### Section 1

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| Controlled Vocabulary Terms                              | |

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Foreword

Every Child Matters emphasises the need to focus on outcomes for all children. The South Gloucestershire Charter for Children and Young People further underlines the right of all pupils to have equality of opportunity and to play a full part in their communities.

“Inclusion in education is a vital aspect of inclusion in society.”

These guidelines have been prepared to support schools in developing their capacity to remove barriers to learning experienced by some children and young people with physical difficulties. We hope that these guidelines will promote a greater understanding of the diverse needs of these pupils, and encourage their successful inclusion in our mainstream schools. We also hope that all staff carrying out an invaluable role working with pupils with physical difficulties find this resource useful.

“Our goal is to create a dynamic and inclusive culture of learning that enables everyone to achieve their potential”

South Gloucestershire Community Strategy 2003

Jane Spouse
Deputy Director for Children and Young People
Introduction

With the increasing emphasis on inclusion in education, there is now an expectation that pupils with physical difficulties attend mainstream schools. Historically, the expectation was for children and adults with physical difficulties to be removed and segregated from society. It was not until the 1944 Education Act that education was made available to pupils with physical or learning difficulties. Provision made through special schools resulted in the segregation of children with physical disabilities from their community. The 1981 Education Act finally introduced the principle that all children should be educated and included within mainstream schools wherever possible. The rights of pupils with physical difficulties was further strengthened by the UN Convention on the Rights of the Child (1989) and the UNESCO Salamanca Statement (1994) which supported the right of every child to education and access to mainstream schooling.

“Every child has unique characteristics, interests, abilities and learning needs…… Education systems should be designed and educational programmes implemented to take into account the wide diversity of these characteristics and needs.” (UNESCO 1994)

The SEN and Disability Act 2001 extended the Disability Discrimination Act 1995 to cover education. From September 2002, all schools:

- Must not treat disabled children less favourably than non-disabled children in admissions, education and related services and exclusions
- Must make reasonable adjustments so disabled children are not at a substantial disadvantage in policies, practices and procedures. This duty is anticipatory.

The Children Act (1989) declared that disabled children are children first. 'Every Child Matters' has emphasised the need to focus on outcomes for all children with every child an individual who matters, and everyone benefiting when children are included as equal partners within their school community.

Inclusion for pupils with physical difficulties does not simply mean attending mainstream school. There is a danger that pupils with physical difficulties “placed” within a mainstream school can experience 'locational integration'; being taught separately from their peers and not being given complete opportunities to mix socially, social and academic experience being mediated by an adult worker. Where pupils with physical difficulties are taught with their peers as subjects of a programme rather than active participants, ‘functional integration’ rather than full inclusion can occur. The Index for Inclusion (2002) states that inclusion involves change and is an unending process of increasing learning and participation for all students.

“Participation means learning alongside others and collaborating with them in shared learning experiences. … More deeply, it is about being recognised, accepted and valued for oneself.” Index for Inclusion. (2002) Tony Booth and Mel Ainscow. CSIE
Inclusive schools value diversity and recognise that impairment and disability are common to all. To include a pupil with physical difficulties effectively, the focus must be on the whole person rather than on one aspect, such as their impairment. The work done to identify and reduce the barriers to learning and participation for this pupil may benefit all other pupils who were not initially seen as a cause for concern.

The emphasis on reducing barriers to participation and learning rather than one focused on Special Educational Needs, moves away from a medical model of disability towards a social model. Within a medical model, the impairment becomes the focus and the disabled child is seen as the problem. Within education, medical model thinking leads to the child having to conform to the system, rather than the system adapting to the needs of the child. A social model defines disability in terms of lack of access, both as social and structural barriers – people are disabled by their environment. The problem is not the disabled child.

Medical model thinking can be seen in the definition of disability within the Disability Discrimination Act where a person has a disability if:-

“he or she has a physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities.”

This contrasts with social model definitions of disability written by disabled people:

“The loss or limitation of the ability to take part in the normal life of the community on an equal level with others, due to physical and social barriers.” (Disabled Peoples International 1981)

“Disability is the disadvantage or restriction of activity caused by a society that takes little or no account of people who have no impairments and thus excludes them from mainstream activity.” (British Council of Organisations for Disabled People)

The guidelines that follow are designed to help schools overcome the barriers to inclusion and enable pupils with physical difficulties to become as independent as possible and valued as individuals within society. We have chosen to use the term physical “difficulty” rather than “disability” or “impairment” in order to indicate that difficulties can be overcome, in line with the social model of disability.
Don’t Mollycoddle Us

Greg Judge, 15, is taking eight GCSEs at the Westwood school technology college in Coventry. He has been paralysed from the chest down following complications in a spine-straightening operation when he was 7. He uses a wheelchair and is doubly incontinent.

“I had my operation when I was in Year 3 and came back to primary school in Year 4. It was easy to slot back in. But after a while most of my friends stopped asking me round. I did have dinner with one about once a week.

In senior school there was an even bigger divide between me and the other kids. The school near my house said it couldn’t take me. So there is a big detour and extra expense. I can understand it. I think it’s also that I’ve always been more mature. My operation was a life-changing event.

Teachers treat me like everybody else. But with assistants it’s a bit more difficult. They talk to me like a pupil, whereas I think it’s a client-carer relationship: they don’t educate me, they do personal care and mobility. I think we should be on an equal level. They don’t agree.

I’ve only been on one school trip. I wasn’t allowed on the rides so I sat in my wheelchair the whole day. The school tries to include me in PE but it’s difficult. If we play rounders I just hit the ball, I can’t go round the pitch. I don’t feel comfortable participating that way.

I think schools need to accept people like me as we are. Don’t try and mollycoddle us, because you’re creating as big a divide as if you were openly horrible. Make special arrangements for us but do it so nobody notices: so we’re not like a glowing red dot in the middle of a sea of black ones.”

Gold K (2005) Independent Ways
TES Extra for Special May 2005 p6-7
CHAPTER 1 How to use these guidelines

If you are anticipating the entry of a pupil with physical difficulties into your school or already have a pupil within your school, these guidelines can help you to:

- Identify and address barriers to their inclusion
- Understand and meet their individual needs
- Involve pupil and their family in planning
- Ensure that pupil fully participates in all areas of school life and curriculum

To promote inclusion of pupils with physical difficulties plan ahead:

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Don’t forget that support and advice is available. On the next page ‘First Steps’ guides you in collating information and seeking advice/support from professionals. ‘Next Steps’ outlines the process as the pupil progresses through school.

“When I get older, I want to help other people like daddy does. I don’t want to have other people help me.”

A comment from a child with a physical difficulty
First Steps

How will my school find out about me?

Talk to my parents/carers

Talk to me

Talk to early years Setting or previous School

Is there a statement? If yes – read

Is specialist equipment needed?

Is a health care plan needed?

Are adaptations needed?

Is a Risk Assessment needed?

Make contact with professional involved

- seating
- walking frames
- communication aid
  
  Physio
  OT
  SLT

- medication
- manual handling

  Paediatrician
  School Nurse
  Specialist Nurse
  OT
  Physio

- environment
- curriculum
- information

  EP
  ISS
  OT
  SLT

Headteacher
Health and Safety officer
DCYP

Physiotherapist
Paediatricians
Occupational Therapist (OT)
Speech and Language Therapist (SLT)
Dept for Children & Young People (EP/ISS)
Other

Is there a statement?

Convene a planning meeting involving parents/carers and relevant professionals

IEPs

Identity training needs for school staff

Establish plans
- Personal Care Plan
- Health Care Plan

Prepare peers

Prepare Pen Picture for colleagues (Appendix 2)
Next Steps

Y1 - Y11

Advice support as needed from ISS, therapists, SEN Education Officer, EP

Y5 Annual Review informs CAP and helps determine appropriate secondary placement

A supported transfer may be requested at this A/R to help schools to liaise with appropriate therapists re accessibility of parents’ preferred school, environmental and specific equipment issues, and plan

Yr 6 Annual Review, involve SENCO, from Secondary School, ISC may support transfer and monitor initial progress

Yrs 7 – 11 Advice/support as needed from Health & DCYP
Some knowledge and understanding of conditions is essential when planning for pupils’ needs. There are a wide variety of conditions which school staff may encounter, the ones listed below are likely to be the most commonly seen, but further information on these and any other condition, some of which may be very rare, can be found via the Contact a Family Directory. This is a very comprehensive directory giving information about hundreds of different conditions which may affect children and young people. The Contact a Family Organisation supplies advice, support and information to parents and professionals.

For Further Information
- Contact a Family Helpline tel: 0808 808 3555
- Contact a Family Professionals Enquiries tel: 020 7608 8700
- www.cafamily.org.uk

Brittle Bone Disease
This is part of a group of disorders known as Osteogenesis Imperfecta. The bones break easily and the affected individuals can have multiple fractures. The severity of the condition can vary greatly.

Difficulties Pupils may Encounter
- Mobility / safety difficulties
- Difficulty carrying things
- Vulnerability in crowded situations
- Lax joints can cause writing difficulties

Further Information
- Brittle Bone Society tel: 08000 282459
- www.brittlebone.org

Cerebral Palsy
Cerebral palsy is damage to the brain either before or during birth or as a result of injury or infection during the early years. It is a non-progressive condition but the functional ability may deteriorate over time. It leads to variable impairment of the co-ordination of muscle action, with the resulting inability to maintain normal movements. The term cerebral palsy covers a wide range of ability and need. Some pupils with cerebral palsy may be of average or above average ability, but this may be masked by their physical impairment affecting mobility and co-ordination, speech and swallowing, sensory impairments such as vision and hearing difficulties. These may be accompanied by epilepsy. Other pupils may have moderate to severe learning difficulties accompanied by physical impairments. There are other pupils who have very minimal impairments.
Main types of cerebral palsy

**Spastic cerebral palsy** – the muscles are stiff and difficult to control, there is a decreased range of movements in the joints. Within this definition there are 3 types of cerebral palsy

- Hemiplegia – either the right or the left side of the body is affected.
- Diplegia – legs are affected, there may be none or some affect to the arms.
- Quadriplegia – all four limbs are affected.

Children and young people with spastic cerebral palsy frequently have associated difficulties. These include:

- Visual problems
- Visual perceptual difficulties
- Spatial awareness/motor planning
- Epilepsy

**Athetoid cerebral palsy** – the muscles rapidly change from floppy to tense in an involuntary way. Pupils find that their movements are hard to control, and it may take a great deal of effort to achieve any activity. Speech may be hard to understand due to difficulty controlling the tongue, breathing and vocal chords. There are also likely to be difficulties with eating and drinking.

**Ataxic cerebral palsy** – the child will have unsteadiness of movement and poor balance, walking may be jerky, hands shaky and speech may be slow and spatial awareness may be impaired.

**Treatment**

Cerebral palsy cannot be cured but it is non-progressive in that the level of the brain damage does not get worse. Pupils will have a physical management programme overseen by a Physiotherapist / Occupational Therapist which aims to maximise their functional abilities. Some pupils may have orthopaedic surgery to release tendons to improve range of movement. Others may have botulinum therapy to relax and lengthen muscles.

**Difficulties Pupils may encounter**

- Mobility
- Co-ordination
- Fine motor skills
- Concentration, attention and listening skills
- Visual perception
- Speech and language
- Vision and hearing
- Eating and drinking skills
- Dressing and toileting skills
Epilepsy
This condition is characterised by the tendency to have recurrent seizures originating in the brain. Onset at any age, and can have many causes. Seizures can range from mild absences to loss of consciousness. Treatment is usually by medication.

Difficulties Pupils may Encounter
- Medication can affect alertness attention, memory
- Information missed due to absences
- Tiredness
- Self-esteem
- Decrease in fine and gross motor skills
- Language and communication skills

Friederich’s Ataxia
An inherited disease of the central nervous system in which there is a progressive deterioration of co-ordination and muscle control. It affects the co-ordination of the muscles of the limbs and those used in speech. It is likely to result in further medical complications as the condition progresses.

Difficulties Pupils may Encounter
- Mobility difficulties
- Decrease in dexterity and gross and fine motor skills
- Problems with posture

Head Injuries, Meningitis, Brain tumour, Stroke
A head injury is any kind of injury to the head and/or brain. Injury, either by accident, infection, stroke or brain tumour might result in loss of function to one or more areas of the brain due to nerve damage.
Difficulties Pupils may Encounter

- Mobility problems
- Paralysis or loss of function of a limb
- Visual impairment
- Epilepsy
- Speech or hearing difficulties
- Reduced stamina
- Short and long term memory problems
- Emotional and behavioural problems

Further information

Headway                  tel: 0115 924 0800
Meningitis Trust         tel: 0845 6000 800
www.headway.org.uk
Children’s Brain Injury Trust  tel: 01865 552467
CBIT Bristol Group       tel: 0117 9186704

Juvenile Arthritis

Arthritis is disease of or damage to the joint surfaces, it can take many different forms. It can be very painful and can result in lack of mobility and stiffness. The condition can be very variable. Treatment is usually by drugs and Physiotherapy and Occupational Therapy.

Difficulties Pupils may Encounter

- Fluctuating condition will give good days and bad days
- Lack of mobility
- Fine motor difficulties
- Depleted energy levels resulting in lack of motivation
- Reduced self-cares skills

Further Information

Children’s Chronic Arthritis Association tel 01905 745595
www.ccaa.org.uk

ME/CFS (chronic fatigue syndrome)

Usually occurs following a viral infection and is characterised by persistent fatigue and muscle pain. The fatigue is made worse by even minimal physical and mental exertion and there is a prolonged recovery period. There is no specific treatment for the condition but the condition is managed by drug therapy for pain, and a slow programme of graded activities to build up stamina.
Difficulties Pupils may encounter
- Fatigue
- Memory loss
- Painful muscles
- Poor concentration
- Depression
- Restricted social life and isolation

Further Information
ME Association tel: 01375 642466
www.meassociation.org.uk

Muscular Dystrophy
Muscular Dystrophies are a group of progressive inherited neuromuscular disorders. The term dystrophy refers to a progressive weakness of the muscles due to a breakdown of the muscle fibre. Some conditions are life limiting and others are milder. There is no known cure for this group of conditions but medical and surgical management with Physiotherapy and Occupational Therapy can improve the quality of life for these children.

