Administration of Medicines in Schools

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Contacts and Addresses (see opposite)

INTRODUCTION

This policy should be read in conjunction with the school's 'Supporting Pupils at School with Medical Conditions Policy'. The policy also applies to activities taking place off-site as part of normal educational activities.

The Children and Families Act 2014 places a duty on the Governing Body to make arrangements for supporting pupils in school with medical conditions. The Governing Body must also comply with their duties under the Equality Act 2010 in ensuring that each child's Education, Health and Care (EHC) plan brings together health and social care needs, as well as their special educational provision.

The aim of this policy is to ensure that all children with medical conditions, in terms of both physical and mental health, are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential. Parents of children with medical conditions are often concerned that their child's health will deteriorate when they attend school. This is because pupils with long-term and complex medical conditions may require on-going support, medicines or care while at school to help them manage their condition and keep them well. Others may require monitoring and interventions in emergency circumstances. It is therefore important that parents feel confident that Ivy House School will provide effective support for their child's medical condition and that pupils feel safe.

ROLE OF THE GOVERNING BODY

1) The Governing Body will ensure that arrangements are in place to support pupils with medical conditions. In doing so they will ensure that such children can access and enjoy the same opportunities at school as any other child. School staff have a professional and legal duty to safeguard the health and safety of pupils. They will wish to do all they can to enable children to gain the maximum benefit from their education and to participate as fully as possible in school life. Children have a right to be educated and should not be excluded purely as a result of requiring medication. *All children must receive a full-time education, unless this would not be in their interests because of their health needs. In some cases, this will require flexibility and involve, for example, programmes of study that rely on part time attendance at school in combination with alternative provision arranged by the local authority.*

2) In making their arrangements the Governing Body will take into account that many of the medical conditions that require support at school will affect quality of life and may be life threatening. Some will be more obvious than others. The Governing Body will therefore ensure that the focus is on the needs of each individual child and how their medical condition impacts on their school life.

3) The Governing Body will ensure that arrangements give parents/carers and pupils confidence in the school's ability to provide effective support for medical conditions in school. The arrangements will show an understanding of how medical conditions impact on a child's ability to learn, as well as increase their confidence and promote self-care. They will ensure that staff are properly trained to provide the support that pupils need.

4) Children and young people with medical conditions are entitled to a full education and have the same rights of admission to Ivy House as other children. This means that no child with a medical condition will be denied admission or prevented from taking up a

place in school because arrangements for their medical condition have not been made.

5) The Governing Body will ensure that the arrangements they put in place are sufficient to meet their statutory responsibilities and should ensure that policies, plans, procedures and systems are properly and effectively implemented. This aligns with their wider safeguarding duties. The Governing Body will ensure that this policy is reviewed regularly and is readily accessible to parents/carers and school staff.

At Ivy House School nursing and health care contracts are also purchased to support the access of pupils with medical needs in school. The support for all pupils with medical needs and medication requirements go through this team.

These guidelines and codes of practice for specific treatments/medications have been produced to support and protect staff who undertake the administration of medicines and to enable staff to act in an emergency.

The following paragraph outlines the Council's position on indemnifying its staff.

The Council fully indemnifies its staff against claims for alleged negligence, providing they **are acting within the scope of their employment**, have been provided with adequate training, and are following the LA's guidelines. For the purposes of indemnity, the administration of medicines falls within this definition and hence the staff can be reassured about the protection their employer provides. The indemnity would cover the consequences that might arise where an incorrect dose is inadvertently given or where the administration is overlooked. In practice, indemnity means the Council and not the employee will meet the cost of damages should a claim for alleged negligence be successful.

2. INFORMATION TO PARENTS/CARERS

Parents/carers are advised, through school information including newsletters, that pupils who are unwell should not be sent to school. However, many pupils need to attend school while taking prescribed medicines either because they are:

i) