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| **Norfolk Fostering Service – Health and Medication** |
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**SCOPE OF THIS CHAPTER**

1989 Children Act

Children and Young Persons Act 2008

Care Planning Placement and Case Review (England) Regulations 2010 Fostering Services (England) Regulations 2011

Special Guardianship Guidance, DfES 2005

Family and Friends Care: Statutory Guidance for Local Authorities 2010

National Minimum Standards for Fostering 2011

Working Together to Safeguard Children 2010

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 **1.** **Principles**

All foster carers will ensure that all medication is kept in a safe place

All foster carers will receive guidance on the administration of medication

All foster carers will keep a written record of all medication, treatment and first aid administered to a young person.

All foster carers will be trained in emergency first aid

All foster carers will ensure that the full course of any prescribed medication is taken.

**2.** **Introduction**

Government guidance on the health of children in care quotes research which shows that Looked After Children and young people share many of the same health risks and problems as their peers, but to a greater degree. Children often come into care with a worse level of health than their peers and the longer term outcomes are also worse for them. They show significantly higher rates of mental disorders, even when compared to children at home in the most deprived groups.

The most common disorders are of conduct, followed by anxiety and depression and hyperactivity. Children in care are more likely to experience bedwetting, coordination difficulties and problems with their sight, speech and language than their peers.

Some aspects of young people’s health have been shown to worsen in the year after leaving care. They are nearly twice as likely to have problems with drugs or alcohol and to report mental health problems during this time.

This underlines just how important it is to attend to the health of children in care.

The Government’s statutory guidance on health matters, “The Health of Looked After Children”, should be read online at: - [**www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-01071-2009**](http://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-01071-2009) .

**3.** **Health assessments**

The key process for doing this is the Health Assessment. All Looked After Children should have one.

The health practitioner who has responsibility for carrying out the assessment has a duty of clinical care to the child. This includes referring the child for any investigations or treatments for conditions that are identified in the assessment. This duty of care continues even if the child is in care for a short time only and after the child returns to live at home. Once an assessment has been done and a plan agreed, it does not cease to exist because the child is no longer in care.

The assessment is carried out when all the information about a child’s health and family history has been gathered. Foster carers will be part of this process of information gathering. Those carrying out the assessment will want to talk to the child as well and there may be a need for a physical examination in some cases. Carers will be expected to cooperate by sharing information and taking the child to any appointments.

The assessment should also provide an opportunity for carers to ask any questions and talk about any health worries they have about the child.

The purpose of the assessment is to:

* give an opportunity to redress any previous neglect of the child’s health
* gather information about the child’s and the family’s health history
* find out whether the child has missed the normal check ups, including dental appointments and whether all the immunisations are up to date
* identify any current health, mental health, emotional and behavioural problems
* recognise any learning or developmental concerns
* ascertain any outstanding appointments or place on any waiting lists
* give advice about any existing health problems and risk factors
* discuss ‘lifestyle issues’
* plan any action and ensure that the recommendations are carried out.

At the end of the assessment a personal health plan will be agreed. This will include the arrangements for further reviews.

**Foster carers/workers responsibilities**

Foster carers/workers will be expected to:

* keep the child with their own doctor and dentist wherever possible and to arrange and accompany them to any appointments with them and any other specialist appointments that the child already has or may need during the time they are with you, unless they are old enough to do this on their own
* where it is not practicable to stay with the same doctor and dentist or if the child is going to stay with you permanently, to register the child with your own doctor and dentist
* take part fully in the Health Assessment
* chase up the child’s social worker if you do not have the information you need about the child’s health, record of immunisations, allergies, medical history etc and any significant aspects of the parent’s medical history
* act as an advocate for the child’s health needs by acting on the recommendations that relate to you in the health plan and alerting the child’s social worker and relevant health professionals to any concerns you have about your foster child’s health
* take the child to any appointments with their doctor as a result of the request for a medical report for statutory Looked After Children’s reviews
* ensure that the child takes all the medication and follows any treatments that are prescribed for them
* maintain a written record of the child’s medical history while they are with you, including appointments, courses of medicine and treatments that have been prescribed and a record any accidents
* encourage the child to participate in the development and review of their health plan and to make sure that they understand and have information about any conditions they have and any significant conditions that may be in their family background
* not to allow young children to get sunburnt by using sun screen and a hat whilst encouraging them to enjoy being outdoors and in the sun
* respect the confidentiality of their health information
* set an example themselves by following a healthy lifestyle and adhering to the best available and most recent health advice.

Foster carers who are providing short breaks to children will only be responsible for maintaining any existing health treatments while they are with you and for coping with any medical emergencies. This is because the responsibility for the child’s health remains with the parents or those who have parental responsibility.

**4.** **Medication and First Aid**

Generally, all medication must be kept out of reach of young children and, if this is not practicable, locked away, except for things like asthma inhalers, which the child has to have with them as soon as they are old enough to take this responsibility. Older children can be given responsibility for their medicines, unless there is a risk of a child using the medicines in the house to take an overdose or they are not capable of taking on that responsibility.

Medicines should be kept in their original containers with the labels on and stored according to the instructions, paying particular attention to temperature. The instructions for taking them should be clearly explained to the child as soon as they are old enough to understand.

Carers must administer the medicine strictly according to the instructions on the label and check the expiry dates on the medication. They should make sure that any medicine is only given to the child for who whom it is prescribed. Any out of date or unused medication should be returned to a pharmacy for safe disposal.

Any repeat prescriptions should be renewed on time and adequate supplies should be kept at all times.

If the child shows any adverse or unexpected reactions to any medicine, you must let the doctor know immediately.

Prescribed medicine should not be discontinued without proper medical advice.

If you have to administer any special medical procedures or first aid, you should be trained how to do it first of all for your own and your foster child’s protection. This includes the use of inhalers for asthma. If you do not receive this training automatically you should contact the Designated Nurse for Looked After Children for advice.

You should keep a written record of all the medicine, treatments and first aid you give, including paracetamol and calpol with younger children. This is not only so that you can pass on detailed information about the child’s medical history and treatments to the next placement, if the child is going to move, but also because it can help you to identify any health worries. It can be useful, for example, to notice whether a child is suddenly taking paracetamol frequently for headaches, which could indicate stress or problems with their eye sight. Keeping a written record of how much medicine is being used and how frequently may be the best way to identify this.

Foster carers should be familiar with Children's Services’ policy on the administration of medicine via the Fostering Handbook.

**5.** **Immunisations**

If you do not have a full record of the child’s immunisations when they come to you, you should chase up the child’s social worker to get this for you. This can be done by contacting the child’s health visitor or getting the information from the doctor’s records.

If your foster child has not received the full range of normal immunisations, you should arrange for this to be done as soon as possible.

Ordinarily this should include the MMR vaccine. If a parent does not want this to be given to their child, the Local Authority can arrange this in spite of the parents’ wishes if the child is on a Care Order, but if the child is in care voluntarily you should discuss this with the parents and the child’s social worker, who can explain the reasons to the parents for having it done.

Everything you need to know about the MMR vaccine can be found at:

 [**www.nhs.uk/Conditions/MMR/Pages/Introduction.aspx**](http://www.nhs.uk/Conditions/MMR/Pages/Introduction.aspx) .

The full normal immunisation schedule and much other information can be found at: [**www.hpa.org.uk/Topics/Infectiousdiseases/InfectionsAZ/VaccinationImmunisation/Guidelines**](http://www.hpa.org.uk/Topics/Infectiousdiseases/InfectionsAZ/VaccinationImmunisation/Guidelines)

In addition to the normal schedule, other vaccinations such as BCG and Hepatitis B are given specifically to children who need them.

More information about this can be found at [**www.immunisation.nhs.uk/immunisation-schedule**](http://www.immunisation.nhs.uk/immunisation-schedule)

Children coming to the United Kingdom from abroad may have no immunisation record.

Details of recommended immunisation schedules for other countries can be found at:

[**www.who.int/vaccines/globalsummary/immunization/countryprofileselect.cfm**](http://www.who.int/vaccines/globalsummary/immunization/countryprofileselect.cfm) .

There will be vaccines offered here that are not available in other parts of the world and children arriving in the United Kingdom should be immunised in accordance with the routine immunisation schedule for this country.

**6. Serious injury or illness and hospitalisation**

In the case of serious injury or illness, foster carers should avoid taking a child to hospital in their car. It is safer to call for an ambulance.

A foster carer must inform the child’s social worker of a serious injury or accident or of the need for a stay in hospital immediately. If this occurs out of normal office hours, the Emergency Duty Team should be contacted instead.

The child’s parents and all those with parental responsibility will also need to be told and given information about what has happened and, if the child is in hospital, where the child is. Normally it would be better for the child’s social worker to do this, but if they are not contactable or are on holiday, then the foster carer should do this. The important thing is that there should be no delay.

