve assistance with:

- positioning
- special eating techniques
- use of modified mealtime equipment such as a Manoy scooper plate
- fact sheet list.

Without assistance, some people may experience extra swallowing problems and complications from dysphagia.

Assisting someone to eat takes considerable time, energy and effort. Mealtimes are very often about socialising and sharing everyday information. Two-way communication creates a pleasant, positive and personal experience for the person being assisted as well as for the carer.



For further information about eating and drinking see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Further information

www.chess.sa.edu.au



A – Z Health Support Index

Airway	The natural passageway via the nose, mouth and throat for air moving in and out of the lungs. It needs to be closed during swallowing to prevent food/fluid entering the lungs.
Airway obstruction	Blockage of the airway due to foreign material in the airway or compression on the airway. This may be life threatening if not dislodged or removed.
Airway protection	Part of the airway is used for both breathing and swallowing so the airway must be protected when swallowing. This is a very complex process involving closure of the vocal folds, upward and forward movement of the larynx (voice box) and a downward action of the epiglottis to protect the open airway. Also upward and backward movement of the soft palate to prevent food and fluid entering the nose.
Altered consistency	Foods or fluids that have been modified in texture or consistency to make eating and swallowing easier.
Alternative feeding	If a person is unable to take in sufficient amounts of nutrients and or fluids for good hydration, nutrition and growth orally, alternative or supplemental feeding may be needed in the short or longer term. This may be via a nasogastric tube, gastrostomy or IV.
Aspiration	Inhalation or penetration of foreign material such as food, liquid or saliva into the airways or lungs below the level of the vocal folds.
Balanced diet	A diet which contains various foods from all the food groups (in adequate amounts).
Bolus	Food/drink which is shaped within the mouth into a soft pulverised and manageable mass, ready for swallowing.
Delayed swallow	The swallow reflex is not immediately triggered when food or fluid reaches the back of the mouth. Instead the reflex may only be triggered after a delay and or from deeper within the throat.
Dehydration	Loss of fluid from the body or inadequate fluid intake.

Glossary cont...

Drooling	Loss of food, fluid or saliva from the mouth. This may be due to poor lip closure and or inadequate swallowing.
Dysarthria	Weakness of the facial and or oral muscles, resulting in speech and/or eating, drinking and swallowing difficulties.
Dysphagia	Difficulty or inability in any of the stages of swallowing. There can be many causes including neurologic, structural, trauma, disease.
Enteral Feeds	A method of delivering nutrients to the body directly to the gastrointestinal tract via a tube.
Epiglottis	A cartilaginous structure at the base of the tongue and at the top of the larynx which closes over the larynx when swallowing to help protect the airway.
Gag	Gag or gag reflex is an automatic response of the body to help prevent foreign material or food or fluid entering the throat before it is ready to be swallowed. It is the opposite response of swallowing and used to assist expulsion of foreign objects, food and fluid.
Gastro-oesophageal reflux	A backflow of contents of the stomach into the food pipe or oesophagus. These gastric juices are acidic and can produce a burning pain in the oesophagus (eg heartburn).
Larynx	Or voice box is the structure at the top of the airway. It contains the vocal cords which produce the voice and also protect the airway and lungs by closing when we swallow. It also moves up and forwards under the epiglottis when we swallow to further protect the airway.
Nasal Regurgitation	Backward flow of food, fluid or saliva which enters the nasal cavity.
Oral Hygiene	Preserving and maintaining good oral health by optimal cleanliness of the oral cavity, teeth, gums and skin.
Oesophagus	Muscular tube (food-pipe or gullet) extending from the throat to the stomach. It carries food and fluid to the stomach using a wave like action. It has strong sphincter (circular) muscles at each end to prevent food and fluid from coming back up.

Glossary cont...

Oral	Of, or pertaining to, the mouth
Pharynx	Commonly referred to as the throat.
Penetration	Where food, fluid or saliva enters the larynx, above the vocal cords. This is usually cleared by swallowing, coughing or throat clearing. But can be potentially for some people if residue is not cleared effectively and can then be aspirated into the lungs.
Posture	Position of the body and limbs.
Protective Reflexes	Cough, gag and swallow are automatic responses or reflexes which are part of the body's defence mechanism to help protect it from harm.
Reflux	Backward or return flow. In swallowing it generally refers to food or fluid flowing upwards or back from the stomach into the oesophagus and or pharynx.
Residue	Debris or remainder of material which is left after the swallow. This can be within the oral cavity in the cheeks, palate or in the pockets of the throat.
Saliva	Secretions from the salivary glands which are essential for lubrication of the mouth and normal bolus formation and easy movement for swallowing.
Silent Aspiration	When food, fluid or saliva enters the airway with no outwards signs such as coughing.
Swallowing	Swallowing is one of the most complex, highly coordinated, efficiently and usually effortlessly performed actions. It takes only seconds and on average we swallow once a minute. We are usually unaware of the act of swallowing. It is the process by which liquids and or solids are moved from the mouth through to the oesophagus.
Swallow reflex	The swallow reflex is an automatic, involuntary reflex triggered by the brain stem when the back of the tongue pushes a bolus of food or liquid against the back of the throat.
Swallow stages	Swallowing is a very complex process and it can be broken into a series of overlapping steps or stages.

Glossary cont...

Stage 1 – Preparatory

Upright stable body position; food or fluid comes from below; we observe food or fluid as moves to the mouth, body moves slightly forward to take in food; chin is slightly tucked. Food or fluid is drawn and held within the mouth using the lips, jaws, cheeks and tongue. Food is chewed into tiny pieces and formed into a bolus.

Stage 2 – Oral

The bolus is pushed to the back of the mouth using a strong wave like action of the tongue. As this happens the soft palate moves up and the back of the throat comes forward to close off the nose and direct the bolus downwards. Chewing can take some time, but once the bolus is ready to be swallowed, moving it back in the mouth usually takes less than a second.

Stage 3 – Pharyngeal

Bolus moves towards the back of the tongue and throat and the swallow reflex is quickly and immediately triggered. This causes the airway to completely close, the larynx moves up and forwards and the oesophagus is pulled open and the bolus is pushed through with a strong wave like action of the throat or pharynx.

Stage 4 – Oesophageal

Relaxation and opening of the sphincters at either end and a smooth wave like muscle action to push the bolus down into the stomach. This action requires 3 key forces of strong pressure to push, good muscle action and also gravity to move the bolus down. This is the slowest phase.

Vocal Folds

Structures within the larynx which can move to vibrate and produce voice and also to block off the airway during swallowing.

3.7 Resources and references

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4 Transfers and positioning support

4.1 Transfers and positioning including the use of therapeutic equipment

Children and students may require assistance to be transferred (for example, from chair to toilet, chair to vehicle) or to be repositioned for comfort, safety and curriculum access. Such needs may be short-term (for example, a student who is in plaster) or long-term (for example, a student who has a physical disability). The level of assistance required will also vary. Some children and students may require supervision for safety and some guidance with their movement; others may be able to participate in transfers and positioning with staff assistance; while others may be fully dependent for all transfers and require the support of up to two assistants or the use of lifting equipment.

Care plan for transfers and positioning

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 transfer and positioning care plan is written by a physiotherapist (or other relevant health professional) to advise on safe, consistent work practices in the transfers and repositioning of children and students. The plan is developed specific to the needs of the child/student, relevant to the setting that has requested the care plan.

In developing the plan, the following factors should be considered:

- The needs of the child or student, the family, education and childcare workers and the therapists, as they relate to accessing the setting or curriculum/activities.
- The personal care needs of the child/student (for example toilet support).

- The goals of the child or student (for example to maximise the child's or student's abilities and independence, to minimise the risk of future orthopaedic problems).
- Child/student's comfort, dignity, independence and learning.

This care plan will form the basis of an individual child or student health support plan. The physiotherapist should be available to provide additional information, training, 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 (for example, toilet transfer)
- level of assistance required (such as standby assistance, cooperative assistance, total dependence)
- type of transfer or positioning required
- equipment required to perform transfer
- situational advice (for example, mobility skills indoors and outdoors, use of special equipment such as sticks and walking frames, or postural equipment for repositioning)
- communication between the worker and the child or student
- learning targets
- any documentation requested from workers (for example, an observation log)
- any other relevant information (for example, minimise muscle spasms by holding the child's or student's hips during transfer).

Various types of additional information can be attached to the plan. There may be some more detailed information about a particular transfer; a transfer and positioning log, in which observations are recorded; or further information about the child's or student's care and positioning needs.

Chest harnesses are used with some students to assist them to maintain upright posturing. Chest harnesses can potentially be a choking hazard: expert information on the safe use of harnesses must always be attached to the plan where there is a harness being used by the student.

The care plan should be readily accessible to all staff at all times. A new staff member should be familiar with and trained to implement a child's or student's care plan before they undertake any manual handling tasks with the child or student.

The staff members supporting the child or student should follow the care plan at all times, unless they consider that the safety of the child or student or their own safety is being compromised. If this is the case, the worksite manager should ensure the family and the physiotherapist who wrote the plan are informed as soon as possible. Changes to the care plan can then be negotiated with the physiotherapist and the family.



