

MEDICAL CONDITIONS POLICY

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1. NQS

QA2	2.1.1	Each child's wellbeing and comfort is provided for, including appropriate opportunities to meet each child's need for sleep, rest and relaxation.
	2.1.2	Effective illness and injury management and hygiene practices are promoted and implemented.
	2.2.1	At all times, reasonable precautions and adequate supervision ensure children are protected from harm and hazard.

2 National Regulations

Regs	90	Medical conditions policy
	91	Medical conditions policy to be provided to parents
	92	Medication record
	93	Administration of medication
	94	Exception to authorisation requirement—anaphylaxis or asthma emergency
	95	Procedure for administration of medication
	96	Self-administration of medication

3 EYLF

LO3	Children are happy, healthy, safe and connected to others.
	Educators promote continuity of children's personal health and hygiene by sharing ownership of routines and schedules with children, families and the community
	Educators discuss health and safety issues with children and involve them in developing guidelines to keep the environment safe for all

4 Aim

The service and all educators can effectively respond to and manage medical conditions including asthma, cystic fibrosis, tube feeding, diabetes, HIV and anaphylaxis at the service to ensure the safety and wellbeing of children, educators and visitors.

5 Related Policies

The Kids' Uni Policies and Procedures apply to Kids' Uni North, Kids' Uni South, Kids Uni CBD, Kids Uni iC – Preschool, Kids Uni iC – OOSH.

Inclusion Policy (CHI-ADM-POL-003)

Death of a Child Policy (CHI-ADM-POL-014)

Emergency Management and Evacuation Policy (CHI-ADM-POL-020)

Enrolment and Booking Policy (CHI-ADM-POL-022)

Nutrition, Food Safety & Allergen Management Policy (CHI-ADM-POL-027)

Health, Hygiene and Cleaning Policy (CHI-ADM-POL-030)

Immunisation and Diseases Policy (CHI-ADM-POL-033)

Infectious Diseases Policy (CHI-ADM-POL-035)

UOW Pulse Ltd Privacy Policy (PUL-BUS-POL-013)

6 Implementation

- 6.1 The service will involve all educators, families and children in regular discussions about medical conditions and general health and wellbeing throughout our curriculum.
- 6.2 A copy of the Medical Conditions Policy must be available to all educators at the service. The policy must also be available to parents of children enrolled at the service, and a copy provided on enrolment. Educators, with the Nominated Supervisor, are responsible for raising any concerns with a child's parents about any medical condition known to the service, or any suspected medical condition that arises.
- 6.3 Any child enrolled at the service with anaphylaxis, allergies, diagnosed asthma or required medication will not be able to attend the service without medication prescribed by their medical practitioner. Families are required to provide this information on the Enrolment Form as outlined below and are responsible for updating the service on any new medication, ceasing of medication, or any changes to their child's prescription.
- 6.4 Families are required to provide information about their child's health care needs, allergies, medical conditions and medication on the Enrolment Form and are responsible for updating the service about of these things.
- 6.5 Information sharing between the family, the service and medical professionals is essential to provide consistent and appropriate care and support for all children with medical conditions.
- 6.5 All educators and volunteers at the service must follow a child's Medical Management Plan in the event of an incident related to a child's specific health care need, allergy or medical condition.
- 6.6 The service will adhere to privacy and confidentiality procedures when dealing with individual health needs.

7 Information that must be provided in the Enrolment Record

- 7.1 The service's Enrolment Form provides an opportunity for parents to help the service effectively meet their child's needs relating to any medical condition.
- 7.2 The enrolment record will include details of any:
 - i. Specific health care needs or medical conditions of the child, including, but not limited too, asthma, diabetes, allergies, tube feeding requirements, HIV, cystic fibrosis and whether the child has been diagnosed at risk of anaphylaxis.
 - ii. If a medical condition is identified, a Medical Management Plan should be provided by the child's parents and registered medical practitioner. This plan should:
 - a. Have supporting documentation if appropriate.
 - b. Include a photo of the child.
 - c. If relevant, state what triggers the allergy or medical condition.
 - d. Outline first aid needed.
 - e. Include contact details of the doctor who signed the plan.
 - f. State when the Plan should be reviewed.

- 7.3 Copies of the plan should be kept with the child’s medication and also accompany them on any excursions.
- 7.4 Where there is a Medical Management Plan, a risk minimisation plan must be developed and informed from the child’s Medical Management Plan.
- 7.5 Parents are responsible for updating their child’s Medical Management Plan/providing a new Plan as necessary and will be regularly reminded at least annually by the service to do this.
- 7.6 Any new information will be attached to the Enrolment Form and kept on file at the service. The Nominated Supervisor will ensure information that is displayed about a child’s medical conditions is updated.

