



TIME OUT
fostering
valuing individual needs

TIME OUT FOSTERING

Healthcare Policy and Procedures

November 2007

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As well as taking children to health appointments and helping children access the services they need, carers are responsible for meeting children's everyday health needs. This includes a range of responsibilities including diet, personal hygiene and health promotion.

All foster carers are required to attend first first aid training every three years. Details of training courses on first aid and health promotion can be found in the Time Out Fostering training programme.

Please speak with your supervising social worker for advice on dealing with specific health issues or accessing the range of services that are available.

Personal Child Health Records

Social workers are expected to obtain the child's Personal Child Health Record (PCHR) from the parent when the child becomes looked after. This should be passed to you and you should ensure that it is kept up to date and returned to the child's social worker at the end of the placement.

Where the child is of sufficient age and understanding, you should ensure the child is given access to the record and helped to understand what other health records are kept and why, as well as how they can access them.

Registering a child or young person placed with foster carers with a GP

The child's social worker will advise you whether you need to register the child with your family GP. This will be the preferred option in most cases, but for some children it may be better for them to remain registered with their own family GP. This might be the case if the placement is going to be very brief or the birth family of an accommodated child have requested this. For some children with complex health care needs or a disability, the continuity and knowledge retained by their family GP may be important.

Health care assessments and plans

Health assessments

The local authority social worker has to arrange an annual health assessment or medical before making a placement or as soon as reasonably practicable afterwards. There is a dedicated nurse for looked after children. The assessment will often include a medical examination but this will not always be the case if the medical practitioner has sufficient information from the child's health care records. This may apply to a child that already requires frequent health assessments for a disability or health condition, or for a child where a medical has recently been undertaken as part of a child protection investigation.

The medical practitioner will prepare a written report of the assessment, which addresses:

- the child's health including their physical, emotional and mental health
- the child's health history including, as far as practicable, their family health history
- the effect of the child's health and health history on their development

- existing arrangements for the child's medical and dental care
- the possible need for an appropriate course of action which should be identified to assist necessary change of medical or dental care
- the possible need for preventative measures, such as vaccination and immunisation, and screening for vision and hearing and for advice and guidance on health, personal care and health promotion issues appropriate to the child's needs

Health care plans

Once we receive the report of the health assessment, we must prepare a plan for the child's future health care if one is not already in existence. The child's health care plan must be recorded on the Care Plan and confirmed at the first review.

The health care plan should be drawn up at the beginning of a placement and reviewed as part of the normal review process. Additional health care planning meetings may be required as needed, for example if a child's medical condition changes rapidly.

The Essential Information and Placement Agreement forms contain information about health care, including treatments. For most children, this information will be sufficient to constitute a health care plan, which will be reviewed through the normal care planning process and via the Assessment and Action Records.

However, some children will require plans that contain more detail. Such children will include:

- those with severe disabilities which require ongoing medical care
- those with conditions such as epilepsy or asthma, where sudden onset is a feature
- those who may need treatment over a lengthy period of time, even though the condition may not be serious in terms of disability or threat to life
- those with treatments which may have side-effects

Where children fit into these criteria, a more detailed health plan will need to be drawn up which addresses the treatment programme for the child and what to do if there is an urgent occurrence.

Further health assessments

A further assessment of the child's health care needs must be carried out:

- at least once every six months before the child's fifth birthday and;
- at least once every twelve months after the child's fifth birthday unless the child, being of sufficient understanding to do so, refuses to consent to the assessment

The child's health care plan should be reviewed on receipt of the further assessment. Ideally, this will take place during the child's statutory review. However, if necessary the health care plan may need to be amended outside of a review and confirmed at the next review.

All foster carers are expected to keep up to date information about the health of the child placed with them in their placement file under 'health'.

Consent to treatment

This is something that should be discussed at the initial planning meeting and agreement reached about what types of treatment carers can consent to, and what should be referred back to the child's parents.