Main Types of Muscular Dystrophy
Duchenne – affects boys and is diagnosed when the child is still young when he begins to have difficulty with mobility. Between the ages of 8 – 11 the boys will become unable to walk, and in their teens they will experience problems with respiratory muscles affecting their breathing. Life expectancy is shortened.
Becker – a milder form of dystrophy which progresses at a slower rate, also affecting boys.
Myotonic – can be congenital or develop later in life. Characterised by delayed relaxation of the muscles after contraction as well as muscle weakness.
Spinal Muscular Atrophy (SMA) – genetically inherited condition causing weakness of the muscles. There are 3 levels of severity of the disease.
Limb- Girdle – progressive muscle condition causing weakness in shoulder and pelvic girdle.
Congenital Myopathies – group of conditions causing muscle weakness and respiratory problems.
Charcot – Marie Tooth - slow progressive muscular weakness.

Difficulties Pupils may Encounter
- Difficulties with mobility
- Frequent falls
- Low stamina and physical fatigue
- Susceptibility to changes in temperature
- Eating and swallowing difficulties
• Loss of power in upper limbs
• Problems with toileting and self-care
• Curvature of the spine and need for specialist seating
• Lack of self – esteem
• Depression

Further Information
Muscular Dystrophy Campaign tel: 020 7720 8055
www.muscular-dystrophy.org

Restricted Growth
May be the result of many medical conditions and the effect may be very marked. Restricted growth falls into 2 main categories, proportionate and disproportionate short stature.

Proportionate short stature – growth is restricted throughout the body and may be associated with chronic heart, lung, kidney or liver disease.

Disproportionate short stature - many conditions can cause this condition which is a relatively normal torso with short limbs and possibly a skull which is different in appearance.

Difficulties Pupils may encounter
• Difficulties with self-esteem as they are often treated as much younger than their years.
• Independence skills as everything is difficult to reach
• Discomfort as seating does not fit them
• Problems with hearing and vision
• Lack of stamina and so walking between areas in the school can be a problem.
• Carrying books etc
• Fine motor skills

Further Information
Restricted Growth Association tel: 01308 898445
www.rgaonline.org.uk

Spina-bifida
This condition is a fault in the spinal column in which one or more vertebrae fail to form properly. This leaves a gap which causes damage to the central nervous system. There are 3 main types of spina bifida and an associated condition is often hydrocephalus (excess cerebral fluid.)

Pupils with spina bifida will vary in both their physical and cognitive ability according to the damage caused by their condition. Mobility can be variable and bowel and bladder incontinence is common. Lack of sensation in lower limbs is common and so sensation of pain is lost. Hydrocephalus can result in a range of learning difficulties.
Difficulties Pupils may Encounter

- Problems with mobility
- Difficulty sitting on the floor.
- Problems with bowel and bladder function and therefore needing to use catheterisation.
- Problems with self-esteem due to need to use frequent catheterisation.

Further Information
ASBAH          tel: 01733 555 988
www.asbah.org

Spinal Injuries
An injury to the spinal cord caused by trauma (road accident, injury), or by infections (viral, tumours etc). The location of the injury on the spinal column will determine the degree of the impairment, the higher the level of injury the more limbs will be paralysed.

Paraplegia – a low level injury causing paralysis to the legs and abdomen.

Tetraplegia – a high level injury occurring as a result of injury to the spine or neck area. It causes part or full paralysis in all four limbs and affects the chest muscles and breathing.

Autonomic paralysis – damage to the autonomic nervous system which controls the involuntary functions of the internal organs and glands eg bowel and bladder function.

Difficulties Pupils may Encounter

- Mobility difficulties
- Bowel and bladder incontinence
- Susceptibility to pressure sores
- Reduced stamina
- Loss or restriction of self-help skills
- Lack of self-esteem
- Recording skills

Further Information
Spinal Injuries Association       tel: 0800 980 0501
www.spinal.co.uk
CHAPTER 3 Issues Around Physical Access

Points To Consider Around The School Site

General
- Parking arrangements – space may be needed for a taxi or parents’ car
- General accessibility of external school site e.g. playground/outdoor area - is it flat or sloping?
- Entrances to school – steps, doors and handles, security systems. Are ramps needed or could another entrance be used?
- General accessibility of internal school site – width of corridors, storage obstructing access, doors & how they are opened and closed, clearly labelled rooms, signage at appropriate level.
- Are there big distances between different areas of the school – this can be very tiring for a disabled child.
- Fire exits – can they be accessed by a child in a wheelchair?
- Consider the safety of stairs – provision of handrails, visual markers

Classrooms
- Position of pupils’ classroom – if the classroom is upstairs consideration needs to be given to re-siting this downstairs.
- Are the rooms organised to allow free movement around with minimum obstructions?
- Tables and work surfaces – can they be accessed by a wheelchair, is there space for specialist/personal equipment?
- Is there space for specialist equipment – e.g. chairs, standing frames, mobile hoist?
- Use of interactive whiteboard may have to be adapted.

Toilet Areas
- Size is important and so is accessibility – can a wheelchair user/ child with walking aid get in and turn around?
- Is there space for a carer?
- Toilet area may have to accommodate a variety of different needs – children with incontinence problems, catheter users, children who need moving from chair to toilet by means of a hoist.
- Can the child access the sink and taps independently?
- Can the child dry his hands, use the mirror independently?
- Is there room for a changing table – this may be needed in conjunction with a ceiling track hoist to dress/undress the child.
- Is there room organised to allow supervision with privacy?
Dining Area
- Is it accessible to all – can pupils using a walker or a wheelchair access the room and get around easily?
- Can pupils using wheelchair/walkers reach the hatch area and carry food to the table?
- Can the wheelchair go under the dining tables?

Computer, Art, DT, Library Areas
- Consider the accessibility of these areas – often the working benches are at a higher level – adjustable tables are often useful here.
- Can the sinks be accessed by a wheelchair user?
- How is the library organised for accessibility and visual accessibility?

Playground/outside areas
- Physical terrain – is the site sloping or flat?
- Outside exits – are they accessible to a wheelchair user?
- Condition of outdoor surfaces – crumbling tarmac, uneven concrete, potholes.
- Icy weather – salting and gritting policy.
- Is there a quiet area – some pupils find it difficult to cope with noise and busy activities.
- Is there outside seating? Pupils with physical difficulties can tire easily.
- Are there areas in the shade? Pupils with physical difficulties are often very sensitive to light.
There are now increasing numbers of pupils with physical difficulties being included into mainstream schools. These pupils have very specific needs that can take some time to really understand. What we tend to notice first are the child’s physical needs; pupils may not be able to walk independently and require assistance (wheelchair/walking frames). In the classroom they may have difficulty manipulating the objects and tools frequently used by other pupils. These difficulties immediately give you an idea about areas of a pupil’s functional needs but they may also experience learning difficulties which may be less apparent. These needs will include:

**Classroom Equipment**

It is important that the pupils are able to use general equipment in the classroom, e.g. pens, scissors, building blocks, paints, computer keyboard. Pupils’ abilities to use their hands to manipulate objects will depend upon the type and severity of the physical disability. Much of the equipment used in the classroom can be adapted to make it easier for pupils to be independent and successful.

- Seek advice and ideas from Occupational Therapy.
- Allow sufficient planning time to adapt equipment.
- Break down the activity into smaller achievable tasks.
- Consider and make changes to learning environment that would enable the pupil to be more fully included. Sometimes minor alterations can make big gains, e.g. pupil’s drawer is the end of a unit to allow entry access.
- Plan sufficient time for the pupil to complete the activity.
- Be sensitive that many pupils dislike being different. Often pupils with physical difficulties don’t like to be the only pupil using specialist equipment.
- Have a range of adapted equipment accessible to the whole class e.g. different handle scissors, non-slip matting and raised boards.

**Moving around the school**

Be aware that the pupils with physical difficulties may be slow and find it very tiring, when moving around school.

- Allow more time for moving around school e.g. from one lesson to another.
- Plan toilet routines e.g. stop at the toilet on the way to the playground.
- Plan so that the pupil can avoid the ‘hustle and bustle’ of a busy corridor.
- Work with peers to develop an awareness of the needs of the pupils with physical difficulties.
- Moving them outside can take longer; pupils often require help to get their coats on and off and may have to change their supportive equipment. This may need an assisted transfer or a transfer using a hoist.
- Consider the position and height of pupil’s coat peg, drawer locker etc.
Consider the layout of the furniture and equipment in the classrooms, corridors and school hall. Just a little thought to layout can help to overcome barriers to inclusion.

Outside areas
Like many children/young people pupils who have physical difficulties may want to be with their peers. They may also like to have more peaceful time with one or two friends or just with an adult.

- Recognise that they may need an adult but would prefer to be alone with their friends.
- Model for peers ways to include pupils with physical difficulties into games/activities, with the aim being for the adult to observe from a distance letting the pupil play independently. The adult should not always supervise directly the pupils, but take a back step to observe their play and make sure they and the other pupils are safe.
- For older pupils with physical difficulties provide access to a safe place, inside or out, where they can meet with friends to socialise.

How a pupil will manage going to the toilet
This is a very important aspect of a child’s life and careful consideration needs to be given with the details of the activity carefully analysed.

- Take time to consult with professionals with regard to any building adaptations and child’s individual needs.
- Refer to the Personal Assistance Plan and Contract.
- Seek advice from OT, Physiotherapists and ISS.
- If pupils have mobility needs, it is essential that all staff working with these pupils have training in manual handling techniques.

Specialist Equipment
This is generally necessary for pupils with physical difficulties. The sorts of equipment you may encounter will include:

- Specialist seating which will vary depending on the pupil.
- Standing frames.
- Walkers.
- Wheelchairs manual and or powered.
- Hoists with slings mobile or tracking from the ceiling.
- Benches, v pillows, wedges and other items.
- Communication aids and computer often with switches and specialist key boards and large joystick.
- Trikes.
- Manual handling equipment such as handling belts, standing turntables, transfer boards, slide sheets.
It is very important that pupils with physical difficulties have the opportunity during the day to change their position. This promotes:

- Access to different areas of the curriculum and classroom activities.
- Have better visual attention and concentration.
- Awareness of their body in a different way.
- Reduced pressure on parts of the body, maintain good posture enable them to weight bear and prevent contractures.
- Breathing and overall alertness.

Specialist equipment tends to take up a lot of classroom space. This can mean that the classroom has to be rearranged, which is not always easy. Time to plan the move from one piece of equipment to another will need to be integrated into the pupils’ school timetables. Careful planning can ensure that transfers are kept to a minimum and manual handling reduced.

**Hidden difficulties**

Pupils with physical difficulties may have hidden difficulties that do not always become evident until they are struggling with the curriculum. Some of the signs to look out for are:

- Distractibility and limited attention.
- Looking very tired and appearing “blank”.
- Lack of motivation and interest.
- Poor understanding of letters and numbers.
- Difficulty controlling the movements of their pencil.
- Difficulty with copying from the board.
- Lack of understanding of top, middle, bottom, right and left.
- Not knowing where to start on a page and finding it difficult to space their work properly on paper.
- Lack of response to general teaching approaches.
- Difficulties picking out images in busy worksheets or books.
- Difficulties with understanding sequences, both verbal and visual.
- Inability to cope with very busy and noisy surroundings.
- Difficulties with short and/or long term memory.

These signs may indicate specific areas of difficulty which include:

- Hand/Eye co-ordination
- Visual Perception
- Visual Motor Integration
- Spatial Awareness
An Occupational Therapist, Educational Psychologist or ISC may suggest and adapt activities that can be included into the curriculum. These can enable pupils to be successful which will increase confidence in their learning and enhance their motivation and self-esteem.

**Issues Around PE**

Physical Education was introduced as a statutory subject within the National Curriculum in 1992. This made a balanced, relevant, and differentiated physical education curriculum a legal entitlement of all pupils in state schools, including those with special educational needs The National Curriculum defined six activity areas:

- Athletic activity
- Dance
- Games
- Gymnastics
- Outdoor and Adventurous activities
- Swimming

Including pupils with physical difficulties in Physical Education lessons can be challenging. However, taking part in physical education activities benefits pupils in many ways. The National Curriculum (DfEE 1999: 129) states that physical education:

- Develops physical competence and confidence,
- Promotes skillfulness, physical development and knowledge of the body in action.
- Provides opportunities for creativity, competitiveness and provides challenges as individuals, in groups and teams.
- Promotes positive attitudes towards healthy lifestyles
- Teaches how to plan, perform and evaluate actions.
- Helps pupils learn about their preferences and abilities and make choices about how to be involved on lifelong physical activity.

In 2004, a CD Rom guide was produced entitled *Success for All: An Inclusive Approach to PE and School Sport* (DfES 2004a) which gives comprehensive guidance on including all children in physical education lessons, both in special school and mainstream settings using the three principles of inclusion.

- Setting suitable learning challenges;
- Responding to pupils’ diverse learning needs;
- Overcoming potential barriers to learning and assessments for individuals and groups of pupils.
The CD Rom also provides video clips of inclusive physical education activities and illustrates how the Inclusion Spectrum works in practice. There is also advice about working in partnership with therapists and other outside agencies. The emphasis throughout the guidance is on providing high quality physical education experiences.

This CD Rom demonstrates that it is possible to include young people with physical disabilities in mainstream settings. For a physical education lesson to be considered as meeting the needs of these pupils we would see pupils, amongst other indicators:

- enjoying what they are doing
- showing a desire to improve and achieve in relation to their own abilities
- showing a willingness to take part in a range of competitive, creative and challenge-type activities, both as individuals and as part of a team or group
- have the confidence to get involved
- understand that physical education is an important part of a healthy lifestyle
- know and understand what they are trying to achieve and how to go about doing it (DfES 2004b:5)

The main tool which is promoted in the CD Rom is the Inclusion Spectrum. According to this model, there are five main ways of organising and delivering an activity: separate, adapted, parallel, modified and inclusive. As it is an activity-centred model, it can contribute to the inclusion of disabled pupils in sports activities as it focuses on activity rather than disability and is a good example of the application of the social model of disability.