8 Identifying Children with Medical Conditions and Communication Plan

- 8.1 Any information that is provided by families relating to medical conditions will be shared with the Nominated Supervisor, educators and any other staff member at the service. Individuals will be briefed by the Nominated Supervisor on the specific health needs of each child.
- 8.2 Information relating to a child’s medical conditions, including the child’s Medical Management Plan, Medical Conditions Risk Minimisation Plan, and the location of the child’s medication will be shared with all educators and displayed in the following areas of prominence to ensure all practices and procedures are followed accordingly.
 - i. Director’s Office
 - ii. All children’s playrooms
- 8.3 All educators at the service must follow a child’s Medical Management Plan in the event of an incident related to a child’s specific medical conditions requirements.
- 8.4 All educators at the service must be able to identify a child with medical conditions easily, by referring to a photo attached to the Medical Management Plan.
- 8.5 All educators and volunteers at the service must be able to locate a child’s medication easily. All Educators are made aware of the locations of medication by the Nominated Supervisor.
- 8.6 The Nominated Supervisor will ensure the display of information meets privacy guidelines. We will explain to families why this is important for the safety of the child and obtain parental consent.
- 8.7 Communication relating to medical conditions for children will include the following steps:

1	On enrolment, or as soon as a family becomes aware of a medical condition, the family will inform the Nominated Supervisor of the medical condition for the child and complete <i>Food Allergy and Medical Condition Notification Form</i> to outline the condition.
2	Nominated Supervisor will provide <i>Risk Minimisation Plan and Administration of Authorised Medication Form</i> for family to take to Medical Practitioner.
3	Family will return these forms, along with a Medical Management Plan, to the centre prior to child starting, or within one week if the child has an existing booking.
4	The Nominated Supervisor will update allergy charts and / or medical conditions summary and provide a copy to cooks and display on food trolleys, in each classroom and add to the folder in the Directors office.

5	Nominated Supervisor will display Medical Management Plan in each classroom
6	Nominated Supervisor will provide copies of Medical Management Plans, <i>Risk Minimisation Plans</i> and <i>Administration of Authorised Medication Form</i> for all educators to read. Once read, educators will sign off on <i>Form 42 – Staff Communication and Sign Off Sheet</i>
7	If changes occur to the child’s condition or the medical plans, the family will inform the Nominated Supervisor immediately and provide updated medical plans. The Nominated Supervisor will provide copies of Medical Management Plans, <i>Risk Minimisation Plans</i> and <i>Administration of Authorised Medication Form</i> for all educators to read. Once read, educators will sign off on <i>Form 42 – Staff Communication and Sign Off Sheet</i> to acknowledge that they are aware of the updated information.
8	In addition to regular conversations between the Nominated Supervisor, Educators and families, the centre will formally request updates to medical conditions information through re-enrolment annually and also through our communication platforms, such as <i>Kinderloop</i> or <i>Hubworks</i> throughout the year.

Please refer to the *Food Allergy and Medical Conditions Checklist and Communication Plan Form* (Form 20) to support this communication process.

9 Medical Conditions Risk Minimisation Plan

- 9.1 Each child with a medical condition will need to have a Medical Management Plan developed with the child’s family and signed off by a Medical Practitioner. The service will use the child’s Medical Management Plan, to also develop a Medical Conditions Risk Minimisation Plan in consultation with the child’s parents and Medical Practitioner, this will ensure that:
- i. Any risks are assessed and minimised.
 - ii. If relevant, practices and procedures for the safe handling of food, preparation, consumption and service of food for the child are developed and implemented. (note we will follow all health, hygiene and safe food policies and procedures)
 - iii. All parents are notified of any known allergens that pose a risk to a child and how these risks will be minimised.
 - iv. A child does not attend the service without medication prescribed by their medical practitioner in relation to their specific medical condition.
- 9.2 Our service will provide support and information to all parents and other members of our community about resources and support for managing allergies, anaphylaxis asthma and diabetes.
- 9.3 Our service will review each child’s medication monthly to ensure it hasn’t expired.

10 Medical Conditions Risk Minimisation Plan: Anaphylaxis/Allergy Management

- 10.1 Anaphylaxis is life threatening. Anaphylaxis is a severe allergic reaction to a substance. While prior exposure to allergens is needed for the development of anaphylaxis, severe allergic reactions can occur when no documented history exists. We are aware that allergies are very specific to the individual and it is possible to have an allergy to any foreign substance.

- 10.2 Anaphylaxis is usually caused by a food allergy. Foods most commonly associated with anaphylaxis include peanuts, seafood, nuts and in children eggs and cow's milk. While developing the Medical Conditions Risk Minimisation Plan and to minimise the risk of exposure of children to foods that might trigger severe allergy or anaphylaxis in susceptible children, our service will:
- i. Not allow children to share food, utensils or food containers.
 - ii. Prepare food in line with a child's medical management plan and family recommendations.
 - iii. Request families to label all bottles with their child's name.
 - iv. Consider whether it's necessary to change or restrict the use of food products in craft, science experiments and cooking classes so children with allergies can participate.
 - v. Instruct educators on the need to prevent cross contamination.
 - vi. Request all parents not to send food with their children that contain highly allergenic elements even if their child does not have an allergy by, placing a sign on the door of each room and the kitchen reminding families about this.
 - vii. As eggs and nuts are very common allergens, the service will have an "Allergy-Aware Egg and Nut policy (refer to Kids' Uni Allergy Management Procedure) which would exclude children or other individuals visiting the service from bringing any foods or products containing nuts or nut material such as :
 - a. Peanuts, brazil nuts, cashew nuts, hazelnuts, almonds, pecan nuts.
 - b. Any other type of tree or ground nuts, peanut oil or other nut based oil or cooking product, peanut or any nut sauce, peanut butter, hazelnut spread, marzipan.
 - c. Any other food which contains nuts such as chocolates, sweets, lollies, nougat, ice creams, cakes, biscuits, bread, drinks, satays, pre-prepared Asian or vegetarian foods.
 - d. Cosmetics, massage oils, body lotions, shampoos and creams such as Arachis oil that contain nut material.
 - viii. Be aware that a child may have a number of food allergies or there may be a number of children with different food allergies, and it may not be possible to have an allergy free policy for all those foods involved. Nut allergy is the most likely to cause severe reaction and will take precedence.
 - ix. When possible, hold non-allergic babies when they drink formula/milk if there is a child diagnosed at risk of anaphylaxis from a milk allergy.
 - x. Instruct food preparation staff and volunteers about measures necessary to prevent cross contamination between foods during the handling, preparation and serving of food, such as careful cleaning of food preparation areas and utensils.
 - xi. Closely supervise all children at meal and snack times and ensure food is eaten in specified areas. To minimise risk children will not be permitted to 'wander around' the service with food.
 - xii. Ensure meals prepared at the service do not contain ingredients such as eggs or nuts.
 - xiii. Consult risk minimisation plans when making food purchases and planning menus.

- 10.3 Allergic reactions and anaphylaxis are also commonly caused by:
- i. All types of animals, insects, spiders and reptiles.
 - ii. All drugs and medications, especially antibiotics and vaccines.
 - iii. Many homeopathic, naturopathic and vitamin preparations.
 - iv. Many species of plants, especially those with thorns and stings.
 - v. Latex and rubber products.
 - vi. Band-Aids, Elastoplast and products containing rubber based adhesives.
- 10.4 Our service will ensure that body lotions, shampoos and creams used on allergic children are approved by their parent.
- 10.5 Risk minimisation practices will be carried out to ensure that the service is to the best of our ability providing an environment that will not trigger an anaphylactic reaction. These practices will be documented and reflected upon, and potential risks reduced if possible.
- 10.6 The service will display an Australasian Society of Clinical Immunology and Allergy inc (ASCIA) generic poster called Action Plan for Anaphylaxis in a key location at the service, for example, in the children's room, the staff room or near the medication cabinet <http://www.allergy.org.au/content/view/10/3/#r1>
- 10.7 Our service will ensure that the auto-injection device kit is stored in a location that is known to all educators, other staff and including relief educators, easily accessible to adults (not locked away), inaccessible to children, and away from direct sources of heat.
- 10.8 Educators should be on the lookout for symptoms of an allergic reaction as they need to act rapidly if they do occur. If a child is displaying symptoms of an anaphylactic reaction our service will:
- i. Call an ambulance immediately by dialling 000.
 - ii. Ensure the first aid trained educators/educators with approved anaphylaxis management training provides appropriate first aid which may include the injection of an auto immune device EpiPen® in line with the steps outlined by the Australian Society of Clinical Immunology and Allergy <http://allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis> and CPR if the child stops breathing.
 - iii. Contact the parent/guardian or the person to be notified in the event of illness if the parent/guardian cannot be contacted.