A proforma for the [transfer and positioning care plan](#) is available from [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Support plan for transfers and positioning

Duties which education and childcare workers agree to undertake to support an individual care plan should be based on the care plan; 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. 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, some worksites 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 site. 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 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.

The health support plan can be reviewed at any time if there are many issues or concerns regarding the safety of child/student or staff when conducting transfers documented in the current plan. The plan could be reviewed if:

- the student's skills deteriorate
- the student's skills improve
- there is a change of equipment for the student
- orthopaedic surgery is to occur
- there is transition to a new site and/or environmental changes e.g. upstairs classroom
- the staff/carer is having difficulty performing the transfer.

Staff members can be requested to document their observations to assist in the review of the plan. For example, a student may use standing transfers that are becoming increasingly difficult. The physiotherapist could request staff members to document their experiences in assisting the transfers over a few weeks, to gain a clearer picture of the student's abilities and difficulties. A decision would then be made by all people involved regarding whether it was safe to continue with standing transfers.

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.



For further information about planning transfers and positioning support see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

4.2

General principles when transferring and positioning

For children and students who have limited ability to change positions, optimal posturing and regular positional changes are essential.

Regular positional changes are required to:

- enhance comfort of child/student
- assist in prevention, minimisation or delay of joint or muscular tightness or development of deformities caused by spending prolonged periods in static and asymmetrical positions
- assist in prevention of pressure sores caused by too much pressure concentrated on one area of body
- provide a variety of experiences.

It is recommended that at least three positional changes are provided throughout the school day, but this can vary from one student to another, depending on the physical status of the child and other risk factors (for example, susceptibility to development of skin breakdown). Positional changes can include:

- lying on their front (supine), back (prone) or side
- sitting on the floor
- sitting in a seat
- standing.

If a child or student has a 'tilt in space' function built into their wheelchair, this can be regarded as another change of position. It is likely that considerable tilt is necessary before there is a measurable reduction in the pressure on the skin.

Optimal posturing in any of these positions is required to:

- ensure child functions at his or her best (for example, a child is going to be able to use their hands more effectively if their trunk and pelvis are well supported and aligned)
- promote interaction and communication
- reduce fatigue and enhance concentration
- facilitate oromotor control, respiration and digestion.

The use of a floor (corner) seat can allow the child to achieve a better sitting position on the floor and to be able to see and use his or her arms for play. The person providing support can then position themselves to interact with the child and assist him or her with the activity.

Positional equipment is often required to achieve positional changes and optimal posturing. Assessment by the child's physiotherapist is required to determine the most suitable equipment required and the program of use. Staff should always contact the physiotherapist if they have any concerns about the use of the prescribed equipment.

4.3

Communication during transfers and positioning

Just as communication is vital in all aspects of life, it is vital during transfers and positioning. If a child or student is moved without understanding what is happening, the experience is likely to be frightening and upsetting. Even though children and students will vary in the level of their responses to communication, that should not change whether or not you communicate with them. Some children and students are used to responding to specific words or phrases during transfers. If you are unsure about this, check with other staff members who are familiar with the child's or student's care.

The benefits of good communication during transfers are that the child or student:

- is more likely to assist and/or cooperate with the transfer
- becomes a participant in the transfer, rather than a passive recipient
- has the opportunity to practise communication in a meaningful way during everyday activities.

As communication is a two-way process, there are two sections on the care plan relating to its use: communication by the support worker and communication by the child or student.

Your communication with the child or student should take into account his or her level of understanding, if this is known. Some children and students will understand your message much better if, in addition to speaking to them, you use symbols, signs or gestures. For others, simplifying what you say will be sufficient.

The type of communication used by the child or student can also vary. Some children and students use speech as the primary method of communication. Others use what is termed Augmentative and Alternative Communication (AAC). This refers to any system a person uses to communicate, in addition to or instead of speech. Some examples of AAC are using pictures or symbols, gestures, eye-pointing, communication boards and electronic devices.

If unsure about how to communicate with a child or student, the best thing to do is to speak to the child's or student's family and speech pathologist. Other staff workers who have known the child or student for a long time should also be able to assist.

Therapists can provide workers with specific manual handling training related to implementation of an individual care plan.

This can include:

- top and tail transfer
- cradle transfer
- side to side transfer
- moving mechanical lifters
- applying hoist sling
- lifting a wheelchair into a car

- wheelchair to car-seat transfer
- working at low levels
- sitting on the floor
- lying positions
- sitting in a seat
- types of seats
- standing
- mobility and mobility equipment
- special considerations for early childcare workers.