If the child's parents retain the right to give consent to medical treatment then you should contact the child's social worker when this is required who will in turn contact the family. In an emergency, where it is not possible to contact the parents or they have not given consent, the final decision lies with the child's social worker or the Duty social worker. This should be defined clearly in the Placement Agreement.

You may consent to medical treatment for the child only in circumstances where the right to consent to treatment has been expressly delegated to you, or in an emergency when it is impractical or against medical advice to delay in order to seek consent.

Consent of the child

Once young people reach the age of 16, they are considered in law to be competent to give consent for their own surgical, medical or dental treatment and any associated procedures such as investigations, anesthesia or nursing care.

The Courts have stated that under 16's are competent to give valid consent to a particular intervention if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed (sometimes known as "Gillick competence"). Only a medical practitioner can decide whether the child is competent.

Children can be helped to develop competence by being involved in decisions about their care from an early age. If a child under 16 is competent to consent to a particular intervention for themselves, it is still good practice to involve the family in decision making unless the child specifically requests that this should not happen and cannot be persuaded otherwise.

As with older children, a request for confidentiality must be respected unless the child is suffering or likely to suffer significant harm without disclosure.

Accidents and emergencies

If a looked after child is involved in an accident, however trivial and whether or not injury is caused, you should always inform your supervising social worker and make a record in your daily log and the accident sheets in the placement file. The supervising social worker will then inform the Local Authority social worker. The local authority social worker should be informing the parents as soon as practicable.

If an injury is serious and requires hospital care and/or an operation then you should contact the child's social worker immediately because the consent of the local authority or the child's parents is required. It is good practice to consult parents before treatment is started although this is not always possible, particularly in an emergency. If the local authority or the parents cannot be contacted then a doctor may make the decision about giving treatment.

If you need to call for an ambulance you will be asked for:

- your address and any particular landmarks for locating you
- your name
- the child's symptoms

You should accompany a child to the hospital and be able to provide information to the hospital about the child. Take the child's health record with you if possible.

Only in an absolute emergency when an ambulance is not available should a child be carried in a car to hospital. If this does happen try and have another adult with you.

Medication (including invasive medication)

Receipt, storage and transfer of medicine

Medicines should be kept:

- according to the instructions
- safe from others, but available when needed - consideration needs to be given to ease and speed of access, for example inhalers. A balance between speed of availability and keeping medicines secure needs to be achieved
- in a lockable box if they need to be refrigerated
- clearly labeled in the container they were supplied in
- in the minimum necessary quantities
- in conditions that will keep them fresh and effective

In respite care situations, agreements should be reached with parents or primary carers that only the quantity of medication necessary for the respite period will be supplied.

All surplus medicine and that which has reached its 'use by' date should be returned to the pharmacist and not flushed down the drain.

When receiving or passing medicines or treatments on, check:

- the child's name is on the label
- the name of the treatment is on the label
- the required dosage is on the label
- the conditions for storing the medicine
- that written permission exists from the parents or doctor for the medicine to be given

When passing on, make sure:

- containers are secured safely
- that the person receiving the medicine understands what it is for

Administration of medicine

Non-prescribed medicine

Non-prescribed medicine means any item given to a child to alleviate an illness that has not been prescribed by a doctor. This includes 'over the counter' medicines, such as paracetamol and cough mixtures.

In general, non prescribed medicines are perfectly safe when given in the correct dose and according to the packaging. However, problems can arise because:

- branded medicines contain a number of different active ingredients and may lead to overdosing if taken in combination with other medicines
- some children are sensitive to certain ingredients in non-prescribed medicines

Therefore:

- take non-prescribed medication seriously as it contains powerful ingredients
- read labels carefully, in particular looking at the active ingredient in the remedy
- make a careful record of when such medicines are given in your daily log
- ask parents, carers or doctors whether the child has any particular problems with any medicines or allergies
- make sure you have parents' written permission to give such medicines as part of the placement agreement process

Read the label on the medicine to check:

- that it is within the 'use by' date

- how much to give for the age and circumstances of the child

Minor ailments may turn into more serious ones. Listen carefully to what a child has to say about their symptoms and make a judgement about their seriousness. Keep an eye on them and keep revising your judgement. Always record medicines given in the health section of the placement file.

Prescribed medicine

Prescribed medicines can contain powerful ingredients and must only be used for the person they are prescribed for and for the particular illness at a particular time.

- read labels carefully and follow instructions
- make sure medicines are stored properly and safely and are used within their time limits
- make a record in your daily log about what and how much is given when
- record any response, whether positive or negative
- monitor the child and take action if necessary

Invasive treatment

Invasive treatment is a prescribed medicine that is given by a means other than by mouth (not including ointments and creams for skin application). This includes rectal medication given as pessaries or in squeeze tubes. It also includes treatments requiring catheters such as tube feeding, disposal of bodily wastes etc.

No foster carer will be expected to carry out invasive treatments unless they are willing to do so and have agreed and received training for the procedure. Once trained to carry out the procedure you will be given a certificate of competence. Do not carry out any invasive treatment until you have received in writing verification that you are trained and competent to carry out the treatment. Parents will need to agree to the procedure being given. The nature of the treatment can be upsetting for children and they need to be afforded as much privacy and dignity as possible.

It is important that carers have as much information as they require about carrying out any procedure. You must make sure you have a written health plan which gives:

- details of what treatment is required
- when it needs to be carried out
- who will give it
- what will happen in the event of something unplanned happening

When carrying out an invasive treatment, follow the principles described above for prescribed medicines. Where possible have another adult nearby, balancing

the care, respect and privacy for the child with the need to be safe and to have another person available should anything go wrong.

Children in charge of their own medication

Children, especially those with chronic conditions, should be given charge of their own medication. Looked after children should have the same opportunities to be responsible for their own health care, but the following additional factors need to be considered:

- any possible danger to other children
- the scope for abuse of the drug
- liability if the drug is misused

Looked after children should normally be encouraged to be responsible for their self-care provided they are of sufficient age and understanding, know how and when to administer the treatment, and can be regarded as trustworthy in terms of not abusing the medication, and keeping it away from others.

Written parental permission must be given for children to be in charge of their own medication. If there is no parent available to give permission make sure you receive written permission from The Local Authority. However, even if you have written permission, you can decide not to allow the child to care for their medication. In these circumstances you must inform the child's social worker.

Before allowing a child to be in charge of their own medication, a discussion should take place with the child, parents (or primary carers) and if necessary, a health professional. The discussion should address the following questions:

- is the child of sufficient age and understanding to manage medication?
- if the medication is mishandled, is it relatively safe for other children?
- is the child considered trustworthy in regard to this task?
- does the parent or primary carer give permission?

If the answer to these questions is yes then you can agree to the child being in charge of their own medication. You still require written permission from the parent or those with parental responsibility or the primary carer.

A contract should be drawn up with the child setting out the conditions under which they will be allowed to retain control of medication, and the conditions under which the right will be withdrawn.

Children and young people who wish to be prescribed medicine without their parents' knowledge or consent

Medicines and treatments should be carried out with as much privacy as possible in a way that is consistent with safe caring. The Local Authority's policy is that medical treatment should be given with the agreement of the child, parents and

medical representatives. However, this partnership may not be possible, particularly with older children.

Where you are aware that a child or young person wishes to be prescribed medicines without the knowledge or consent of their parent, you should encourage them to consider the advantages and disadvantages of this. You must then decide whether you think they understand the issues.

You must inform the child that they will need to speak with their social worker about their wishes. The social worker should arrange to speak with the child or young person as soon as practicable, and also seek out your views.