11 Medical Conditions Risk Minimisation Plan: Asthma Management

- 11.1 Asthma is a chronic lung disease that inflames and narrows the airways. While developing the Medical Conditions Risk Minimisation Plan our service will implement procedures where possible to minimise the exposure of susceptible children to the common triggers which can cause an asthma attack. These triggers include:
- i. dust and pollution
 - ii. inhaled allergens, for example mould, pollen, pet hair
 - iii. changes in temperature and weather, heating and air conditioning
 - iv. emotional changes including laughing and stress
 - v. activity and exercise

- 11.2 A Medical Management Plan and Risk Minimisation Plan will be completed for each child with asthma. In addition, practices will be carried out to ensure that the service is, to the best of our ability, providing an environment that will not trigger an asthmatic reaction. These practices will be documented and reflected upon, and potential risks reduced if possible.
- 11.3 The service will display an Asthma chart called First Aid for Asthma Chart for under 12 years or Asthma First Aid in a key location at the service, for example, in the children's room, the staff room or near the medication cabinet <http://www.nationalasthma.org.au/uploads/content/22-NAC-First-Aid-for-Asthma-Chart-Kids-FINAL.pdf> or <http://asthmaaustralia.org.au/wp-content/uploads/2012/07/AA-Live-Well-with-Asthma-0512-WEB.pdf>
- 11.4 An asthma attack can become life threatening if not treated properly. If a child is displaying asthma symptoms, our service will ensure first aid trained educators/educators with approved asthma management training immediately attends to the child.
- 11.5 If the procedures outlined in the child's medical management plan do not alleviate the asthma symptoms, or the child does not have a medical management plan, the educator will provide appropriate first aid, which may include the steps outlined by Asthma Australia as follows:
- i. Sit the child upright and stay with the child and be calm and reassuring
 - ii. Give 4 puffs of blue reliever puffer medication
 - a. Use a spacer if there is one
 - b. Shake puffer
 - c. Put 1 puff into spacer
 - d. Take 4 breaths from spacer
 - e. Repeat until 4 puffs have been taken
 - f. Shake, 1 puff, 4 breaths
 - iii. Wait 4 minutes, if there is no improvement, give 4 more puffs as above
 - iv. If there is still no improvement call emergency assistance 000
 - a. Keep giving 4 puffs every 4 minutes until emergency assistance arrives
 - v. Contact the child's parent or authorised contact where the parent cannot be reached.
- 11.6 The service will ensure that an asthma First Aid Kit is stored in a location that is known to all educators, other staff including relief educators, easily accessible to adults (not locked away), inaccessible to children, and at room temperature in dry areas. An Asthma First Aid kit should contain:
- i. Blue or grey reliever puffer.
 - ii. A spacer device that is compatible with the puffer.
 - iii. A face mask compatible with the spacer for use by children under 5.
 - iv. 70% alcohol swabs for cleaning devices. Note puffers, spacers and face masks from the Kit must be thoroughly cleaned after each use, if they are reusable, to prevent cross contamination. To clean:
 - a. Remove canister from puffer and wash device (but not canister) in warm water with kitchen detergent.
 - b. Do not rinse or rub dry, allow devices to air dry.

- c. When dry, wipe the mouth piece inside and outside with a 70% alcohol swab.
- d. When completely dry, replace the canister and ensure puffer is working correctly.

12 Medical Conditions Risk Minimisation Plan: Diabetes

- 12.1 Diabetes is a chronic condition where the levels of glucose (sugar) in the blood are too high. Glucose levels are normally regulated by the hormone insulin.
- 12.2 The most common form of diabetes in children is type 1. The body's immune system attacks the insulin producing cells so insulin can no longer be made. People with type 1 diabetes need to have insulin daily and test their blood glucose several times a day, follow a healthy eating plan and participate in regular physical activity. See <http://www.diabeteskidsandteens.com.au/whatisdiabetes.html> for an online presentation for children explaining how diabetes affects the body.
- 12.3 Type 2 diabetes is managed by regular physical activity and healthy eating. Over time type 2 diabetics may also require insulin.
- 12.4 While developing the Medical Conditions Risk Minimisation Plan our service will implement procedures where possible to ensure children with diabetes do not suffer any adverse effects from their condition while at the service. These include ensuring they do not suffer from hypoglycaemia (have a "hypo") which occurs when blood sugar levels are too low. Things that can cause a "hypo" include:
 - i. A delayed or missed meal, or a meal with too little carbohydrate
 - ii. Extra strenuous or unplanned physical activity
 - iii. Too much insulin or medication for diabetes
 - iv. Vomiting
- 12.5 Children with Type 1 diabetes may also need to limit their intake of sweet foods. Our service will ensure information about the child's diet including the types and amounts of appropriate foods is part of the child's Medical Management Plan and that this is used to develop the Risk Minimisation Plan.
- 12.6 Staff will not be injecting children with insulin if diabetic as staff are not trained medical officers qualified to undertake this procedure. In the event of major concerns regarding insulin levels of a child then an ambulance will be called.
- 12.7 If a child is displaying symptoms of a "hypo" our service will:
 - i. Ensure the first aid trained educator provides immediate first aid which will be outlined in the child's medical management plan and may include giving the child some quick acting and easily consumed carbohydrate.
 - ii. Call an ambulance by dialling 000 if the child does not respond to the first aid and CPR if the child stops breathing.
 - iii. Contact the parent/guardian or the person to be notified in the event of illness if the parent/guardian cannot be contacted.