For further information about transfers and positioning safe practice principles see [A – Z Health Support Index](#) on the *chess* website: www.chess.sa.edu.au.

Further information

www.chess.sa.edu.au



A – Z Health Support Index

4.4 Glossary

Abduction	Any limb movement away from the body sideways (for example, raising an arm or leg out to one side).
Adduction	Movement of limbs towards the body sideways (for example, ringing legs together).
Ambulator	A person who uses walking as his or her main method of mobility. There are two categories: <ul style="list-style-type: none">▪ community ambulator-walks indoors and outdoors for some activities, but sometimes uses a wheelchair for long trips▪ household ambulator-walks indoors with/without use of special equipment, frequently independent for transfers. Wheelchair is needed for community access.
Cerebral palsy	A disorder of posture and movement resulting from damage to the developing brain. It is non-progressive but not unchanging over time.
Contracture	Shortness of tendon, ligament and/or muscle, which limits joint movement.
Cooperative assistance	The person helps with the transfer according to the person's own abilities, but the transfer must be assisted by one or more adults to be successful.
Cradle lift	A transfer assisted by one person, where the child is cradled in his or her arms. Only recommended for use with small, light children (for example, 16kg or under).
Cross-legged sitting	Sitting on the floor with legs crossed in front.
Deformity	An abnormal position of any body part that cannot be corrected actively (by the person) or passively (by another person's hands or a splint).
Dependent assistance	The child or student is fully dependent upon the assistance of one or more adults for transfers.
Diplegia	Weakness or paralysis of the lower limbs but there may be some involvement, to a lesser extent, of the upper limbs.

Glossary cont...

Diplegia	Weakness or paralysis of the lower limbs but there may be some involvement, to a lesser extent, of the upper limbs.
Extension	Straightening of the limbs or body.
Extensor spasm	Increased tightness of the muscles which normally straighten the body and limbs (for example, extensor spasm in the arm muscles will straighten it out).
Flexion	Bending of the limbs, head or body
Flexor spasm	Increased tightness of the muscles that bend the body.
Half-ring sitting	Sitting on the floor with one leg straight and the other leg rotated outwards and bent at the knee.
Hemiplegia	Weakness or paralysis of the limbs on one side of the body.
Hypotonic	Lower than normal muscle tone, leading to an excessive amount of movement around joints.
Independent assistance	The child or student transfers by him or herself, while one or more adults stand by in case of unforeseen safety issues.
Kneeling	<ul style="list-style-type: none">▪ Four point—on hands and knees.▪ Upright—on knees only.▪ Half-kneeling—on one knee with the other bent and foot flat on the floor in front.
Long-sitting	Sitting on the floor with legs out straight in front.
Lunge position	A position adopted by assistants for transfers. It involves standing with your feet at least shoulder width apart. One foot points forwards, and the other foot points in the direction you are transferring towards.
Mechanical lift	A transfer assisted by two people using a hoist. One person operates the hoist while the other person guides the child's or student's position.
Paraplegia	Weakness or paralysis affecting the legs only. This term usually refers to paralysis after a spinal cord injury.

Glossary cont...

Passive movement	Movement performed by you using the child's or student's limbs or body (that is, bending and stretching the foot).
Pelvis	Muscles, bones and joints around the hips and lower back region.
Prone	Lying on the stomach.
Quadriplegia	Weakness or paralysis affecting all four limbs.
Rotation	Turning of the legs at hips, arms at shoulders, twisting of the trunk between shoulders and hips.
Side-to-side transfer	A transfer assisted by two people. One person supports and moves the left side of the child's or student's body and the other person supports and moves the right side of the child's or student's body in the direction of the transfer.
Spasticity	Increased stiffness or muscle tone felt in a person's limbs or trunk. The muscle spasm can often be felt as resistance when the body parts are moved. The limbs are hard to bend or straighten because of the spasticity of the muscles.
Standing transfer	A transfer assisted by one or two people, who support the child or student in standing. In order to use this transfer, the child or student must be reliable at taking his or her weight through the feet.
Supine	Lying on the back.
Top and tail lift	A transfer assisted by two people. One person supports and moves the upper part of the child's or student's body and the other person supports and moves the lower part of the child's or student's body in the direction of the transfer.
Triplesia	Weakness or paralysis affecting three limbs with one limb relatively spared.
Trunk	The part of the body between, and including, the shoulders and hips.

Health



chess Training

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



chess Research

Details of the research partnerships



chess A – Z Health Support Index

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



chess Education Services

Hospital (and other health) education services



chess Resource Materials

child health and education support services resources and forms