It is the social worker's responsibility to discuss the matter with their Manager, who will make a decision and be responsible for ensuring that the child and carers are informed.

Normally, the record relating to this issue will be kept in the Confidential section of the child's file and will not be accessible to parents without legal guidance being sought.

Please see the [Safer sex](#) section below for information on young people being prescribed contraception.

Diet

A healthy diet is essential to children's development. However, you must remember that what you and your family eat is not necessarily what a child is used to. Individual likes and dislikes should be discussed with parents and you should also respect any religious requirements or other wishes, such as if a child is vegetarian. It is normally advisable to attempt to reach a compromise with foster children in areas of dispute.

Young people should be encouraged to take part in shopping for food so that they can make choices and develop an awareness of budgeting.

Immunisations

We expect all looked after children to receive the full range of immunisations recommended by the Department of Health. The child's immunisation history will be recorded on the Essential Information Record prior to or at the point of placement. The need for further immunisations should be considered as part of the health assessment and incorporated into the health care plan.

Where the birth parent of an accommodated child objects to a particular immunisation (e.g. MMR - measles, mumps, and rubella), their wishes must be respected if the child is not of sufficient age and understanding to give their own

consent. However, we may seek legal advice with a view to seeking court permission for the immunisation to take place.

Dental care

The child must have a regular check-up at least every six months, either by the school dentists or their own dentist. It is the foster carer's responsibility to ensure that children receive the necessary dental care both by encouraging good dental hygiene and making the necessary appointments. Good dental care involves twice daily brushing ideally with low fluoride based toothpaste and as the young person gets older daily flossing. Products containing sugar are bad for the teeth and should be kept to a minimum, however if sugar is consumed then the teeth should be cleaned as soon as possible afterwards.

Optical care

The health care plan will identify any specific needs the child has for optical care and the arrangements for meeting these will be recorded in the Placement Agreement. Eye tests should be carried out at least once a year.

Bereavement

Children may find themselves in foster care following the death of a parent or carer. Children's capacity to cope with sad emotions increases with age and maturity. Apparent lack of sadness may lead you to believe they are unaffected by the loss. Normal signs of grief in children, particularly young children, include bed wetting, loss of appetite, tummy upsets, restlessness, disturbed sleep, nightmares, crying, attention seeking behaviour, difficulty concentrating, increased anxiety and clinginess.

Older children often display changes in personality and alterations in their normal behaviour including signs of depression, sleep and appetite disturbances, angelic behaviour, rudeness, learning problems, lack of concentration and refusal to go to school. In adolescents a bereavement can cause a regression to a younger, more dependent stage in their development. Emotions may be suppressed, resulting in a display of apparent indifference or lack of feelings. In a search for love and affection, they may develop premature new sexual relationships.

It is important to let the child have time to grieve and to listen if they want to talk about the person who has died.

Self-harm and eating disorders

Self-harm

You may care for child or young people who injures themselves. Some may cut their arms or legs; others bang or bruise their bodies. Self-harm also includes burning, scratching, pulling hair, scrubbing or anything that causes injury to their body. Some children or young people take tablets, perhaps not a big overdose but enough to blot things out for a while.

Sometimes the young person harms himself or herself because they want to die, but often it is more about staying alive. They may hurt themselves to help get through a bad time. This is their way of coping. They will be in pain and could be trying to show that something is wrong. It is important that you take their self-harming behaviour seriously and don't overlook it as 'attention seeking behaviour'. The young people could attempt suicide or hurt themselves just once or twice. Other young people use self-harm to cope over a long time. They may hurt themselves more often if they go through a bad patch.

The young person may stop self-harming when they are ready. They may sort their problems out and find other ways of dealing with their feelings. It might take a long time and they might need help, but things can get better.

It is very difficult to stop the young person self-harming if they don't want to, and it is important to listen and support what they want to do.

Eating disorders

If a young person is starving themselves or binge eating, they could well be trying to cope with problems that have nothing to do with food. Anorexia and bulimia nervosa often begin when a child wants to avoid painful feelings – a solution for difficult problems. It's a way of controlling something in their life. Eventually the eating disorder can take control of the young person. The most important step is for the young person to acknowledge they have a problem. Once they have done this, vital help can be sought.

Children as young as seven or eight years old can develop eating disorders and are also at particular long term risk from the effects of malnutrition. They may not be ready to face their problem and may reject all attempts of help. It is important that you provide a supportive role that will give them hope at the most difficult times - even though they can't express their gratitude.

Anorexia Nervosa

A young person with anorexia nervosa will be terrified of being a 'normal' weight. They will think about food all the time, count the calories in every piece of food and work out elaborate ways of avoiding eating. It can destroy their self-confidence and seem as if the only thing they are good at is controlling what they eat. They may feel that no one can love them for whom they are inside. Some young people who suffer from anorexia nervosa may deny they are ill, and still feel fat although their low body weight shows otherwise. Many sufferers are so scared that they lie about what they eat and angrily reject any offer of help.

Possible symptoms:

- severe weight loss
- distorted ideas about body weight and size
- excessive exercising
- vomiting or purging
- social isolation
- emotional and irritable behaviour
- difficulty sleeping
- loss of menstrual periods
- perfectionism
- feeling cold, poor circulation
- growth of downy body hair

Bulimia Nervosa

Sufferers of bulimia nervosa will probably maintain 'normal' body weight, yet they still think constantly about calories and dieting. The young person will binge – 'a dustbin for feelings' - their resort when they feel angry, sad or rejected. It leads to guilt or self-disgust, and results in extreme measures to get rid of the food.

Some sufferers express their disgust by harming themselves or developing addictions to alcohol, drugs or exercise. On the outside the young person may seem popular and able to cope, but inside they feel insecure and vulnerable. Many sufferers are aware of their problems and desperately want to change, but are frightened of other people discovering their secret way of coping.

Possible symptoms:

- bingeing - eating large amounts of food
- vomiting or purging after eating
- disappearing to the toilet after meals
- secretive and ritual behaviour
- feeling helpless and lonely
- erratic menstrual periods
- swollen salivary glands
- sore throat and tooth decay caused by vomiting
- dehydration and poor skin condition
- lethargy and mood swings
- social isolation

Substance misuse

Sadly, a great many children and young people come into contact with drugs. Fortunately, most just experiment and come to no harm. Many of us also use socially and legally acceptable drugs such as caffeine (coffee and tea), nicotine

(cigarettes) and alcohol. Drugs can also have a positive effect if prescribed for a medical condition.

It is, however, easy to become addicted and looked after children may be more inclined to look for solace, escape and excitement in drugs because of their past experiences and the way they feel about themselves.

Drugs

These days there is a very wide range of drugs that children may come into contact with. These include cannabis (blo, grass, weed), stimulants (speed, whizz), ecstasy ('E', dove), heroin, crack, cocaine and hallucinogens (acid). Many of these drugs have 'street' names that change with fashion; these are shown in brackets.

Many young people will try taking drugs and stop immediately. Sadly, others will not. It is important not to jump to conclusions, but be alert to the signs such as sudden changes in behaviour, mood swings, loss of appetite, 'drunken' behaviour, asking for money without explaining why it is needed, changes in friendships, etc.

The young person and their friends must never be allowed to bring illegal drugs onto your premises. If you discover any evidence of substances that you know or suspect are illegal, you should ring your local police station and then speak with your supervising social worker.

A very useful leaflet is "Young People and Drugs" by the Fostering Network – ask your supervising social worker for a copy.

Solvents

Solvent abuse is normally localized, i.e. confined to a particular group at school. It is most common amongst the 12-16 year age range. The most used substances include glues, paints, dry-cleaning fluids and petrol or lighter fuel. Unfortunately most solvents are readily available although it is now possible for shops to refuse to sell such substances to young people under age 16.