13 Risk Minimisation Plan: Cystic Fibrosis (CF)

- 13.1 The Nominated Supervisor will ensure that all educators have an understanding of this condition and the additional needs of a child with CF.
- 13.2 For each child enrolled in the service with CF, a Medical Management Plan will be developed by the Nominated Supervisor in conjunction with the child's family and medical practitioner. It will be based on the child's health support needs as identified in their CF care plan and other care information (for example if the child also has asthma or diabetes).
- 13.3 A Medical Management Plan for a child with cystic fibrosis should address the following components:
- i. overall wellness - there may be frequent hospitalisation or additional infection control issues. Families may need to be notified if there is a virus present in the service as they may choose to keep their child at home.
 - ii. diet - children with CF have difficulty maintaining their weight and growth patterns as they cannot absorb vitamins, fat and proteins. Dietary plans may need to be put in place by a medical practitioner. Children who need additional food supplements may receive them through a gastrostomy button located in their stomach. There are no routine care issues associated with a gastrostomy button however if the area becomes red or inflamed parents should be informed immediately.
 - iii. therapy and care - there may be a visiting physiotherapist who supports the child while in the service.
 - iv. internal body temperature control – a child with CF will have problems with internal temperature control and may need to be reminded to adjust their clothing to help maintain their temperature. Temperature controlled classrooms are beneficial to a child with CF. Sal tablets may also be required during warm weather.
 - v. curriculum participation issues – increased fatigue or feeling tired is common for a child with CF. Adequate rest opportunities need to be provided. During periods of infection a child with CF may have difficulty breathing, they will also experience low energy levels and reduced concentration. Regular exercise is beneficial to children with CF, it stimulates coughing and builds up strength and endurance of the breathing muscles. Children with CF can also become dehydrated quickly, frequent drinks and maintaining consistent body temperature are important.
 - vi. potential emergency/first aid situations – emergency situations associated with CF are rare. If children have an intravenous line for medication there may be first aid responses which need to be documented and included in the Medical Management Plan.
- 13.4 The information should focus on what educators need to know to provide routine and emergency care. It will be used by educators in planning support for the child.

In addition, a medical management plan documents individualised support which educators have agreed to provide in the areas of:

- i. first aid
- ii. supervision for safety
- iii. personal care, including infection control
- iv. behaviour support and
- v. additional curriculum support to enable continuity of education and care.

14 Skin Complaints

- 14.1 Rashes are common in children. They can be caused by many different viral infections and may not be infectious. It is important to be able to describe the rash as this may help with diagnosis.
- 14.2 When viewing a rash educators should also consider if the child is unwell. The rash may not affect the child's well-being at all.
- 14.3 There are however, usually other signs and / or symptoms to consider in conjunction with a rash. These might include:
 - i. Fever
 - ii. Unusual behaviour (cranky or less active; cries more than usual; seems uncomfortable; just seems unwell)
 - iii. Loss of appetite
 - iv. Vomiting;
 - v. Headache; stiff neck
 - vi. Frequent scratching
 - vii. Crusty skin / discharge from skin
 - viii. Diarrhoea
 - ix. Severe, persistent or prolonged cough
 - x. Trouble breathing
 - xi. Dark, tea coloured urine
 - xii. Grey or very pale faeces

15 When observing the Rash

- 15.1 When observing the rash the following signs should be considered?
 - i. What colour is the rash (dark red like a blood blister? Pink? Red?)
 - ii. What does the rash look like? Small, red, pinheads / fine and lacy / large red blotches / solid red area all joined together / blisters
 - iii. How does the rash feel to touch? Raised slightly, with small lumps / swollen
 - iv. Is the rash itchy?
 - v. Where on the body did the rash start? (eg:- head, neck?)
 - vi. Where is the rash now? (eg:- head, neck, abdomen, arms, legs?)

16 Heat Rash

Educators are to remove outer layers of clothing from a child and allow the child to cool down. Rash should be checked again in half an hour to see if disappearing.

17 Reporting of Rashes

- 17.1 All rashes should be checked by other room educators to get a consensus on what it might be and whether there is cause for concern for the child's health (and potentially that of the other children and also educators).
- 17.2 After doing this then the Nominated Supervisor should be consulted for a final decision on whether it is suitable for the child to remain at the service.
- 17.3 All rashes should be documented on the "illness form". Staff must regularly check the appearance of the rash and note time and any changes on the form. This is important information a doctor may need.
- 17.4 If concern is expressed about the rash then the child must be isolated from others until the parent can collect the child from the centre. If educators are concerned about serious symptoms in conjunction with the rash or perhaps the rash being purple, or spreading very quickly, then an ambulance must be called.
- 17.5 Meningitis is a dangerous disease that affects children and youth very rapidly. Hospital treatment is imperative. Meningitis can occur at any time but seems to peak around September / October each year.
- 17.6 If in doubt as to a child's wellbeing with regards to a rash then always call the parent immediately.

18 Eczema

- 18.1 In the case where children have eczema then an initial doctor's certificate must be produced stating this. The centre staff will then follow any treatment prescribed by the Doctor.
- 18.2 A child with eczema is not excluded from attending as this is a chronic condition that has to be managed.

19 Nappy Rash

- 19.1 Nappy rash commonly happens when a baby's skin is exposed to wet or dirty nappies for too long. Urine is sterile (there are no germs in urine). However, germs on the baby's skin and in the nappy can change chemicals in urine into other chemicals. These include chemicals such as ammonia, which is very irritating to skin. Leaving a wet nappy on a baby for long periods of time can make the rash worse.
- 19.2 Some babies get nappy rash no matter how well they are cared for. Others do not get nappy rash, even when they are not changed very often. Some babies may have very sensitive skin and rashes on other parts of their bodies. Others may have infections, such as thrush, which make the rash worse. Some babies only get nappy rashes when they have a cold or some other viral illness.
- 19.3 Most cases of nappy rash can be treated successfully at home.

19.4 Educators should advise the parent if the baby's nappy rash looks severe, is hurting the baby or doesn't clear up within a few days. The baby should be taken to a doctor for a check and medical clearance in that situation.

19.5 The signs of nappy rash include:

- i. Inflamed skin – the skin around the genital area and anus looks red and moist.
- ii. Blistering – the skin may blister and then peel, leaving raw patches (ulcers).
- iii. Spreading – the rash can spread onto the tummy and buttocks.
- iv. Ulcers – small ulcers can sometimes form on healthy skin near the area of the rash.

All of this damage to the skin is very sore and the baby can be very unsettled, especially when they pass urine that comes into contact with the rash. Many babies with nappy rash do not sleep well, waking often due to pain.

19.6 Common causes of nappy rash include:

- i. Sensitive skin
- ii. A trigger factor or 'agent'

19.7 Sensitive skin

Babies who have rashes on other parts of their bodies, such as cradle cap or eczema (on the face or under the chin), are more likely to get nappy rash. – This tendency is often inherited – other members of the family may also have had rashes including nappy rash.

19.8 Some things can trigger nappy rash, including:

- i. Ammonia – chemicals in urine may be changed into ammonia, which 'burns' the skin.
- ii. Thrush (candida) – thrush exists in faeces (poo) normally but the levels rise sometimes without obvious causes. This can occur when a baby needs antibiotics for another infection. Thrush can make a nappy rash much redder and more painful.
- iii. Chemical exposure – chemicals in nappy-soaking solutions, laundry detergents and fabric softeners can irritate the skin of very sensitive babies. Some baby wipes may cause irritation if they contain alcohol. Some scented soaps or baby lotions can also irritate the skin of some babies.
- iv. Plastic pants – these may keep the baby's clothes clean and dry, but they prevent airflow. Because the clothes do not get wet, a baby may be left in a wet or dirty nappy for a long time and this keeps the baby's skin wet.
- v. Friction or rubbing – rough nappies can rub and chafe at the baby's sensitive skin.