**7. Consent to Medical Treatment**

General consent from parents and others with parental responsibility to give first aid, medicines and any other form of medical or preventive treatment is contained in the placement plan. This is needed where the child is in care voluntarily.

Although it is not strictly required where the child is on a Care Order (because the Local Authority has parental responsibility) it is best practice to consult and share information with those with parental responsibility about their child’s health, especially about any major changes or decisions that have to be made. This is because the Local Authority should only make decisions for the parents where they demonstrate that they are incapable of making them in the child’s interest.

If a child has a serious accident and has to go to hospital in an emergency, every effort should be made to contact the parents in order to get their consent to any treatment, regardless of whether there is a Care Order or not. If they cannot be contacted, the foster carer can give consent to major treatment in the best interests of the child after listening carefully to the advice of the medical staff in charge.

The circumstances in which foster carers can and cannot give their consent to medical treatment should be discussed and recorded in the placement plan or health plan in the light of the individual circumstances of the child, so that they know what has been delegated to them.

**Young people aged 16 and 17**

Once young people reach the age of 16, the law presumes that they are capable of giving consent themselves to any medical, dental or surgical treatment and any other investigations, procedures or anaesthesia. They can sign any consent form themselves.

However, it is still good practice to encourage them to involve their family in any such decision. If they ask for their confidence to be kept, it must be respected, unless disclosure without their consent can be justified on the ground that keeping confidentiality would cause the young person significant harm. The decision to override their wishes and the justification for it should be recorded.

**Young people aged 15 and under**

Young people under the age of 16 are presumed in law not to be able to make decisions about their health care. However, the courts have ruled that under 16 year olds will be able to make these decisions if they have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”. This is sometimes referred to as ‘Fraser competence’, so called because it is named after the Judge in the court case. In other words, there is no specific age in law at which a child or young person can or cannot consent to treatment; it all depends upon the individual child and the seriousness and complexity of the treatment.

Even if a young person under the age of 16 is capable of giving informed consent, it is still considered good practice to involve the family in the decision making unless the young person specifically objects to it and cannot be persuaded otherwise. As with older children, any request from the child for the family to be kept out of the decision must be respected unless it was likely to cause the young person significant harm.

**8. What to do if a child dies in your care**

Some foster carers who are looking after children with some serious illnesses will be aware that their foster child has a short life expectancy and will be able to prepare for this. If the child you are looking after has a history of attempting suicide or is at risk of killing themselves through their behaviour you should also know about this possibility when you agree to take the child. What to do in these circumstances and all the support that is available to you should be covered in the child’s Care Plan, health plan and the placement agreement.

However, there may be unforeseen circumstances when a child in care dies accidentally. If the child is seriously injured, but still alive, you should contact the emergency services immediately and go with the child to the hospital, as any parent would do. If you are contacted by a hospital or the Police to let you know that there has been an accident or that your foster child has died, you should go to the hospital straightaway.

Although it may not be the most important thing on your mind at the time, the child’s social worker should be contacted as soon as practicable to let them know what has happened (or their manager if they are not available or the Emergency Duty Team, if it happens out of normal office hours).

You should **not** have to tell the parents. This will be done by the child’s social worker or their manager, if they are on holiday.

The child’s social worker will also discuss the funeral arrangements with the child’s family and any specific religious and cultural beliefs about death and mourning, so that foster carers and social workers can make sure that the family’s preferences are respected.

In the event of a sudden death, there is likely to be an inquest, which you may have to attend. Depending upon the circumstances of the death, there may also be a Serious Case Review, which will be conducted by Children's Services. This is a formal procedure for establishing what happened and what can be learned from the case to prevent such things happening again.

In every case of a child dying in care, Children's Services has to notify the Chief Inspector at OFSTED, the Secretary of State, the Primary Care Trust and the responsible Local Authority, if the child has been placed outside their own authority’s area, of the death, but you will not be involved in this.

It is essential that at times like this you look after yourself and give yourself some space to mourn and grieve. Your family placement social worker will be the key person who is there to support you through it.

The Norfolk Safeguarding Children Board has issued protocols for a variety of agencies that may be involved when a child dies. Foster carers can read these at [**www.nscb.gov.uk**](http://www.nscb.gov.uk) by clicking on ‘procedures and protocols’, then on ‘safeguarding children in specific circumstances’. Protocol number 20, “Sudden unexpected infant/child deaths”, includes information about anticipated deaths as well as sudden, unexplained deaths.

**End**