Sniffing solvents reduces the intake of oxygen and depresses breathing and heartbeat. The result is disorientation and lack of control – very like being drunk. The after-effects of sniffing include headaches and loss of concentration.

Lasting damage as a result of sniffing appears rare although in the short-term, users risk death or injury through accidents or choking on vomit should they lose consciousness. Daily signs of sniffing can be sores around the mouth (from using bags), general fatigue and lack of concentration.

Alcohol

Alcohol is a socially accepted and well-promoted way of being accepted by friends, enjoying oneself, feeling confident and relaxing. For all these reasons it is attractive to young people and is still relatively cheap. As foster carers you will have your own views and habits about drinking. However, the law is quite clear on the purchase and consumption of alcohol and you are expected to set a good example, especially as many foster children come from alcohol-abusing families.

The law is as follows:

- it is an offence to give alcohol to any child under age five
- children under age 14 are not allowed in the bar areas of certain pubs
- children under age 18 are not allowed to drink at a bar or purchase alcohol in a pub or off-license

According to the Institute for the Study of Drug Dependence, nearly two-thirds of adolescents drink at least once a week and over 40% of 16 year olds report that they drink in pubs. Young people are therefore under great pressure to conform and sadly there are often few other places for them to meet. Young people need to be taught sensible drinking habits and foster children should be discouraged from behaving illegally. On the other hand, it is not possible to control their leisure time and promoting a relationship of mutual trust is important. Confronting them about drinking or any other behaviour is likely to be counter-productive. If alcohol consumption seems to be becoming a serious problem then you should seek professional advice as soon as possible.

If a young person returns to your home under the influence of drugs or alcohol then you may seek emergency medical attention for them if you feel it is necessary. If you are in any doubt or are concerned about managing the situation then you should seek immediate advice from your supervising social worker or Out of Hours Team.

Bed wetting (enuresis)

Bed-wetting is very common and not always confined to young children. Most children achieve full control of their bladders between the ages of three and four, some continue to wet until about six years and some, mainly boys, may continue beyond that.

Theories about the causes of bed-wetting differ widely. Although it is important to eliminate specific medical complaints, it is generally accepted that persistent bed-wetting is an indication of some emotional disturbance or anxiety. For this reason it is not uncommon amongst foster children.

The first steps in dealing with the problem are purely practical. Ask your supervising social worker for a plastic mattress cover and ensure that you have a plentiful supply of linen. Secondly, it is important that the child is not made to feel guilty and it often helps to involve them in such things as changing the bed in order for them not to feel completely out of control of the situation. Thirdly,

ensure that the child does not have a large drink immediately before going to bed.

Some children also wet during the day and encouraging them to go to the toilet at regular intervals can sometimes relieve this. Both day and night wetting may also be tackled by using what is commonly known as a “star chart”. That is, the child is given a star to put on a chart for every day or night they stay dry. By the end of a specified period they will have earned a treat. Although this sounds easy, it can be quite difficult to set realistic standards and you should consult the child’s social worker and/or health visitor before attempting this.

Most children naturally grow out of wetting. For many, a stable period in foster care will largely solve the problem and the problem will only re-emerge during times of stress or anxiety. If this is the case, it is a good idea to keep a record of such occasions.

Safer sex

Young people need clear, accurate information about the risks of sexually transmitted diseases and pregnancy. They may also need help in understanding the anatomical, psychological, emotional and social aspects of sexual relationships, as these may have been distorted through sexual abuse and wrong information.

Many looked after young people suffer from low self-esteem and do not consider that protecting themselves from infection or pregnancy is within their power. Discussions about safer sex should encourage young people towards greater self-respect and taking control of how they want relationships to develop.

Contraception

All young people should grow up with some knowledge of contraception and should receive advice about sexual relationships. Some instruction will be received at school but you should be ready and prepared to talk these things over as necessary.