The CD Rom is a very interactive tool and can be used both by individuals to aid planning, as well as for training sessions with larger groups of staff. There are many useful resources, including exemplar planning and links to useful organisations.

References:

DfES (2004a) Success for All: An Inclusive Approach to PE and School Sport Annesley: DfES

Use of ICT

For pupils who struggle to form letters, who tire easily or have limited motor control, computers may be their only way of getting their thoughts down on paper. Most pupils find it easier to word process and hit keys to complete text than to form letters. Using the keyboard helps pupils with poor motor control or arthritis to gain confidence.

There is now a wide range of software and hardware available as alternatives to using the traditional keyboard and mouse. These can suit learners with varying physical disabilities.

This type of technology includes:

<table>
<thead>
<tr>
<th>Support for writing</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Desktop PC          | ● Easily upgraded.  
                     | ● More stable once in the correct position.  
                     | ● Is quite robust.  
                     | ● Can support alternative keyboards and mice.  
                     | ● Can support all types of software. | ● Takes up a lot of room.  
                     |                     | ● Can be isolating if placed so child faces wall.  
                     |                     | ● Cannot be moved around school with the child on a daily basis. |
| Laptop              | ● Can provide mobile resource for children.  
                     | ● Can support various keyboards and mice.  
                     | ● Can access a large range of software.  
                     | ● Some now connect easily to wheelchairs. | ● More vulnerable to damage.  
                     |                     | ● Battery life can range from 2 hours to 8 hours.  
                     |                     | ● Keyboard may be too small for some children.  
                     |                     | ● Tracker pad can sometimes be knocked causing loss of programme etc.  
                     |                     | ● Can be very heavy to carry around all day. |
| NEO by AlphaSmart   | ● Inexpensive and lightweight word processor.  
                     | ● Simple to use.  
                     | ● Files automatically saved.  
                     | ● Can print directly from the machine,  
                     | ● Files easily transferred to a main computer for editing in Word or printing.  
                     | ● 700 hours of battery life using non rechargeable batteries. | ● Screen is small.  
                     |                     | ● May need an angle rest to improve vision.  
                     |                     | ● Additional software is limited at present.  
                     |                     | ● Software can be very expensive. |
## Support for writing

<table>
<thead>
<tr>
<th>DANA By AlphaSmart</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Lightweight and fairly simple to use.</td>
<td>● Stylus pen is easy to lose and hard to pick up and hold for children with some motor skills difficulties.</td>
</tr>
<tr>
<td></td>
<td>● Larger screen than the NEO.</td>
<td>● Time and training is needed in order to use the machine to its full potential.</td>
</tr>
<tr>
<td></td>
<td>● Secondary children find the palm-top technology useful.</td>
<td>● Screen is still quite small.</td>
</tr>
<tr>
<td></td>
<td>● Additional palm-top software can be added from various palm websites.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Can print directly from the machine.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Touch screen and stylus pen. Has a handwriting recognition facility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● 25 hour battery life and quickly recharged.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Additional memory cards are available.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● USB ports for easy transfer of files and printing.</td>
<td></td>
</tr>
<tr>
<td>Tablet PC</td>
<td>● Can be lightweight.</td>
<td>● Screen is accessed by stylus pen and again is easily lost and often difficult to hold.</td>
</tr>
<tr>
<td></td>
<td>● Has the capability of a full PC. Infra-red and wireless transfer of data.</td>
<td>● Needs training to use.</td>
</tr>
<tr>
<td></td>
<td>● Screen can be changed from landscape to portrait.</td>
<td>● Sometimes software adapted for Tablet PCs needs to be used.</td>
</tr>
<tr>
<td></td>
<td>● On-screen keyboard and writing pad.</td>
<td>● Requires USB peripherals such as, keyboards, CD Rom, mice etc.</td>
</tr>
<tr>
<td></td>
<td>● Battery life 6-8 hours.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Alternative keyboards and mice can be attached.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Has a handwriting recognition facility.</td>
<td></td>
</tr>
</tbody>
</table>

## Keyboards etc.

<table>
<thead>
<tr>
<th>Keyboards etc.</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miniature keyboards</td>
<td>● Same size as a laptop keyboard saves space.</td>
<td>● No separate number pad</td>
</tr>
<tr>
<td></td>
<td>● Some now have built in tracker pads and wrist rests. (Ideal for those with limited hand movement).</td>
<td></td>
</tr>
<tr>
<td>Keyboards with built in tracker balls</td>
<td>● Standard size keyboard.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Stable trackerball with no additional wires.</td>
<td></td>
</tr>
<tr>
<td>Keyboards etc.</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>---------------</td>
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<td>--------------</td>
</tr>
</tbody>
</table>
| Large keys keyboards (Big Keys Keyboards, Jumbo Board etc.) | ● Often have coloured keys.  
● Keys are chunky and robust  
● More visually inviting.  
● Useful for children with visual difficulties.  
● Some offer ABC or Qwerty layouts.  
● A choice of upper or lower case keys available.  
● Some are set up to work without a mouse etc. | ● Difficult to learn to touch type because of distance between keys.  
● Some have no shift button so cannot be used with software that needs it.  
● Can be quite expensive. |
| Standard size keyboards with coloured keys, lower case keys etc. | ● Keys have different colours for vowels, consonants and function keys.  
● Lower case is recognisable by Infant children. | ● Can be expensive |
| Key guards | ● These cover the keyboard and prevent unwanted presses of the keyboard.  
● Supports pupils with a tremor or motor skills difficulties. | ● Sometimes it is difficult to find the correct guard for your keyboard. Often easier to buy the keyboard and guard together. |
| Keyboard gloves | ● Cover keyboards and protect them from spills.  
● Can have lower case letters or an Alphabet layout.  
● Some have high contrast keys to support pupils with visual difficulties.  
● Some have symbol support for each letter. | ● Often has to be purchased with the keyboard.  
● Sometimes pupils find it difficult to “feel” the keys. |
| Keyboard angle rests | ● Very useful for pupils with visual difficulties.  
● Often provides children with a better angle to type from especially if wrist rest are also provided. | ● Can make keyboard more cumbersome. |
Overlay Keyboards

IntelliKeys
- IntelliKeys comes with six standard overlays that can be used with any word processor.
- Computer recognises bar codes on the back of overlay and sets keyboard up for automatic use.
- Plugs into a desktop or laptop computer.
- Easy to make your own overlays.
- Useful for pupils with physical, visual or cognitive difficulties.
- A good selection of additional software available.

Concept Keyboard
- Very easy to make your own overlays.
- A4 or A5 layouts.
- Software available for all PCs.
- Useful for pupils with physical, visual or cognitive difficulties.

Mice

<table>
<thead>
<tr>
<th>Mice</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Mini mice/tiny mouse | - Half size of standard mouse.  
|                    | - Often the best fit for pupils with small hands.  
|                    | - Some can be programmed to provide double click by pressing the centre wheel.                                                             | - Can be too small for some pupils.                                             |
| Tracker balls      | - Much easier to control than a standard mouse.  
|                    | - Can be set up with guards for children with severe motor difficulties.  
|                    | - Available in several shapes and sizes.  
|                    | - Some have jacks for connecting switches.                                                                         | - Can be cumbersome and take up a lot of room.                                  |
| Touch Pads         | - Usually found on laptops but can now be bought separately.  
<p>|                    | - Can be set up for individual needs e.g. Speed, pressure, double clicks, scrolls etc.                                             | - Can be accidentally knocked or brushed.                                      |</p>
<table>
<thead>
<tr>
<th>Mice</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Joysticks    | - Can be an advantage as may be familiar to them, for instance on a wheelchair.  
               - Can be controlled with an elbow or even a chin.                         | - Can be easily knocked.                                                      
               - Stability can be an issue.                                              |
| Switches     | - A good alternative to a mouse.                                            | - Needs software that will “scan”.                                            
               - Very robust.                                                          | - Often need to be mounted for correct angle for pupil’s access.             |
|              | - Able to be hit by any part of the body, even used under pupil’s arm.       |                                                                               |
|              | - Many shapes colour and sizes can be obtained.                             |                                                                               |
|              | - Some battery run switches can be used away from computer as a means of communicating individual sentence, words etc. |                                                                               |
|              | - Some can be squeezed or wobbled.                                          |                                                                               |
|              | - Can be used in pairs one replaces the left mouse.                         |                                                                               |
| Tablet Pad   | - Provides greater accuracy.                                                | - Small wired pen.                                                           |
|              | - Replicates the screen.                                                    | - Mouse buttons are often small.                                              |
|              | - Can be used for graphics and mapping.                                     |                                                                               |
|              | - Can now be wireless.                                                      |                                                                               |
| Dual mouse connector | - Very useful for dual control of the mouse.                                | - Need to be careful to choose the connector with correct plugs and pins.   |
|              | - Can connect a trackerball, and mouse etc. to one computer.               |                                                                               |
| Head pointer | - Used instead of mouse giving hands free control.                          | - Needs careful training                                                      |
|              | - A dot placed on the head allows you to control the cursor, dwell-click and used an on screen keyboard. | - Often needs additional “dwell” software.                                   |
## Communication Aids

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Used literally to give users a “voice”.</td>
<td>- Not often seen in mainstream schools</td>
</tr>
<tr>
<td>- Many available, from those that give pupils mobile support for individual words, to those that give the pupil a complete ‘voice’ and run other software.</td>
<td>- Staff and user need training</td>
</tr>
<tr>
<td>- To support complex machines.</td>
<td>- Can be very expensive.</td>
</tr>
</tbody>
</table>

## Software

<table>
<thead>
<tr>
<th>Software</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clicker</strong>&lt;br&gt;By Cricksoft</td>
<td>- Supports, comprehension, vocabulary, spelling, grammar and writing. &lt;br&gt;- Speeds up writing tasks and prompts recall of words and sentences. &lt;br&gt;- Can input individual words or phrases. &lt;br&gt;- Provides both auditory and visual support for writing. &lt;br&gt;- Many additional software topics can be added to basic package. &lt;br&gt;- Free grids can be downloaded from their website. <a href="http://www.cricksoft.com.uk">www.cricksoft.com.uk</a></td>
<td>- Needs some preparation of grids for individuals.</td>
</tr>
<tr>
<td><strong>ClozPro</strong>&lt;br&gt;By Cricksoft</td>
<td>- Text can be imported from a word processor, other software, scanner and the web. &lt;br&gt;- Activities can then be designed for individual pupils. &lt;br&gt;- Very quick and easy to set up. &lt;br&gt;- Has visual and auditory prompts. &lt;br&gt;- Support for reading and comprehension.</td>
<td>- Requires some word processing skills.</td>
</tr>
<tr>
<td>Software</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Wordbar By Cricksoft</td>
<td>● Can be used with any word processing software.</td>
<td>● Needs grids prepared for pupils.</td>
</tr>
<tr>
<td></td>
<td>● Provides individual word bank which can be set up as a dictionary.</td>
<td>● Planning time is also required.</td>
</tr>
<tr>
<td></td>
<td>● Can have grids with phrases and symbols.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Will read text back to child once sentence complete.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● A good move up from Clicker when pupils reach secondary school.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Additional grids available from web site address above.</td>
<td></td>
</tr>
<tr>
<td>Co-Writer</td>
<td>● Adds word prediction, grammar and vocabulary support.</td>
<td>● Pupils must work between two windows.</td>
</tr>
<tr>
<td></td>
<td>● Reads words to pupil.</td>
<td>● Only one sentence at a time is posted to word processor.</td>
</tr>
<tr>
<td></td>
<td>● Can be used with any word processor.</td>
<td>● Keyboard short cuts cannot be used while programme is running.</td>
</tr>
<tr>
<td></td>
<td>● Support for phonic spelling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Each user has individual dictionary</td>
<td></td>
</tr>
<tr>
<td>Penfriend XP</td>
<td>● Word prediction software.</td>
<td>● Needs Windows XP although earlier versions are around.</td>
</tr>
<tr>
<td></td>
<td>● Can be used from childhood to adult.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Can be used with any word processor etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Learns pupil’s preferred writing style and grammar.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Will read words and sentences back to pupil.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Each user has individual dictionary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Speeds up writing and allows fewer key presses.</td>
<td></td>
</tr>
<tr>
<td>Voice recognition</td>
<td>● Speech converted to text as user dictates.</td>
<td>● Training the software is still an issue.</td>
</tr>
<tr>
<td></td>
<td>● Can be used with a Dictaphone</td>
<td>● Works more efficiently if corrections are made as they happen.</td>
</tr>
<tr>
<td></td>
<td>● Corrections can be made.</td>
<td>● Needs quiet surroundings in order to be accurate.</td>
</tr>
<tr>
<td></td>
<td>● Gives access to whole of Windows and World Wide Web.</td>
<td>● Check recent research on Becta website. <a href="http://www.becta.org.uk">www.becta.org.uk</a></td>
</tr>
<tr>
<td></td>
<td>● Can act as a “reader” for text.</td>
<td></td>
</tr>
</tbody>
</table>
There are many software and hardware providers but a useful selection of catalogues to have at hand are:

**REM** – tel: 01458 254700 – [www.r-e-m.co.uk](http://www.r-e-m.co.uk)


**Inclusive Technology** – tel: 01457 819790 – [www.inclusive.co.uk](http://www.inclusive.co.uk)

**Keytools** – tel: 023 8058 4314 – [www.keytools-training.co.uk](http://www.keytools-training.co.uk)

This is by no means a definitive list of ICT support material because things are continually moving on. However, it will provide you with a starting point to find ways to support, enable and include pupils with physical difficulties in our schools.

Request for an ICT assessment for a pupil with a statement of special educational needs may be made through the annual review process. Requests should be made when there is clear evidence that ICT resources are needed, over and beyond, that which are available to pupils in schools. Consideration should also be made as to whether pupils have the skills and ability to maximise the use of additional specialist equipment. The Case Advisory Panel (CAP) will consider the evidence within the annual review documentation and may then request further information, using a proforma, before requesting an Inclusion Support Coordinator to complete an ICT assessment. A report with advice regarding hardware is then returned to CAP to consider. The LA may fund the purchase of hardware to support pupils’ needs but there is an expectation that software is purchased by the school as part of the provision it makes for pupils with SEN.