19.9 Suggestions to treat or prevent nappy rash include:

- i. Change baby more frequently.
- ii. Use disposable nappies, which absorb the urine quickly and leave the surface of the nappy (that is next to the skin) dry.
- iii. Use only soaps made for babies and baby wipes that do not have alcohol in them. Wipes made for babies do not have alcohol but adult wipes often do. Alcohol stings badly on damaged skin.)
- iv. Clean baby's bottom with plain water at nappy changes. If this does not clean the skin well enough, try sorbolene cream – a simple and soothing cream.

- v. Use a barrier cream, such as zinc and cod liver oil or zinc and castor oil, to keep wetness away from baby's skin.
 - vi. Make sure cloth nappies are changed often and, whenever possible, do not put plastic pants over them.
 - vii. Rinse thoroughly all washed nappies to remove traces of detergents and other chemicals. Then, if possible, dry them in a tumble drier – this makes them much softer than drying them in the sun.
 - viii. Don't put a nappy on baby whenever practical.
 - ix. Give pain relief if necessary. Rashes such as nappy rash are very painful, especially when urine gets onto them.
 - x. Seek medical advice.
- 19.10 If the baby's nappy rash doesn't improve after a few days, see a doctor. The nappy rash may be infected (for example, by thrush) or baby's skin may be very sensitive.
- 19.11 If the doctor suggests creams for thrush or steroid creams (such as hydrocortisone cream), follow the directions for use. Wash the skin well, put a thin layer of the cream on, then (after a couple of minutes) cover the skin and the cream with a barrier cream, such as zinc and cod liver oil. (Note: zinc creams leave stains on nappies and clothes. Many people use disposable nappies while treating nappy rash.)

20 Human Immunodeficiency Virus Infection (HIV) and the AIDS Virus

- 20.1 Children with the HIV virus will be accepted into the service.
It is the Nominated Supervisor's responsibility to educate and inform educators, other staff and parents about HIV/AIDS. One of the main problems surrounding HIV/AIDS is a lack of understanding which leads to an unfounded fear to the virus.
- 20.2 The following provides basic information on HIV/AIDS -
- i. AIDS is a medical condition which can damage a bodies' immune system.
 - ii. It is caused by a virus which is transmitted through the exchange of bodily fluid and is primarily passed on through sexual contact.
 - iii. The AIDS virus can be transmitted through blood products. However, the risk of contracting AIDS from a blood transfusion is minimal and said to be about one in 1,000,000.
 - iv. There is no evidence of the spread of the virus to children through other means at this time.
- 20.3 The confidentiality of medical information must be adhered to regarding an infected child.
- 20.4 Educators will carry out routine hygiene precautions at all times to prevent the spread of any infections by following the service's relevant policies and procedures.
- 20.5 Educators will exercise care in regards to the exposure of bodily fluids and blood and the service's hygiene practices will be used to prevent the spread of infection. Similarly, if the need arises to perform CPR on a child infected with HIV a disposable mouth to mouth mask will be used.

- 20.7 Children who have abrasions or open wounds will cover them while at the service. If these abrasions cannot be covered for any reason unfortunately the child will have to be excluded from the service until the wound has healed or can be covered.
- 20.8 Educators and other staff who have been infected by HIV are not obliged to inform their employer but are expected to act in a safe and responsible manner at all times to minimise the risk of infection.
- 20.9 No child, educator, other staff, parent or other visitor to the service will be denied First Aid at any time.

21 Tube Feeding

- 21.1 Tube feeding may be required if a child demonstrates:
 - i. Difficulty in swallowing.
 - ii. Severe gastro-oesophageal reflux.
 - iii. Poor gag reflex
 - iv. Recurrent aspiration of food and fluids into the lungs.
 - v. Obstruction of the esophagus.
 - vi. Under nutrition and/or hydration.

- 21.2 There are four types of tube feeding:
 - i. Gastrostomy - Surgical creation of an opening into the stomach to provide for administration of food for those that cannot swallow. This method is used if the feedings are to be long term and the stomach is functioning normally.
 - ii. Jejunostomy- Surgical creation of a permanent opening, performed between the surface of the jejunum and the abdomen wall. This is usually done when the stomach cannot function normally.
 - iii. Nasogastric- A soft silicone tube inserted through the nostril down the esophagus and into the stomach, usually for short term medication.
 - iv. Skin level gastrostomy device- a plastic device that sits on the abdomen inserted through a gastrostomy in place of a tube.

Note - Nutrition is supplied in form of liquid formulas or a dissolvable form only. Tube feeding may be used for medication and / or nutrition.