The child’s social worker should be contacted when you feel that they need more specialist advice about contraception. Before contraception can be arranged for a girl who is looked after, whether accommodated or under a Care Order, there must be a discussion with the social worker.

Although the general principles outlined above apply, a doctor may arrange contraception for a person under 16 without consultation with anyone in a parental role if they believe the young person to be capable of making their own reasoned and mature judgement. Our aim should be to help young people

achieve a measure of concern and respect for themselves and for their own health.

First aid kits

All foster carers must undertake first aid training every two years. Time Out Fostering training programme includes a bi yearly course on first aid.

The contents of a first aid box should be kept in a clean dry airtight container. Do not keep the container for example in a bathroom and make sure it is clearly labelled. All members of the household should be able to access first aid. Remember that items like antiseptics, aspirin and paracetamol should not be stored in a first aid box. These items should be stored as medicines. (See above for the storage of medicines.)

The first aid kit should include:

- ten individually wrapped sterile adhesive dressings
- one sterile eye pad
- one triangular bandage
- one sterile covering for a serious wound
- six safety pins
- three medium size sterile dressings
- one large sterile dressing
- one extra large sterile dressing
- one pair of surgical style gloves

Death of a child in foster care

The death of a looked after child or young person is a rare occurrence. All foster carers involved in the death of a foster child will need help and support whatever the circumstances surrounding the death. We recognise the emotional commitment that carers make to a foster child – even if they have only been with the family a short time – and will ensure that you receive support, help and guidance from the agency should a child die in your care.

HIV and hepatitis

HIV

Where we know that a child or young person is HIV positive, the information will always be shared with their foster carers. Deciding who 'needs to know', and the issue of confidentiality generally, will form part of the continuing discussions with the carer.

In making a placement, prospective foster carers will initially be approached to explore the issue in principle without revealing the child's identity. Identifying details will only be shared when agreement had been reached about the placement.

Children and young people with HIV may require social care in the form of day care, respite care, residential care, flexible care, adoption or foster care, plus counselling, advice and support. It is recognised that HIV encompasses many issues people find hard to talk about, namely sex, sexuality, race, disability and death.

We will provide training, education and support to foster carers working with children who are potentially at risk of developing HIV. This will ensure that foster carers with worries or concerns about HIV are reassured and that services are provided appropriately and sensitively. We are equally committed to ensuring that people, including children and young people, are not put at risk by cross-infection.

Adults, children and young people have the potential to suffer extreme prejudice and harassment if it is known that they or their parents are HIV positive. It is therefore particularly important that this information is shared only with the child's express consent and that the number of people who know is kept to the essential minimum.

An HIV infected child may be vulnerable to picking up infections, and exposure to measles and chicken pox is of particular concern. Ailments and minor accidents may require immediate medical attention.

Transmission of HIV

Children and young people may be infected with HIV in several ways: from an infected mother to her baby whilst in the womb or during birth; through breast feeding; through receiving contaminated blood or blood products; through intravenous drug use; and through sexual intercourse with an infected person.

The virus itself is not very strong and easily dies outside the body. Even in its wet state, the virus only lives for 20 seconds when exposed to the air. It is destroyed outside the body by heat, drying, soap and water, detergents and bleach.

- you cannot get the virus from ordinary social contact
- the virus cannot be passed on through touching, shaking hands or through saliva or tears
- sharing cups, cutlery, glasses, food, clothes, towels, door-knobs etc. present no risk and neither does using the same toilet seat as a person who has AIDS or the virus
- you cannot catch the virus by social kissing, coughing or sneezing
- swimming pools are safe

Hepatitis

Hepatitis B is a highly contagious blood borne condition that is more infectious than HIV because there are potentially more areas of risk of transmission (for example, it could be passed on via saliva). There is a slightly higher incidence of Hepatitis B amongst people who have been in long-term residential care, particularly those with learning disabilities. For this reason, staff and foster carers working with people with learning disabilities are advised to seek vaccination. You should speak with your supervising social worker if you have concerns about this.

Foster carers not working with the above groups are not considered to be at risk of contracting Hepatitis B as long as standard hygiene procedures are followed whenever blood or other body fluids are involved. Please discuss this with your supervising social worker if you have any concerns.

Good hygiene practice

The use of good hygiene practices in all daily activities will prevent cross-infection of many infections, including HIV infection and Hepatitis B.

The Government recommends the following basic hygiene precautions as good practice in all situations:

- cover cuts or sores on the hands with waterproof plasters or dressings
- wash your hands thoroughly before carrying out any first aid on cuts or broken skin
- wash your hands after clearing up any body fluids such as blood, semen, urine or faeces
- use plastic gloves for first aid whenever possible
- use rubber gloves for heavily soiled material
- do not share toothbrushes, razors or towels
- cuts should be washed with soap and water
- any splashes of blood should be washed off immediately
- domestic bleach, diluted one part in ten, should be poured on to spilled blood as soon as possible and then covered with paper towels
- disposable items, such as paper towels, tampons, etc, should be burnt or flushed away
- non-disposable items, such as terry nappies or bedding, should be washed in a machine at 80°C

Health promotion

Good health goes beyond having access to healthcare services. Achieving positive outcomes in the health of looked after children also require promoting good health both by education and by example.

Social workers and carers should seek opportunities to engage children in age appropriate health education activities. This may range from active play for younger children through to one to one discussions with a teenager embarking on their first sexual relationship. Record any conversations of this nature.

Social workers and carers also need to promote good health by their own example. Talking about healthy diet while providing unhealthy food for the child is not the best way to encourage them to eat healthily. Equally, discussing relationships and the need to respect others will not mean much if you lack confidence in listening and talking to the child or to challenge bullying.

Mental health

Many looked after children will have emotional and behavioral problems and some will have significant mental health issues.

The likelihood of a child experiencing mental health issues is influenced by certain risk factors that should be clearly recorded in the Placement Plan. Some of these will remain present throughout a child's life, such as past abuse or genetic factors. However their impact will be mediated by resilience factors for the child and access to appropriate services.

Resilience in children can be promoted by ensuring that they have the opportunity to form consistent relationships with adults and children and to achieve in both education and leisure activities. Good planning and support for carers can also promote positive attachments and stable placements.

Effective care will reduce the likelihood of looked after children and young people experiencing some of the secondary consequences associated with poor mental health, such as non-school attendance, educational failure, juvenile crime and placement disruption.

There should be no assumption that because children and young people are looked after they have mental health problems, as such an assumption is not only stigmatizing but may lead to failure to investigate possible physical causes for difficulties. However, evidence suggests that many mental health difficulties are missed in this group of children and young people, in particular the effects of grief and loss and resulting depression in younger children.

Young people aged 16 and over may be particularly vulnerable at the point of leaving care and managing their lives with fewer supports than other young people. Thought should be given to appropriate services for this age group.

All professionals and carers who work with looked after children have a responsibility to promote their mental health and emotional well being. You may do this by building secure relationships with children and ensuring that their basic needs are met. However, at times you may need to seek additional advice or training from child mental health professionals, in order to meet children's needs.

If you have concerns about a child's mental well being then you should discuss them with the child's social worker and GP who will arrange for any specialist advice that may be required.

Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services provide a range of treatment services to children and young people aged under 18 who suffer from emotional, psychological and/or psychiatric distress. Your supervising social worker can give you more information about this.

Hospitalisation when away from West Sussex

Although rare, there are times when children or young people in your care may have to stay in hospital away from West Sussex (if they become ill during a holiday for example). It is expected that the carer will arrange for the child's return. If you have concerns about this please discuss it with your supervising social worker.