General advice about the use of ICT, hardware and software, is available from the Inclusion Support Service.

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### Useful ICT skills

<table>
<thead>
<tr>
<th>Description</th>
<th>Useful ICT skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Keyboard shortcuts</td>
<td>Use of ALT and CTRL keys to speed up choices and control common actions.</td>
</tr>
<tr>
<td>Use of templates</td>
<td>Word templates where regular format is used.</td>
</tr>
<tr>
<td>Use of “Access” in control panel of Windows</td>
<td>Slowing mouse speeds, keyboard repeat rates. ‘Sticky’ keys etc.</td>
</tr>
<tr>
<td>Auto correct on ‘Word’ (Tools)</td>
<td>Reduces time and effort</td>
</tr>
<tr>
<td>Using ‘snap to default’ in mouse properties</td>
<td>Always takes mouse back to original starting place</td>
</tr>
<tr>
<td>Customising the desktop to individual users</td>
<td>Common format each time child logs on.</td>
</tr>
</tbody>
</table>
Self esteem is about how pupils feel about themselves and what they think they can do. This plays a large part in children’s emotional well-being. It is made up of a number of separate dimensions, but the two most important for all pupils are physical appearance and social acceptance.

As they develop their self-esteem, pupils set their own goals formed by a combination of how they think their parents, families, friends and teachers would like them to be and how they would like to be themselves – the ‘looking-glass’ effect.

When constant experiences tell them they are not going to achieve these goals at the level they would wish, their self-esteem can take a nasty knock. Pupils with a physical difficulty are likely to realise sooner than able-bodied peers that their potential in several areas is reduced and that even with considerable effort some goals are unobtainable.

All pupils can generalise failure and feel that they are useless. It is critical therefore, that pupils with physical difficulties who may experience this earlier or more often than peers, are treated in a sensitive and understanding way to support and develop the ‘feel good factor’ about themselves.

To build self esteem, pupils need to feel “loved”, “valued”, “capable” and “competent”.

School from Year 9 Pupil’s Perspective

- Initially, I thought school was going to be really hard
- People would be making fun of me
- Work and homework would be really hard
- People wouldn’t be nice to me because of the way I am and that I was a ‘weirdo’ and I wouldn’t make any friends and be lonely.
- I worried about getting around the school and asking for help because I thought people would ignore me and walk off.
- It was scary going in the lift at first because it wasn’t a lift where you could just go in and press a button and there wasn’t a roof, so
- I was glad that someone was always in the lift with me.
- I was scared of going along corridors with lots of other people because I thought they would tell me that I was in the way and knock into me, with people towering

- over me it made me feel 5 inches tall and was quite frightening. Getting into the classrooms was really hard because there was always something or someone in the way. Even now, 3 years on, there are still things in my way, but people are more considerable and do make way for me.
I thought the teachers would be nicer to me than they were to everybody else, feel sorry for me and treat me differently because of the way I am. I didn’t want that and it didn’t happen and I was glad about that because I am just like everybody else, but in a wheelchair.

It’s been three years since I started at this school. Nobody made fun of me like I thought they would. I’ve got lots of friends from year 7 to year 11, but to make these friends, I’ve been as nice to people as they have to me and shown them that I am no different to anyone else. I can get all around the school and go anywhere my friends go, so I never feel left out at break and lunch times. The only time I do feel left out is during activities week because some of the activities are inaccessible, like sports day and the non-uniform walk.

Self esteem and learning

- Don’t make assumptions about strengths and weaknesses based on pupils’ perceived difficulties.
- Allow a degree of risk taking and support failures – we tend to shield pupils with physical difficulties.
- Give lots of varied experiences – obtain a balanced profile of abilities.
- Identify the essentials – pupils with physical difficulties can find school very tiring and often cannot sustain focus and effort on all tasks right through the day; improving daily life skills such as handling money would be a priority over neater handwriting.
- Identify to the pupils why the task is important and how it fits into developing short/long term skills “If we can do this over the next few weeks by half term we should be able to………”.
- Involve the pupils in target setting including the IEP and ask what they would like to improve. You may make suggestions and set certain targets, but the students should feel in control of their learning and setting the pace.
- Don’t try for perfection – ‘best fit’ is ok; targets should be challenging, but not repetitive – when pupils have attained a reasonable level of ability and further improvement is not probable, the target should be changed.
- Bite-sized learning is better – some pupils may need targets that are achieved very rapidly.
- ‘Slow is often fast enough’ – many classrooms are driven by pace and attainment; remember the fatigue factor and adapt accordingly – pupils who feel constantly behind the rest of the group and urged to catch up will eventually disengage.
Praise carefully – unrealistic praise is demeaning and pupils will lose credibility with peers if they are over-valued – pupils know!
Praise need not always be verbal – a piece of work well presented on the wall can speak volumes about how a pupil is valued.
Sometimes it may be appropriate to reduce the outcome e.g. 5 sums instead of 10. The journey is as important as the destination. Remember that learning is a hard process.

Self Esteem and Physical Care

In enabling pupils with physical difficulties to be included in school life, it may be necessary for staff to carry out personal/care procedures, which ordinarily, children/young people would undertake for themselves. These may include eating, drinking and toileting.

In order to preserve pupils’ self esteem it is essential that they feel they have control of the situation, can modify the support given on any particular occasion and their wishes will be respected.

Do not assume or make decisions on what kind of help pupils want – this takes away control and forces them to become passive/helpless. Negotiate.
Establish that the level of help is flexible, not fixed – even on a daily basis.
Be sensitive to cues – they may not need help.
Ask permission “Would you like me to…….”
Give options to encourage choice.
Don’t push! – if help is not required, stand back.
Propose other options – don’t act unilaterally “Shall we ask someone else to help us with this?”
Allow pupils to take the lead – “How do you want me to help with this today?”
Establish routines – when you have worked out a way together of helping for a particular task, there is no need to keep on asking – just check that pupils are still happy with the routines and not wanting to change it.
Don’t be too busy or in control.
Keep smiling and see the funny side together.
Use the time for toilet routine positively – reinforce learning in a fun way
Allow pupils to make the toilet environment their own – posters/pictures. (Avoid it becoming a storage space).
Be aware that pupils grow – check height of rails, seating, steps and other equipment
Self Esteem and Friendship

School is about more than the curriculum. It should widen our life experiences and provide opportunities to develop our personalities and find out who we are and who we want to be.

Pupils with physical difficulties may or may not be attending the local neighbourhood school and be brought by special transport. Some pupils may need special arrangements in break and lunchtimes and require regular provision for therapies etc outside the classroom.

If this is not managed carefully, the pupil can easily be excluded from everyday social experiences with peers such as coming to school and breaktime. They can be perceived as a guest or visitor, as they are often supported by adults and may feel outside of the everyday pupil friendship circles. Pupils with physical disabilities need to be treated in the same way as their peers to ensure that they are accepted as equal members of their group.

- TAs assigned for many hours a day to support physical and learning needs, need to be sensitive to this and not become the total supporter, carer, advocate and best friend.
- Pupils need a variety of people in these roles the same as their peers.
- No pupil should have a TA ‘velcroed’ to their side during lessons – there should always be daily occasions when the LSA physically moves away, allowing peers to interact and support each other.
- Care needs to be taken in the positioning of a supporting adult. Sitting constantly by the side of the pupil creates a physical barrier – sitting opposite or standing behind the pupil may be just as effective, but allow peer interaction.
- The TA needs to be seen to be able to support other pupils’ learning and not be identified solely for the support of one pupil’s learning – acknowledging the pupil as part of a group is essential.
- Pupils with physical difficulties need opportunities to misbehave the same as their peers – this cannot happen if they have no physical space and have a constant adult ‘minder’.
- Similarly, pupils need to have the same consequences when they misbehave as their peers, such as missing break times etc.
- The classroom teacher needs to be identified as the main director of classroom learning and behaviour of all pupils – there is no separate agenda for pupils with physical difficulties – differentiated approaches are planned and managed by the teachers and implemented/supported by the TA. Expectations are therefore standard for all pupils.
- It is very easy for the TA to become the supporter, carer, advocate and best friend. The pupil with physical difficulties needs a variety of people in these roles the same as their peers.
Friends and best friends tend to choose each other – however, pupils with physical difficulties may not develop friendships with their peers spontaneously. ‘Buddy’ systems, initiated by staff may prove a starting point for informal friendship, but peer help needs to work both ways otherwise a ‘helping’ culture develops with peers.

Seating is critical to fostering friendships – pupils need to be offered choice whenever possible within the practical constraints of specialist seating/equipment.

‘Friends fall out’ – adults need to allow this to happen and not coax peers into sustaining friendships because of a pupil’s physical difficulties.

Many pupils have a differentiated programme, which can be very individually based – however if this is the predominant method of learning and there is not a good balance with group situations, friendships cannot flourish.
CHAPTER 6 Working in Partnership with Parents/Carers

Take time to develop a relationship with the parents/carers. Understandably these parents/carers will have additional anxieties and it is important that time is given to gain their trust. Parents/carers of pupils with physical difficulties have considerable knowledge and experience of their child’s needs and condition.

- Use their knowledge as it is specific to their child.
- Invite them in to talk about their child and the child’s needs.
- Plan with them the induction of the pupil to the school.
- Encourage parents/carers to share information regarding the professionals involved.
- Parents/carers may require more than average contact with school but this needs to be managed for the best interests of the child.
- Parents/carers of pupils with serious, life threatening conditions may require daily contact:
  - Establish and maintain a Home/School Liaison Book (TA responsibility, but monitored by the class teacher).
  - Identify a key contact person e.g. TA, class teacher or Form Tutor.
  - Establish telephone or e-mail contact.
  - Determine a regular cycle of meetings in negotiation with parents/carers.

For many parents/carers the diagnosis of a medical condition can be devastating and they may take years to come to terms with the situation.

- Be sensitive to the needs of the parents/carers as well as to those of the pupils.
- Recognise that the pupils’ needs may suddenly change, e.g. through surgery so that this may increase family’s anxieties and stress levels.
- Be aware that not all medical intervention/treatment is successful or achieves the desired outcomes that parents/carers wish.
- Remember that parents/carers availability may be limited by other family commitments, i.e. the needs of other siblings.
- Be aware that parents/carers may be overwhelmed by the number of professionals involved in supporting their child.
- A few parents/carers may choose specific therapeutic programmes, which may not be endorsed by other professionals. However, they have a right to explore all avenues.
- Always advise parents/carers of contact with external agencies.

School should set realistic expectations for an individual pupil in negotiation with parents/carers.

- Parents may be anxious about their child’s absence from school because of medical appointments.
It can be hard to juggle between meeting the pupil’s physical and learning needs. ‘Life is a balance’.

School, parents and pupil need to identify and agree priorities – these are not just IEP targets e.g. learning to type is a life long skill and time may need to be taken out of the curriculum.

Be aware that pupils need to maintain a positive attitude about school.

Some conversations, e.g. funding or access issues, need to take place without the pupils present whilst others should include them.

Where you can find out more

Useful books and resources:

- Scope Early Years Unit, 2004 Play talks, Fun ideas to promote communication through play. London. Scope.
Useful video:

Useful websites:
- British Council of Disabled People www.bcodp.org.uk
- Scope www.scope.org.co.uk
- Association of Spina Bifida and Hydrecphalus www.asbah.org
Appendix 1 Who Can Help?

School Team

Head teacher
- To ensure that the provision within the school meets children’s needs
- To promote inclusive practices in the school.

SENCO
- Collates specialist information about particular physical conditions or illness and disseminates knowledge to colleagues.
- Supports all staff with curriculum planning and school accessibility.
- Overall responsibility for the management of teaching assistants supporting SEN pupil.
- Establishes and maintains liaison with parents ensuring that there is a clear understanding of whom to contact in school and how.
- Establishes and maintains liaison external agencies, e.g. health.
- Either provides or organises training as required.
- When necessary, sets up and monitors health care plans with input from parents and relevant specialist professionals.
- Ensures procedures are followed with regard to the Code of Practice, e.g. IPPs, IEPs. Or Annual Reviews

Class teachers
- Responsible for planning and delivering an appropriate academic and social curriculum that is accessible to the pupil.
- Responsible for drawing up an IEP in consultation with SENCo.
- Linking with parents, colleagues and external professionals for advice.
- Managing the deployment of teaching assistants in their classroom.

Teaching Assistants
- Supporting the pupil in all school activities as necessary.
- Supporting the pupil in developing independence.
- To carry out therapy programmes.
- To seek advice and inform the teacher, SENCO or other professionals of child’s progress and/or changing needs.
- To contribute to IEPs and the Annual Review process.
Parents

- Have knowledge and experience of meeting their child’s condition/illness and needs. This knowledge is invaluable to schools.

Support Team

- Pupils with physical disabilities may be known to a number of professionals. For example:

Community Paediatrician

- Specialist doctor for pupils who maintain regular links with pupil and family. Co-ordinates other health professionals to be involved as necessary.

Physiotherapist

- Provides advice and assistance on pupil’s mobility needs. Ensures that correct handling and positioning equipment is identified and provided. Provide individual therapy to pupils, give advice and training to carry out therapeutic programmes. Provide advice on lifting and handling of a specific pupil. Offer recommendations on the inclusion of pupils in the PE curriculum.

Occupational Therapist (Health)

- Supports the achievement of optimum functional performance of skills in all areas of life. Complete assessments of the child’s motor, sensory, perceptual and social skills for the development of life skills. May provide therapy programmes and advice on adapting aspects of the curriculum and classroom environment. May give advice on handling techniques specific to pupils and assess for specialist seating.

Occupational Therapist (Social Services)

- Provides specialist advice on adaptations of the school environment in close liaison with colleagues from across agencies. This may include specialist equipment, e.g. hoists, or structural adaptations. In the home environment works to promote maximum independence of the child by advice, provision of equipment or adaptation of the environment.