- 21.3 Any child who is to be tube fed at the service must provide a Medical Management Plan from a medical practitioner to guide educators through the process and to outline actions to be taken in an emergency. The plan should also include guidance around the use and expiry of formula, any oral hygiene procedures and care and / or cleaning of the equipment.
- 21.4 Educators will be trained in this procedure before placement of child/ren. Training will be relevant and specific to procedure and equipment used. Re-training must occur on a periodic basis to ensure currency of knowledge.

- 21.5 If any problems, reactions or doubts arise during the procedure, educators must call the ambulance on phone number **000**.
- 21.6 The area of administration must be clear and free of any obstructions. Two educators will:
- i. Re-check the dosage and details of the medication or medical procedure immediately before it is given to the child.
 - ii. Follow the medical procedure as outlined by the child's Doctor, Specialist or Parent.
 - iii. Follow the appropriate sterilisation procedure as outlined by the Health Professional/Medical Practitioner.
 - iv. Discard any disposable equipment appropriately, as outlined by the Parent, Doctor or Specialist. A medical sharps container is required for used needles and syringes.
- 21.7 Educators will secure the positioning of the equipment and ensure that other children cannot access the equipment during feeding.

22 Educator Training and Qualifications

- 22.1 The approved provider must ensure that at least one educator attending the service:
- i. Holds a current approved first aid qualification.
 - ii. Has undertaken current approved anaphylaxis management training and
 - iii. Has undertaken current approved emergency asthma management training
- 22.2 Our staffing Arrangements Policy has more details about educator training and qualifications in this area.
- 22.3 Educators in our service recognise how serious anaphylaxis is and will undertake steps to minimise the possibility of occurrence. The service will maintain the following in relation to educator qualifications for anaphylaxis:
- i. All educators in all services whether or not they have a child diagnosed at risk of anaphylaxis undertakes training in the administration of the adrenaline auto-injection device and cardio- pulmonary resuscitation.
 - ii. Educators must be employed by us for 6 months before they can serve food to children.
 - iii. Trainees are not trained and therefore are not permitted to serve food to children.
 - iv. Educators will not serve food to children until they have signed the *Staff Declaration – Providing Meals to Children form (Form 35)*.

23 Supervised Self-Administration of Medication by Children over Preschool Age

- 23.1 The service permits children of school age to self-administer medication.
- 23.2 Educators must supervise the child during this process. To promote consistency and ensure the welfare of all children using the service, educators will ensure each child follows all administration of medication, health and hygiene policies and procedures.
- 23.3 The self-administration of medication must be negotiated with, and approved by the child's parents. This information will be detailed in the child's Medical Management Plan and the Medical Conditions Risk Minimisation Plan if appropriate, and the location of the child's medication for self-administration must also be noted and made available to educators.

23.4 The service will record all instances of supervised self-administration of medication as per the Administration of Medication Policy.

24 Sources

Education and Care Services National Regulations 2011

National Quality Standard

Asthma Australia

National Asthma Organisation

Australasian Society of Clinical Immunology and Allergy www.allergy.org.au

Australian Diabetes Council

Anaphylaxis Australia

www.betterhealth.vic.gov.au

Westmead Children's Hospital – information site

Staying Healthy in Child Care 5th Edition, National Health and Medical Research Council

25 Review

The policy will be reviewed every 2 years, or as needed. The review will be conducted by:

- Management, Employees, Families and Interested Parties

26 Version Control Table

Version Control	Date Released	Next Review	Approved By	Amendment
1	August 2012	August 2013	Michele Fowler Manager – Kids Uni	
2	March 2013	August 2013	Michele Fowler Manager – Kids Uni	Paragraph inserted re application of policies across all centres. Migrated into new QA format. This policy replaces the Skin Complaints and Rashes Policy and the Asthmatic Policy.
3	August 2013	August 2014	Michele Fowler Manager – Kids Uni	12.6 removed wording "Our service will ensure our first aid trained educator is trained in the use of the insulin injection device (syringes, pens, pumps) used by children at our service with diabetes." And replaced with Staff will not be injecting children with insulin if diabetic as staff are not trained medical officers qualified to undertake this procedure. In the event of major concerns regarding insulin levels of a child then an ambulance will be called. Minor editorial changes made.
4.	Aug 2014	Aug 2017	Michele Fowler Manager – Kids Uni	Reviewed with no changes required
5.	Feb 2018	Feb 2021	K.Grose – Children's Services Manager	Updated references to NQS Updated conditions for educators serving food.
6.	Jul 2018	Jul 2020	K.Grose – Children's Services Manager	Added detail to communication plan. Combined HIV, Tube Feeding and Cystic Fibrosis Policies into this one policy.