Speech and Language Therapist

- Assesses children’s speech, language and communication skills. Develops and advises on specific programmes. May advise on alternative means of communication, e.g. Makaton, systems using symbols or communication aid. Can offer advice on eating and drinking.

School Health Nurse

- Supports and advise schools on a variety of health and medical issues, e.g. organising training for school staff on specific conditions, such as epilepsy; Establishes medical procedures and draws up health care plans; sets up support for school when the pupil has a deteriorating condition.
Social Worker

- Supports the pupil and family on a variety of issues, e.g. social or financial needs. Completes a holistic assessment of social needs of children/young people within their family and arrange appropriate support services. Within South Gloucestershire there is a specialist team providing this support – CHAD (Child, Health and Disability Team.)

Teacher of the Deaf, Teacher for the Visually Impaired

- Have further qualifications in their sensory field and provide advice and support to schools for pupils with physical difficulties as appropriate.

Educational Psychologists

- Educational Psychologists provide a consultation and assessment service to school staff, parents and other services and agencies, to help promote the development and learning of children and young people.

Inclusion Support Coordinator

- Teacher with additional qualifications and/or experience in special educational needs. Provides specialist advice and support to schools in promoting the inclusion of pupils with physical difficulties. The ISC has a key role in liaising and coordinating professionals involved with the pupil.

Voluntary Agencies/Support Groups

- A number of agencies offer advice and support to families and schools, e.g. SCOPE. May be able to access funding for resources, specialist equipment. Some may provide awareness training to schools. They also provide holiday play schemes e.g. Care Forum.
Appendix 2  Model of Information for School Staff

Pen Picture of (name) 
Updated August 2004

Photograph Of pupil

My name is_________________. I am _____ years old, I am in ___ class and I have Cerebral Palsy. CP is caused by an injury to the brain around the time of birth. My limbs are affected, especially my legs. I am able to walk independently with the aid of a Kaye Walker, but this is tiring for me, so for long distances, I use a wheelchair that I can self-propel. I am able to crawl around the classroom and I can get onto and off seats of my own, though on slippery surfaces it may be helpful for you to steady the chair. Sometimes I use a standing frame as this gives my legs a good stretch and also helps me to use my arms in a more controlled way. In class, I use a Samson seat, which gives me extra support and enables me to sit with good posture, which in turn helps my arm function. For carpet time/assembly, I usually sit on the floor, although occasionally I’ll sit on a chair. Generally I am a very happy, cheerful boy and enjoy coming to school. I arrive with ____ and ____ in the school bus. They also take me home. We have a lot of fun in the bus with _____ (other pupils).

1 Communication
I communicate very well and really enjoy singing. I pick up lots of phrases and am quite a charmer! I am unable to produce some speech sounds well, but generally my speech is very clear. I am certainly not shy with people in school. I work on some exercises at home, with the speech and language therapist and with Resource Base staff.

2 My personality
I have a great sense of humour, but I am generally well behaved. I like routine and can sometimes be awkward if I am working with someone new. This is not because I dislike them, it is just because I like to work with people I know and trust. If you are new to working with me and I am awkward, then being firm and following the school rules works well. I have never been on a red card so this strategy must work!

3 Self-help
I am beginning to become independent and now do much more for myself now, for example, I can put on my coat, scarf, gloves and hat with help. I am also able to take them off again and hang them up by myself, although I need help with my zip. I am getting better at dressing myself but I need help. I am much more independent in the toilet, although I still require some assistance (see RB staff for more details).
4 Vision
I have hypermetropic astigmatism and long sight and need to wear my bi-focal glasses at all times. I have a problem known as ‘crowding’ in which letters surrounding the one I am looking at cause confusion. This stops me from maintaining accurate visual control on a target, particularly when reading. My eye movements are very weak and I tend to move my head instead of my eyes. I work with Mum and Dad on exercises to try to improve my eye movements. However, as a result of my poor eye movements I:

- Am unable to focus accurately.
- Am slow to change focus.
- Am unable to sustain fixation and focus.
- Find it difficult to ‘stabilise’ the visual world.
- Find it difficult to maintain eye contact, so my social development may be affected.
- May at times have double vision.
- Get tired more easily than most when working.

In order to help me in class you could try the strategies outlined at the end.

5 Gross Motor Skills and Mobility
When using my walker, or when crawling, I do not use rotation of my trunk or pelvis. This is due to increased postural tone and lack of 3D awareness. Not using rotation makes it difficult for me to change and sequence positions, to notice things around me and limits the use of my upper body. I have blocks of Occupational Therapy to work on my gross motor skills (as well as fine motor, spatial awareness and body awareness). Each day I have a physiotherapy session in school with Resource Base staff. The physiotherapist visits once per fortnight to see how I’m getting on.

6 Fine Motor Skills
I am unable to use my left hand to grip. With my right hand I can support objects, open my fingers and hold objects, but I cannot manipulate them. This limits the use of my right hand. All of my fine motor activities are limited by my decrease in motor planning and ability to make clear and planned directional movement. It is thought that I am right handed, but because my right hand is more affected by my CP, I have to use my left hand.

7 Sensory/ Perceptual Abilities
Due to my CP, I have difficulties with sensory feedback from my limbs and joints and with balance reactions and 3D sense of self. This shows itself in my difficulties with planning and organising 3D movements and with knowing how to make visual motor directional movements with my arms.
8 Recommendations

- My laptop computer helps me to access the curriculum, as handwriting is so difficult for me.

- Give me visual cues to help guide my hand-eye co-ordination e.g. a green dot at the start and red dot to mark where to finish. Verbal cues are used a lot by Resource Base staff when I am writing or drawing and these really help, especially when I am doing something new.

- Dot to dot works well to help me to develop letter formation and picture work.

- It’s easier for me if work is presented on a worksheet rather than on the board, as I don’t have to keep re-focussing.

- If you have a small version of a big book, this will help me if I am expected to read aloud.

- If you have to present something on the board for me to copy, it is helpful if you use different coloured pens for alternating lines, as this will help me to re-focus.

- When I get onto place value, it would be helpful to present the sums with clear lines to indicate tens and units and two coloured lines to show me where to put the answer.

- An arch level file with Dycem mat (sticky matting) is helpful when I need to write, draw or read.

- A ruler with a handle is helpful. I have one in class.

- I should practice large gesture movements of the shapes and forms before working on the fine control with a pencil.

- If you pass me my equipment at arms length, slightly behind, me so I have to turn and reach them it will encourage rotation and more 3D movements.
Appendix 3  Specialist Equipment

Wheelchairs
- Normally supplied by Wheelchair Services based at Southmead Hospital, there is usually a waiting list to be assessed.
- Referral by Occupational Therapist or Physiotherapist.
- Wheelchairs are sometimes funded by private or charitable means, the main charity being Whizz-Kidz.

Manual wheelchairs
- These are self-propelling by the child or pushed by a carer.
- They may be fairly basic, or for children with greater postural and support needs may incorporate spinal moulds to accommodate the shape of the child and prevent deformity.
- These chairs may be quite heavy to push.

Indoor Powered chairs
- There is a strict criteria for provision of these chairs.
- They are sometimes provided to assist children with severe mobility difficulties to access a large school site more easily.
- Can only be used indoors

Outdoor powered chairs
- There criteria for the provision of these chairs.
- Only supplied if the child has been an indoor powered chair user first.
- If a child has the ability to use a powered wheelchair it can open up his world.

Specialist Seating
- Good seating is essential to facilitate support and comfort and therefore enable attention, concentration and learning.
- Correct seating can help correct poor posture.
- It can maintain optimum posture for pupils who have abnormal muscle tone or cannot support themselves.
- It can help prevent deformity.
- It can improve heart and lung capacity
- It can allow a disabled child to join in activities.
- It can assist ease of transfers to other equipment.
- It can often help to accommodate different height working surfaces.

Types of Seating
- Large range of types available from different firms (Jenx, Leckey, R82, Smirthwaite etc)
- Seating is usually adjustable to allow for growth or change of posture.
- Assessment by Occupational Therapist or Physiotherapist.
Possibly funded by SEN section for placements other than in resource bases and special schools.

Its use should be monitored with advice from appropriate therapist.

Standing frames

Standing frames enable children who cannot stand/have difficulty standing unaided to attain an upright position without much effort.

Use of a standing frame has the following benefits -
2. Improves hip joint development and reduces the likelihood of bone thinning.
3. Improves digestion/circulation etc.
4. Enables improved upper limb and fine motor skills functions by providing good trunk stability.
5. May reduce the likelihood of scoliosis in some children.

Standing frames are usually used daily for up to an hour at a time, during lesson time.

Standing frames may be upright or leaning forward or backwards. The child’s physiotherapist will advise on the most appropriate standing frame and the best way to get the child in and out. Standing frames need to be set up to fit the child and adjusted regularly as the child grows by the physiotherapist.

Standing frames may be funded by PCT. Assessment and application for funding is usually done by the physiotherapist.

Walking frames

Walking frames enable children with poor control/movement of the legs to walk. They offer improved balance and allow the child to use his/her arms to help support their legs during standing and walking.

Most walking frames have 2 wheels and 2 legs, or 4 wheels. A walking frame may be used in front of the child (rollator) or behind the child (K walker).

A child with a walking frame will need extra room in and around the classroom to use it and may have difficulty turning around in small spaces as the wheels usually do not swivel and the child has to lift the walker to turn.

Most children soon learn to get from a chair/floor on to their walking frame and back again, but need to practice a specific way of doing it (as advised by the child’s physiotherapist). It is better to help the child to get on to their walking frame by verbal/physical facilitation rather than by lifting them into it, as this does not enable the child to learn to be independent.

Walking frames are funded by the health service; assessment is by the physiotherapist.
Appendix 4  Risk Assessment

Risk Assessment is a legislative requirement contained in the Management of Health & Safety at Work Regulations, which have been in force since 1992.

In simple terms a risk assessment is the process followed in order to establish a safe way of working. It is an important aspect of inclusion as the process followed will identity what issues exist for a pupil and how best to manage these in order that the pupil can access the school safely. Relevant risk assessment include management of medical needs and manual handling.

The risk assessment process however is note solely based on the needs of the pupil but will also consider whether staff can deliver what is indicated as necessary and whether to do so staff need training or equipment. This aspect is sometimes overlooked as the focus is often on getting pupils into school but it is no less essential.

Risk assessment are required to be reviewed regularly and revised as necessary. For risk assessment involving pupils revision is frequent as medical conditions change as do their weight and physical capabilities.

For additional detail on Risks Assessment requirements:

- For general details – see pages 1.050/7 of the H & S Manual.
- For guidance on risk assessment involving medical needs see Appendix 5.
- For guidance on manual handling see Appendix 6.
- For guidance on safety in a fire see Appendix 7.
Appendix 5

This is the guidance currently available from South Gloucestershire Department for Children and Young People and may be found on the intranet; Department for Children and Young People/Achievement & Inclusion/Schools Personnel/Schools Health & Safety/Health & Safety Manual for Schools. The DfES in March 2005 issued updated guidance, ‘Managing Medicine in Schools and Early Years Settings’. Reference: 1448-2005DCL-EN and is available online at www.teachernet.gov.uk/publications.

SOUTH GLOUCESTERSHIRE COUNCIL
DEPARTMENT FOR CHILDREN AND YOUNG PEOPLE
GUIDANCE NOTE
ADMINISTRATION OF MEDICATION IN SCHOOLS

This guidance note is supplemental to the Council’s Administration of Medication Policy and does not supersede any part thereof.

PURPOSE

The guidance note has been produced in order to provide background information on managing medical needs in schools. It provides a basic overview on the management of medical needs, including information on a number of the more common medical needs that may need to be addressed in schools. It also includes a model school policy that can be adapted to suit the needs of individual schools. The guidance is based on practical experience and the DfEE good practice guide, Supporting Pupils with Medical Needs.

LEGAL REQUIREMENTS

There is no legal requirement on staff in schools to administer medication to pupils but there are a number of legislative requirements whose effect, in practice, has resulted in school staff administering medication.

Primarily there is the legal requirement to educate children. Consequently schools need to make arrangements to allow children with medical needs to attend school where practicable. Once in school pupils are owed a “duty of care” and staff also act in loco parentis.

The prime responsibility for a child’s health however lies with the parents. In situations where staff do agree to administer medication the Council provides an indemnity for them should there be unforeseen complications as a result of undertaking the agreed procedure.

MEDICAL NEEDS

It is indicated in the DfEE good practice guide that “most pupils will at some time have a medical condition that may affect their participation in school activities”. The guidance note, however, goes on to indicate that medical needs do not include short term medical requirements, e.g. finishing a course of antibiotics for an ear infection. For the purposes of this guidance any occasion where administration of medication takes place comes under the definition of medical needs.

This is felt to be appropriate because the initial procedures to be followed when administering medication for short term needs are the same as for managing any longer term medical conditions.
a) **Short Term Medical Needs** - These are where pupils are to all intents and purposes fit for school following an illness, but who need to finish up a course of antibiotics, or are recurring conditions, e.g. ear infections, which might occur every few months. The medication required to allow the pupil to return to and/or remain in school would only need to be administered for a few days.

Schools have generally sought to minimise the number of pupils in school with short term medical needs. This is due mainly to storage problems associated with keeping the medication on site and also because of the actions of some parents. For example parents have simply dropped their child off at school, with medication, and left without informing staff. Given the above where the schools aim is to minimise administration of short term medication this can be supported.

Other short term medical needs can occur, however, in a situation where pupils are taking part in a school trip. As indicated in the Administration of Medication Policy no Non Prescribed medication should be given to a child who is 12 years old or younger. On any school trip, except those in the immediate vicinity, i.e. for swimming, inter school matches, etc., parents will need to be asked to give their approval for the trip and indicate any special considerations, which will include medical needs. It is important that parents be made aware that the school can not obtain and/or give non prescribed medication to children aged 12 or younger, without permission from the parent. If their child(ren) are likely to suffer from headaches, period pains etc., they will need to advise the school what tablets their child(ren) can take and give written permission for these to be administered.

b) **Long Term Medical Needs** - These are medical needs which will effect the pupil for extended periods and probably most of their lives, e.g. anaphylaxis, asthma, epilepsy.

Such medical needs are now common, or becoming common, conditions. Consequently most schools will now, or in the future, have pupils with long term medical needs in attendance. Managing their needs is usually straight forward, if time consuming,, but on occasions the site, storage problems and access to medication make it difficult.

Some of the long term medical conditions which schools try to manage are quite worrying, especially when staff first become aware of them, as there is a possibility the child might die. A clear policy and effective arrangements need to be established and maintained both to manage the condition and to offer staff reassurance and support.

**The overall aim is to ensure pupils’ with medical needs receive the same standard of Education as any other pupil. If this is done and, in the worst scenario, a pupil dies everyone involved will be upset. Hopefully however they can take some consolation from having made the child’s time at school as normal as possible.**

**NB** Information on some of the common medical needs is attached as appendix 5a to these guidance notes.

**SCHOOL POLICY**

Each school must establish its own policy on the administration of medication taking into account any limitations on facilities, number of volunteers, etc. A model school policy is attached which schools should alter to suit its particular circumstances (Appendix 5b).
The following items will need to be considered.

a) **Volunteers** - The school should establish whether staff are prepared to administer medication. A number of trades unions advise their members not to undertake this task as it is outside the scope of their employment. The Council does appreciate the concerns of the trades unions in this respect but a blanket no on administering medication is considered unreasonable. Legal advice also indicates that if staff were to do nothing for a pupil in need of assistance, they would be more likely to face legal proceedings than if they tried to help. Having said this some of the demands made on staff are unreasonable and there will be times when even though staff are willing to help it will simply not be possible to accommodate the request.

b) **Storage of Medication** - Generally medication needs to be both accessible to the pupil immediately and also secure. These requirements are sometimes contradictory. The following is advised as a general hierarchy of best practice.

i) **It is kept on the person** - This will be possible for pupils who are expected to manage their own medication, asthma inhalers are commonly carried by pupils at schools. It is rarely possible for very young children to carry their own medication and it would not be appropriate where the medication is required in an emergency situation, for example if the pupil could lose consciousness, or where the pupil is not deemed to be responsible.

ii) **Kept in classroom** - this can be effective in infant, junior or primary schools where pupils are taught generally in one classroom or are close by at all times. The pupils’ medication can be kept in a drawer or in a small bag. Keeping the medication and paperwork in some form of waterproof bag, able to be carried by a SMSA/teacher on a school trip, can be especially useful. As on occasions the medication needs to be secured, to prevent the possibility of misuse, classrooms will not always be appropriate.

iii) **Kept in central location** - This works especially well in small schools where pupils and staff are all close to the central location. Medication kept centrally in an office of a secondary school would only be acceptable where the pupils can be relied upon to come to the office, or in case of emergency medication, if someone will always be present and able to respond immediately they are summoned. This solution tends to be the best in terms of ensuring medications are kept secure.

As part of the school policy it should be made clear what storage arrangements are to be made. Some flexibility will, however, be needed given the individual circumstances of the pupils concerned.

c) **Training or Instruction**

All staff involved with administering medication need to be provided with information on what is expected of them and about the condition. In many circumstances no specific “hands on” training is required, see the comments on training made under competence in appendix 5a for specific medical conditions, but where invasive techniques are concerned training is essential. As will be appreciated giving a spoonful of medicine to a pupil is straightforward, at least if the pupil cooperates, but administering rectal diazepam is not.
Where training is required the recommendation is that a qualified medical practitioner or a specialist trainer provide the training. Qualified medical practitioners will include GP’s, Consultants, Paediatricians and Nurses. School Nurses have regularly provided training which has proven especially effective. This being because they have specific knowledge of the pupil and, because they are often known to staff, staff feel more able to ask questions. First aid providers can also include certain techniques on training courses, e.g. anaphylaxis and use of EPI-PEN.

**SUMMARY**

Every school needs to identify a clear policy on administration of medication and bring this to the attention of Staff/Governors/Parents and Volunteers. Requests to administer medication should be received sympathetically and where difficulties exist in agreeing to the request these should be explained to the parents.

For further advice see
Appendix 5c – Request to administer medication form
Appendix 5d – Sample letter to parents
Appendix 5e – Record of medication
Appendix 5f – Health Care Plan
MEDICAL CONDITIONS

1 - ASTHMA

Background Information
Asthma is a common condition that requires regular medical supervision. Approximately 1 pupil in 20 has asthma so most schools will probably have several pupils in attendance who are asthmatic.

An asthma attack occurs when an individual's airways contract as a result of a trigger. Triggers vary but include viral infections, cold air, pollen etc. Exercise and stress are also triggers or can contribute to/aggravate the results of attacks. An asthma attack is characterised by coughing, wheeziness and difficulty in breathing.

Asthma is normally effectively managed by the use of medication and pupils at a very early age learn to manage their own medication.

Emergency Arrangements
The information in the Health Care plan under this heading will normally indicate the following or similar:

Should (name of pupil) have difficulty breathing, or continue to cough, or appear to be wheezy he/she should be given the opportunity/encouraged to use his/her medication immediately. If it is possible to identify the trigger and remove it, i.e. move indoors out of cold air or away from pollen, then this should be done. The pupil should be comforted/given support as appropriate.

If after medication is administered there is no improvement in the condition or the condition deteriorates then medical advice must be sought and/or an ambulance called.

NB the medication can take some 5 to 10 minutes to take effect but if the child is becoming distressed or unduly tired call an ambulance.

Medication Requirements
The information in the Health Care plan under this heading will normally indicate the following or similar:

(Name of Pupil) will make use of his/her inhaler/nebuliser at (indicate when he/she will need to use the inhaler/nebuliser if regularly)/as and when required. This may be more frequently in cold weather or prior to PE. The pupil will normally require (indicate usual number of “puffs”) __ puffs.

The inhaler/nebuliser contains (add information on chemical) and is kept in (classroom/office)/carried by the pupil. The inhaler is blue/brown and is marked with his/her name or the nebuliser is marked with his/her name.

The pupil is able to use the inhaler/nebuliser without assistance/requires assistance with the inhaler/nebuliser. This will involve reminding the pupil to use the inhaler/supervising the pupils’ use of the inhaler/helping to hold the nebuliser.

Competence
All staff are able to assist in reminding pupils/supervising pupils taking the medication. The parent/guardian/school nurse/first aider will demonstrate the use of inhalers/nebulisers’ as appropriate.
2 - EPILEPSY

Background Information
Epilepsy is a condition which affects around 1 pupil in 130 which means that many schools will at some point have children attending with this condition.

The symptoms of children with epilepsy are normally well controlled by medication and seizures are unlikely during the school day. In the majority of cases the trigger/s which cause an epileptic fit are unknown although certain factors, i.e. tiredness, anxiety sometimes affect a pupils susceptibility. Flashing or flickering lights, video games etc. can be triggers for seizures in some pupils. Parents should be encouraged to tell schools of likely triggers so that action can be taken to minimise exposure to them.

Not all pupils with epilepsy will experience major seizures (commonly called fits). Where pupils do the nature, frequency and severity of the seizure will vary greatly between individuals. Some can exhibit unusual behaviour, e.g. plucking at clothes, repetitive movements etc., experience strange sensations, or become confused instead of, or as well as, experiencing convulsions and/or loss of consciousness.

Examples of different types of seizures are given below:

a) Tonic Clonic Seizures
During tonic phase of a tonic clonic seizure the muscles become rigid and the person usually falls to the ground. Incontinence may occur. The pupil’s pallor may change to a dusky blue colour. Breathing may be laboured during the seizure. During the clonic phase of the seizure these will gradually cease. Some pupils only experience the tonic phase and others only the clonic phase. The pupil may feel confused for several minutes after a seizure. Recovery times will vary with some pupils requiring a few seconds to recover whilst others will need to sleep for several hours.

b) Absence Seizures
These are short periods of staring, or blanking out and are non-convulsive generalised seizures. They last only a few seconds and are most often seen in children. A pupil having this kind of seizure is momentarily completely unaware of anyone/thing around him/her, but quickly returns to full consciousness without falling or loss of muscle control. These seizures are so brief that the person may not notice that anything has happened. Parents and teachers may think that the pupil is being inattentive or is day dreaming.

c) Partial Seizures
Partial seizures are those in which the epileptic activity is limited to a particular area of the brain.

d) Simple Partial Seizures (when consciousness is not impaired)
This seizure may be presented in a variety of ways depending on where in the brain the epileptic activity is occurring.

e) Complex Partial Seizures (when consciousness is impaired)
This is the most common type of partial seizure. During a temporal lobe complex partial seizure the person will experience some alteration in consciousness. They may be dazed, confused and detached from their surroundings. They may exhibit what appears to be strange behaviour, such as plucking at their clothes, smacking their lips or searching for an object.

Emergency Arrangements
The information in the Health Care Plan will vary considerably but will indicate the symptoms where known, i.e. in case of tonic clonic seizures whether the pupil will fall to the ground, become incontinent etc. The emergency medication required will normally be administration of rectal diazepam. The information in the Health Care plan under this heading will normally indicate the following or similar:
Should (Name of Pupil) suffer a seizure, which will normally involve __________________, nothing is to be done to stop or alter the course of the seizure Unless Emergency Medication is required. The pupil should not be moved unless he or she is in a dangerous place but something soft can be placed under his or her head. The pupil’s airway must be maintained at all times. The pupil should not be restrained and there should be no attempt to put anything into the mouth. Once the convulsion has stopped, the pupil should be turned on his/her side and put into the recovery position. Someone should stay with the pupil until he or she recovers and re-orientates.

or

Should (Name of Pupil) suffer an epileptic fit which lasts for __ minutes or more/suffers __ seizures then he/she will need to have rectal diazepam administered. The competent member of staff, in company with a second adult, will administer the medication. Initially __ milligrams of rectal (add in name of drug) _____ will be administered. In the event there are difficulties administering the medication, e.g. diarrhoea, call an ambulance. If the fit/seizures continue a second dose of __ milligrams of rectal (add in name of drug) are to be administered. If the fit/seizures continue for __ minutes call an ambulance, See Emergency Contact above, and notify family contact.

Medication Requirements
In the case of Epilepsy this section will usually be left blank. This is because in most cases involving epilepsy in schools only emergency medication will be required.

Competence
Staff who volunteer to administer the emergency medication must have received training from an approved source. This will involve information on the specific type of epilepsy, the possible triggers and instruction/demonstration on administering the medication.

3 - DIABETES

Background Information
Diabetes affects around 1 pupil in 700 so schools may not come across this condition very often. It is a condition where an individual’s hormonal mechanisms do not control their blood glucose levels.

The diabetes of the majority of pupils is controlled by two injections of insulin each day. These will not normally need to be given during school hours but children with diabetes need to ensure that their blood glucose levels remain stable. This will involve using a testing machine, at regular intervals, which may need to be done during the school day.

Pupils with diabetes must be allowed to eat regularly during the day which may involve eating snacks during class-time or prior to exercise. If a meal or snack is missed, or after strenuous activity, the pupil may experience a hypoglycaemia episode (a hypo) during which his or her blood sugar level falls to too low a level. Staff in charge of physical education classes or other physical activity sessions should be aware of the need for pupils with diabetes to have glucose tablets or a sugary drink to hand.
Hypoglycaemic Reaction
Staff should be aware that the following symptoms, either individually or combined, may be indicators of a hypo in a pupil with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking
- lack of concentration
- irritability

Each pupil may experience different symptoms and this should be discussed when drawing up the health care plan.

NB Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control. If any such symptoms are noted these should be brought to the attention of the parent.

Emergency Arrangements
The information in the Health Care Plan under this heading will normally indicate the following or similar:

Should (name of Pupil) suffer an hypo, which will normally involve him/her appearing drowsy/starting to shake/becoming irritable/______________, he/she should be given the opportunity/encouraged to take a glucose tablet/sugary drink/_____. The hypo should pass within (usually 10 - 15 minutes) _____ and if it persists past this time call an ambulance, see Emergency Contact above, and notify the family contact.

If the pupil recovers within ___ minutes he/she should be encouraged to consume a slower acting starchy food, e.g. glass of milk.

Medication Requirements
The information in the Health Care Plan under this heading will normally indicate the following or similar:

(Name of pupil) will need to be reminded to check his/her blood glucose levels at lunchtime/breaktimes/ /Specify period_____. The pupil will need no assistance/help with the test kit but is to use the kit in _____, so that he/she is not likely to be disturbed by other pupils.

Competence
All staff are able to assist in reminding pupils/supervising pupils using the test kit. The use of the test kit will be demonstrated to staff by parent/school nurse as appropriate.

4 - ANAPHYLAXIS

Background Information
Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment. No figures have yet been provided for the number of pupils who currently suffer from this condition but a number of schools already have pupils in attendance who have been diagnosed with the condition. When these severe allergies are diagnosed, the children concerned are made aware from a very early
age of what they can and cannot eat and drink and, in the majority of cases, they go through the whole of their school lives without incident. Schools can help to ensure this by asking all parents not to provide certain foods for their children and explaining why.

The most common cause of anaphylaxis is food, e.g. legumes (nuts), fish, dairy products. Wasp and bee stings can also cause allergic reaction. In its most severe form the condition can be life-threatening, but it can be treated with medication. This may include antihistamine, adrenaline inhaler or adrenaline injection, depending on the severity of the reaction.

For some children, the timing of the injection may be crucial. This needs to be clear in the health care plan and suitable procedures put in place so that swift action can be taken in an emergency.

**Allergic Reactions**
Symptoms and signs will normally appear within seconds or minutes after exposure to the allergen. These may include:
- a metallic taste or itching in the mouth
- swelling of the face, throat, tongue and lips
- difficulty in swallowing
- flushed complexion
- abdominal cramps and nausea
- a rise in heart rate
- collapse or unconsciousness
- wheezing or difficulty breathing

Each pupil’s symptoms and allergens will vary and will need to be discussed when drawing up the health care plan.

**Emergency Arrangements**
The information in the Health Care plan under this heading will normally indicate the following or similar:

*Should (name of Pupil) have/thought to have consumed any food product containing legumes/_____ and/or exhibits/indicates the following symptoms, wheeziness/difficulty breathing/ abdominal cramps/_______ he/she will be given the EPI-PEN adrenaline auto injection into the fleshy part of the thigh. An ambulance will also be called, See Emergency Contact above, and the Family Contact notified.*

**Medication Requirements**
In the case of Anaphylaxis this section will usually be left blank. This is because in most cases involving anaphylaxis only emergency medication will be required.

**Competence**
Staff who volunteer to administer the emergency medication must have received training from an approved source. The training will cover information on the cause of the allergic reaction and instruction/demonstration/practice on administering the medication, i.e. using the EPI-PEN. The use of the EPI-PEN is quite simple but staff usually like refresher training from time to time as the EPI-PEN is rarely used.

Training can be provided by GP/Consultant/School Nurse/First Aid provider.
MODEL
(The text in bold & italics requires a choice to be made by the school as to the exact policy they
wish to follow.)

_________________ SCHOOL POLICY
ON
MANAGING MEDICAL NEEDS

This policy is supplemental to the Council’s Policy on the administration of medication and ________
School’s H&S Policy.

1 - Statement

The school policy is to try and accommodate requests from parents to administer medication/long term medication where this is necessary for the child to continue to be educated at school.

To this end the following procedures must be followed to ensure that all concerned, staff, parents, pupils and, where relevant, health professionals are aware of the pupil’s condition and what steps have been agreed either to manage the condition or in place should an emergency arise.

2 - Definitions

Short Term Medication - This is medication which is needed to allow the pupil to return to the school for a few days whilst completing a course of antibiotics or whose administration is for a couple of weeks or less.

Emergency Short Term Medication - This is medication which parents may approve of for administration as part of a school trip. Examples might be for medication for headaches, insect bites etc.

Long Term Medication - This is medication required to manage a long term medical need, i.e. asthma, epilepsy etc., where the medication will be required for extended periods.

3 - School Procedure

3.1 Request to Administer Short/Long Term Medication

The school will only administer medication where a “request to administer medication” form has been completed by the parent(s)/guardian(s) of a pupil. No medication will be given unless this form is completed. The form is to be completed prior to the pupil starting at the school or, is already in attendance, as soon as the condition is identified.

NB If a pupil simply turns up with medication it may be necessary to send the pupil home.

3.2 Request to Administer Emergency Short Term Medication

The school will administer emergency short term medication as part of a school trip. If parents wish the school to administer such medication this must be indicated on the consent form. The consent form gives parents the opportunity to flag up any particular needs of the pupil, e.g. medical, dietary etc.

Parents are to be reminded that the school is unable to administer medication to children 12 or younger, without the written permission of parents and information on what medication the child can have.
3.3 Assessment of Request

Following receipt of a “request to administer medication” form the Headteacher or designated person will discuss with staff the nature of the request and whether or not they are willing to administer the medication. The Headteacher or Designated person will also identify whether staff are competent to administer the required medication.

(Staff are deemed competent to administer medication in tablet form orally or as medicine orally but must have received training in any for medical techniques required, e.g. use of EPI-PEN for anaphylaxis. See competence to administer medication below.)

3.4 Health Care Plan

If staff are willing to administer the medication a Health Care plan for the pupil will be prepared. This will indicate date of request for administration and of approval and will provide as much information on the medical condition as is available. The health plan follows a standard format but will vary dependent on the medical needs, e.g. short term or a specific condition.

3.5 Notification to Parents

Parents will then be notified that the school have agreed to administer the medication requested and a copy of the health plan provided. Parents will be advised that it is their responsibility to notify the school of any changes in the medication.

3.6 Record of Administration

In cases where medication is administered a record is to be made of the dose and time when administered. This is necessary for all medicines administered but where it is a regular administration of medication this can be by a simple checklist. Other administration of medication needs to have more detail included and this information shared with the parents/guardians.

(This is very useful in trying to identify patterns and likely triggers which bring on a medical condition which may result in a much more positive situation for the pupil.)

3.7 Review/Revision of Health Care Plan

This can occur quite often especially in the early stages when there is a degree of experimentation required with medication to find out what is most effective. Equally information gleamed from experience of administering medication at school can also have an effect on the plan. Generally the expectation is that it will be for parents to confirm changes in writing to the school and it will be for the school to alter the plan to reflect this information.

4 - Staff Liability

See Appendix 3 of the Council’s Statement of Policy on Administration of medication.
REQUEST TO ADMINISTER MEDICATION FORM

Parents/guardians are advised that, unless you complete and sign this form the school will not administer medication to your son/daughter/ward. The Headteacher and staff must still agree to administer medication as this is a purely voluntary act on their part.

DETAILS OF PUPIL

Surname ________________________________ Forename(s) __________________________

Home Address

________________________________________

Date of Birth ______________________________ Class/Form _______________________

CONDITION OR ILLNESS

Type of Condition or Illness _______________________________________________________

Name & Type of Medication _______________________________________________________
(as described on container)

How long will your child require the medication _______________________________________
(ongoing or specific time span)

FULL DIRECTIONS ON USE

Dosage & Method _________________________________________________________________

Timing ____________________________________________________________

Special Precautions ____________________________________________________________

CONTACT DETAILS

Name of Parent/Guardian _________________________________________________________

Address _________________________________________________________________

Daytime Telephone Number _____________________________________________________

Alternative Telephone Number _________________________________________________

I understand that I must personally deliver the medicine to Head/Secretary/Class Teacher and accept that this is a voluntary service provided by the school.

Signature of Parent/Guardian ___________________________ Date _________
SAMPLE LETTERS TO PARENTS

TO:PARENT/GUARDIAN

Dear

Further to your request for the school to administer medication to _____ I am writing to advise you that in this case the school is able to accommodate the request.

It would be appreciated therefore if you could arrange to meet with me/________ to discuss the arrangements in this respect which need to be included in ____’s Health Care Plan.

OR

From the details provided on the “Request to Administer Medication Form” the attached Health Care plan has been produced and it would be appreciated if you would confirm that this plan is felt to be appropriate.

I trust that the above is clear and would hope that ____ will/continue to participate fully in the activities of the school.

Yours sincerely

Headteacher

TO:PARENT/GUARDIAN

Dear

Further to your request to administer medication to ______ I very much regret that this request is unable to be accommodated.

This is because the school does not have

a)anyone who is willing to administer the medication
b)the space to accommodate storage of short term medication as indicated in the school policy on administration of medication/______.

If a) add Can I suggest therefore that we meet to discuss possible alternative arrangements.

Yours sincerely

Headteacher

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Appendix 5e

RECORD OF MEDICATION ADMINISTERED TO

(NAME OF PUPIL)_____________

HE/SHE SUFFERS FROM ___________. THIS CONDITION REQUIRES THE ADMINISTRATION OF ___________ REGULARLY/IN AN EMERGENCY. WHERE STAFF ADMINISTER MEDICATION THIS MUST BE NOTED BELOW.

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<th>DATE &amp; TIME</th>
<th>DOSE GIVEN</th>
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<th>OBSERVATION/COMMENTS</th>
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HEALTH CARE PLAN

This Health Care Plan has been produced for _______ Class/Form ______ only. 
He/She suffers from __________________ (add in name of condition)

Date Plan agreed for implementation 
and/or Period plan in 
place for : _________________________

Date of Review : __________________

CONTACT INFORMATION

Family Contacts

1) Name : __________________________ 2) Name : __________________________ 
   Relationship : ____________________ Relationship : ____________________ 
   Phone No. (Home) : ________________ Phone No. (Home) : ________________ 
   (work) : ________________ (work) : ________________

Medical Contacts

3) GP Name : ________________________ 4) OTHER Name : ____________________ 
   Phone No. ________________________ Title : ____________________ 

   Phone No. ________________________

Emergency Contact

DIAL 999, ASK FOR AMBULANCE, GIVE ADDRESS OF SCHOOL AS BELOW

_________ School, ________________________________

and inform the operator of the medical condition.

EMERGENCY ARRANGEMENTS
(Add information on what constitutes an emergency for the pupil and what to do if this occurs.)
**COMPETENCE**
(Add in information on staff deemed to be competent to deal with the medical needs of the pupil. Staff should be indicated in priority order where appropriate.)

**MEDICATION REQUIREMENTS**
(Add in information on the normal medication requirements if applicable.)

**FOLLOW UP CARE & RECORDING**
(Include details of what to do following an incident if the child remains in school. A record of the incident, whether or not the child remains in school, needs to be added to the details of medication administered form.)

**COPIES OF HEALTH CARE PLAN SENT TO**
1 - Parent/Guardian : (Add in name and date provided) ____________________________
2 - Child’s Individual School File
3 - Personnel who have agreed to administer medication : (Indicate number of copies)
4 - Copy kept with Medication if not carried by the pupil
5 - Copy to GP/Consultant.
6 – If pupil has statement of special needs, which indicates transport needs to be provided, a copy must also be sent to the Education H&S Officer. He will liaise with transport provider to check that adequate emergency arrangements are in place during transport.
Appendix 6  Guidance Note for Schools on Manual Handling Operations Involving Pupils

This guidance note has been produced to assist schools where there is an indication a pupil may require assistance that involves manual handling. Manual handling assistance being defined as any situation where staff are required to physically lift or support pupils, but this does not include restraint.

1- LEGISLATIVE REQUIREMENTS
The Manual Handling Operations Regulations 1992 require that Employers, where it is not possible to eliminate the need to undertake a manual handling, undertake a risk assessment of the operation and take steps to reduce the risk of injury. This expands on the implicit required contained in the Health & Safety at Work 1974 that the employer ensures the health, safety and welfare both of employees and those affected by the undertaking.

2- RESPONSIBILITIES

2.1- LOCAL AUTHORITY (LA) – the LEA has delegated the day-to-day responsibility for completing risk assessments to the Headteacher.

2.2 – GOVERNING BODY – For Aided Schools the Governing Body is the employer and as with the LEA has in most cases delegated the day-to-day responsibility for completing risk assessments to the Headteacher. The Governing Body, whether the employer or not, is required to ensure that risk assessments are undertaken.

2.3 – EDUCATION H & S OFFICER – The Education H & S Officer can provide guidance on completing risk assessments and where schools identify concerns with manual handling operations they should ensure that the H & S Officer is kept informed. The H & S Officer is also responsible for reviewing this guidance.

2.4 – HEADTEACHER – The Headteacher is identified as responsible for ensuring that risk assessments are completed. Heads will though usually delegate the duties to a named individual and in cases where there are a number of pupils present who require manual handling assistance schools should appoint a Manual Handling Coordinator.

2.5 – MANUAL HANDLING COORDINATOR – The Manual Handling Coordinator will be an employee of the school assessed as competent to complete the initial manual handling assessment/checklist in order to identify if a pupil will need assistance. The Manual Handling Coordinator will then liaise with other relevant staff and outside bodies as required as necessary, making use of the detailed assessment/checklist, to ensure that safe systems of work are identified and implemented.

2.6 – OTHER AGENCIES/SECTIONS – A variety of other agencies can have input with regards a pupils' needs and these will not only be from an education perspective.

2.6.1. HEALTH AUTHORITY – Occupational Therapists and Physiotherapists will often already be working with a child prior to the child attending school and will be able to provided advice on what is done and why. They will continue to work with the child and can provide support and guidance to schools.

2.6.2 – SPECIAL EDUCATIONAL NEEDS/INCLUSION SUPPORT – These sections can advise on the needs of the child and assist in identifying and providing equipment and support.
3 – RISK ASSESSMENT

A risk assessment is a process that is followed in order to identify a safe system of work. The safe system of work required in this case being the practice or procedures to be followed to meet the needs of the pupil, having due attention to staff capabilities. This process is therefore best undertaken at school level whilst it is essential that the significant findings are recorded and brought to the attention of staff.

STEP 1 – For any pupil there is indicated to be a need for manual handling assistance the initial Assessment/Checklist form attached as appendix 1 is to be completed. This form will identify if the manual handling request is considered to be a low risk task, for which no further assistance is required, or if a more detailed assessment is necessary. It should be noted that the vast majority of situations would warrant a more detailed risk assessment.

If a more detailed assessment is required go to Step 2 if not required then proceed to Step 8.

STEP 2 – Complete the detailed assessment checklist attached as Appendix 2. Part 1 of the checklist deals with the individual pupil characteristics. As much detail is required as possible about the pupil, his/her medical condition and what this means for the pupil. This will also identify if there are any behavioural characteristics that can impact on the manual handling operation. Part 2 of the checklist aims to identify in more detail what manual handling is involved. In particular what equipment the pupil needs to use, what this will involve and where is will take place.

Once the form is completed proceed to Step 3.

STEP 3 – The manual handling coordinator will make a judgement as to whether what is being requested can be undertaken safety. If the judgement is that it can be this will need to be built into a system of work.

If felt able to build into a safe system of work go to Step 5, if not go to Step 4.

STEP 4 – Discuss whether there are alternative ways of meeting the pupil’s needs. This will usually involve discussion with external bodies. Once additional detail has been obtained go to Step 3. If however having reviewed the situation no alternative ways have been identified contact the H & S officer.

STEP 5 – Detail the safe system of work identified. This must cover:
   a) What the pupils’ condition is and how this manifests itself
   b) What the operations are
   c) How the operations will be carried out.

NB See Appendix 3 for an example of a system of work.

Once a system of work is drafted proceed to Step 6.

STEP 6 – Introduce the safe system of work. This will initially need to involve discussion with the staff who are expected to assist in the operation. This step should identify if any amendments are required and whether there is a need for staff training or instruction.

If staff training or instruction is identified as necessary proceed to Step 7, if not proceed to Step 8.
STEP 7 – Provide any Necessary Instruction or Training. Depending on what is identified there may simply be a need to instruct staff on specific items of equipment for the pupil or, if the school has no one with manual handling training, could involve staff needing to attend a manual handling training course.

STEP 8 – Review the system of work regularly or when changes occur. Such changes could involve the pupils’ condition, where the operation is to take place or changes in staff capabilities. Regularly could be annually, termly or more frequently.

CONCLUSION

The checklists provided aim to assist establishing information so that an informed decision on what can be accommodated is made. It is stressed that manual handling is expected to take place in schools but where the risk assessment process is either not followed or not followed effectively, injuries do occur. By using this process such occurrence should be minimised.
Appendix 6a  Manual handling in practice - Risk assessment for pupils
initial assessment / checklist

Although in most cases a detailed manual handling risk assessment will be required, this
checklist is used to confirm that this is necessary.

1 – PUPILS’ WEIGHT
There have been a number of different indications about what an adult could reasonably be
expected to lift. Where the lift is viewed as a close lift, one that is near to the body, the
advice is that most adults are capable of lifting approximately 10kgs (circa 22lb).

<table>
<thead>
<tr>
<th>QUESTION 1 – Does the pupil weigh 10 kgs (22lbs) or less?</th>
<th>YES/NO</th>
</tr>
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</table>

If you answer YES to Question 2 if you answer NO a detailed assessment is required

2 – PHYSICAL CHARACTERISTICS
In this respect the aim is to identify where there are individual factors that will make any
manual handling operation more difficult. The following are examples where this would be
the case.
- Broken Limbs
- Pain
- Fragility
- History of Spasms

| QUESTION 2 – Does the pupil have any physical characteristics
that will make the manual handling operation potentially more difficult? | YES/NO |
|---------------------------------------------------------------------|--------|

If you answer NO go to Question 3. If you answer YES a detailed assessment is
required?

3 – BEHAVIOUR
In this respect the aim is to identify whether the child exhibits behaviour that could make a
manual handling operation more difficult. This will usually be where the pupil is
uncooperative and struggles.

| QUESTION 3 – Does the pupil understand what is required and is
the pupil cooperative? | YES/NO |
|------------------------------------------------------------------|--------|

If you answer YES to Question 4. If you answer NO detailed assessment is
required?

4 – ASSISTANCE REQUIRED
The more complicated the support the more likely a detailed risk assessment will be required.
The following are common operations that schools undertake.
- Support with Toileting (This is assistance aimed at stabilising pupil).
- Support in Standing (This is assistance aimed at stabilising pupil).
- Lifting into/out of Wheelchair
- Lifting onto/off of Toilet.

| QUESTION 4 – Does the manual handling only involve supporting
the pupil? | YES/NO |
|-------------------------------------------------------------|--------|

If you answer NO then a detailed assessment is required. If you answer YES then the
checklist is complete and no risk of significant injury has been identified? You will
though need to set a review date.

Signature __________________________________________ Date __________________

Date for Review __________________________________________
Appendix 6b  Manual handling in practice - Risk assessment for pupils detailed assessment / checklist

Where there is a need for a detailed risk assessment the following checklist is to be completed. This will record relevant information from the risk assessment process and help identify the safe practice to be employed.

1 – INDIVIDUAL PUPIL CHARACTERISTICS
As much detail as possible is required about the pupil.

1.1 – PUPIL DETAILS: Need to establish the following:

<table>
<thead>
<tr>
<th>a) Weight of the pupil</th>
<th>__________ kgs</th>
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<tr>
<td>b) Height of pupil</td>
<td>__________ metres</td>
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<tr>
<td>c) The likely period over which the weight and height are likely to remain similar</td>
<td>__________ months</td>
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</table>

1.2 – MEDICAL CONDITION: Need to establish the pupils medical condition and what physical impact this might have on the pupil which will effect the manual handling operation:

<table>
<thead>
<tr>
<th>a) What is the pupils medical condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) As a consequence of this condition does the pupil exhibit any of the following?</td>
</tr>
<tr>
<td>Fatigue (pupil will be less able to help and more likely to need assistance)</td>
</tr>
<tr>
<td>Pain (Will effect how the person can be lifted)</td>
</tr>
<tr>
<td>Skin Condition (will effect how the pupil can be lifted)</td>
</tr>
<tr>
<td>Fits (A pupil who fits is an increased hazard for any manual handling operation)</td>
</tr>
<tr>
<td>Spasm (A pupil who goes into spasm is an increased hazard for any manual handling operation)</td>
</tr>
<tr>
<td>Fragility (A pupil with fragile bones or inability to weight bear is an increased hazard for any manual handling operation)</td>
</tr>
<tr>
<td>Issues surrounding muscular tone (A pupil with low tone could have difficulty supporting themselves)</td>
</tr>
<tr>
<td>Other (please be specific)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) As a consequence of the condition does the pupil have any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leg braces (A pupil with leg braces will represent an increased hazard for any manual handling operation)</td>
</tr>
<tr>
<td>Cast – leg, arm or body (A pupil with a cast on will represent an increased hazard for any manual handling operation)</td>
</tr>
<tr>
<td>Intravenous tube (A pupil with an intravenous tube will complicate the manual handling operation and increase the risk to the pupil)</td>
</tr>
<tr>
<td>Other (Please be specific)</td>
</tr>
</tbody>
</table>

If you answer YES to any of the above this will make the lift more complicated and you may well need input from Occupational Therapist/Physiotherapist/Manual Handling Advisor. If you answer NO to all the operation is viewed as being manageable.
1.3 – BEHAVIOUR: Need to establish if the pupil has any behavioural characteristics that will make the manual handling operation more difficult

<table>
<thead>
<tr>
<th>a) Does the pupil understand what is required of them?</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Does the pupil cooperate with the staff?</td>
<td>YES/NO</td>
</tr>
</tbody>
</table>

If you answer YES this is viewed as reducing the risk of the operation. If you answer NO then there is a greater risk.

2– MANUAL HANDLING OPERATIONS

Need to identify what equipment the pupil may need to use and what types of operations will be required.

2.1– EQUIPMENT: Pupils in schools will have a variety of personal mobility equipment and/or therapeutic equipment that they will need to use. Any equipment that they may use needs to be identified.

<table>
<thead>
<tr>
<th>a) Does the pupil have any of the following equipment:</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Powered Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Walking Frame</td>
<td></td>
</tr>
<tr>
<td>Standing Frame</td>
<td></td>
</tr>
<tr>
<td>Supportive/Therapeutic Seating</td>
<td></td>
</tr>
<tr>
<td>Moulded Seating</td>
<td></td>
</tr>
</tbody>
</table>

| b) Have staff received instruction on how the pupil is move in/out of the equipment available? | YES/NO |

If you answer NO to b) this must be established before proceeding, as this is required to inform answers to 2.2

2.2 – TYPE OF TRANSFERS: Any manual handling operation will usually involve one or more of the task below and you may need to build them up as a sequence. As much detail as possible is required.

<table>
<thead>
<tr>
<th>Type of Transfer</th>
<th>Equipment/Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair to chair</td>
<td>(Please detail what this will involve, e.g. remove sides from wheelchair, lift child up, move into position by other chair and lower pupil onto seat)</td>
</tr>
<tr>
<td>Chair to stand</td>
<td>(This could be from a wheelchair or an ordinary chair)</td>
</tr>
<tr>
<td>Chair to Floor</td>
<td>(This could be from an ordinary chair or wheelchair to floor, whether for physio or play)</td>
</tr>
<tr>
<td>Floor to chair</td>
<td>(The reverse of the above)</td>
</tr>
<tr>
<td>Floor to stand</td>
<td>This transfer is unusual, as will normally have an intermediate stage, i.e. floor to chair, chair to stand)</td>
</tr>
<tr>
<td>In/out standing frame</td>
<td>(This is usually from a standing position in/out of the frame)</td>
</tr>
<tr>
<td>Transfer to toilet</td>
<td>This will usually be from a wheelchair)</td>
</tr>
</tbody>
</table>
Type of Transfer | Equipment/Special Instructions
---|---
Chair to changing bed  (This is usually from a standing position) |  
In/out transport (This can simply be wheeling a wheelchair onto vehicle but could also involve lifting pupil into out of car seat) |  
In/out ball pool |  
In/out swimming/Hydrotherapy pool |  
Other |  

2.3 – LOCATION OF MANUAL HANDLING OPERATIONS
The location of the operation is important as there needs to be sufficient space for staff to manoeuvre equipment and to position themselves to undertake the operation.

| For any location where a manual handling operation is likely to take place |
|---|---|
| a) Is there sufficient space for the operation? | YES/NO |
| b) Is the floor surface level? | YES/NO |
| c) Is the surface free from any contamination that will effect the lift? (Needs to be free from grease and preferably dry, toilets can therefore be a concern) | YES/NO |
| d) Is the area likely to remain free from disturbance? (In classrooms there is the possibility of other pupils moving through the area) | YES/NO |

From the above a system of work will be established and this checklist will be kept as evidence of why the system has been established.

Signature___________________________________ Date_________________________
Appendix 6c  Example - Manual Handling - system of work for a pupil in Class 2T

BACKGROUND
The pupil suffers from a degenerative muscle condition and wears a calliper on the left leg. The pupil is generally cooperative and understands what is required. He occasionally suffers from low tone but is generally able to walk with a stick.

MANUAL HANDLING SUPPORT

The pupil needs assistance in standing
- This involves stabilising the pupil. A designated member of staff will stand to the left hand side of the pupil and hold his arm as he stands. Once upright he has a stick and can walk to toilet or wheelchair or therapeutic seat unaided. On days when he is suffering from low tone someone should walk with him.

The pupil needs some assistance with equipment
- This comprises wheeling wheelchair and positioning seating to allow him to sit. He may then need the chair he is sat in pushed into a more comfortable working position.

The pupil needs assistance in toileting
- This comprises being wheeled to the toilet and assistance in standing up from wheelchair. A designated member of staff will stand to the left hand side of the pupil and hold his arm as he stands. He/she then needs assistance in taking down underwear but can sit on toilet unaided. The toilet has supports either side that allows him to stand up unaided. Will need assistance in pulling up underwear.

N.B. Two persons must be present to assistant pupil with dressing/undressing due to child protection concerns.

COMPETENT PERSONS
The following people have received instruction and are known to the pupil as persons identified to assist him.

CLASS TEACHER
CLASS TEACHING ASSISTANT
DEPUTY HEAD

REVIEW
Although the condition is identified as degenerative the advice is that the degeneration will be gradual. As a consequence it has been concluded that a Six Monthly review is appropriate.

Signature____________________________________  Date______________________
Appendix 7 Safety in a Fire

All schools will have in place procedures to be followed in the event of a fire and will ensure that evaluation procedures are practised frequently, this usually involving a walk through practice during September each year and three full drills. The procedures in place should cover the practice that will apply to persons with difficulties. Although these will vary from site to site they will follow certain basic guidelines.

The basic guidelines being that

- Lifts are not to be used in a fire evacuation; this is because in a fire it is likely that the power will fail.
- Persons who have difficulty with mobility should be last out of a space if their evacuation will delay others exiting the space.
- Where persons with physical difficulties are not at ground level horizontal evacuation will take place. Horizontal evacuation means movement on the level to a place of safety, protected stairwell, furthest from the seat of the fire.
- No attempt should be made to transfer a pupil to a more appropriate piece of mobility equipment, e.g. standing frame to chair, if this would delay evacuation. In an emergency it is acceptable to physically lift someone out of a building.

If additional information is required is required the initial contact should be with the Schools Health & Safety Officer.
Appendix 8 Training

The admission of a pupil with physical difficulties needs careful planning and that includes training of teaching and support staff. Training is the responsibility of the receiving school guided by professionals from health, education and social services. School may have to contribute towards the cost of training.

- Be aware that some training must take place before the pupil starts school, e.g. manual handling training.
- An Inclusion Support Co-ordinator can assist with advice and arrangements for appropriate training.
- A number of agencies will provide training according to their expertise and particular knowledge of the pupil.

<table>
<thead>
<tr>
<th>Training Need</th>
<th>Suggested Trainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling</td>
<td>CPD Programme</td>
</tr>
<tr>
<td>Disability Awareness and Inclusion</td>
<td>ISS CPD Programme</td>
</tr>
<tr>
<td>Communication Aids/ Augmentive Comm.</td>
<td>SLS</td>
</tr>
<tr>
<td>Medication</td>
<td>School Health Nurse</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>School Health Nurse, Epilepsy</td>
</tr>
<tr>
<td>Accessing Curriculum</td>
<td>ISS OT</td>
</tr>
<tr>
<td>ICT</td>
<td>ISS CPD Programme</td>
</tr>
</tbody>
</table>
Appendix 9  Example of Personal Assistance Plan

Name

Class  DoB

Transfer of pupil (give details e.g. hoist/standing transfer)

Equipment needed (e.g. hoist, turntable, step, adapted toilet seat etc)

Adjustment of clothing
(Specify level of help needed in removing and adjusting clothing)

Wiping/Cleaning required

Working towards independence (specify target area – see below)

Any other information
(e.g. agreement for LSA to leave toilet until called back etc).

The pupil may need help in developing their concept of control. This is especially important as puberty is approached. Building skills in decision making and working positively with their support assistant is a skill, which they will need support and encouragement to develop.
Appendix 10  Contract for Personal Assistance

(Example of contracts drawn up between young person and assistant)

Name of pupil/student
Mary Brown

Name of support Assistant
Jane Smith

Date drawn up
15th September 2004

Area of personal assistance required
Help in the toilet

As your assistant you can expect me to:
• Treat you with care and respect at all times.
• Check that you’re comfortable and not embarrassed.
• I will check before I do anything that involves touching you or your clothing.
• Use the methods agreed in your personal assistance plan.
• Listen carefully if there is something you would like to change about the way I help you.
• You can tell another person about this who will talk to me about it.

Signed ………J Smith

As a student who needs help you can expect me to:
• I will try whenever possible to let you know in advance that I will need the toilet so you can be prepared.
• I will try whenever possible to use the toilet at break or agreed times.
• I will only use the emergency signal for real emergencies.
• I will let you know if I want you to stay or leave whilst I am in the toilet.
• I will tell you if I am uncomfortable or embarrassed.
• I may talk to someone else who will let you know if I would like something changed.

Signed ……M Brown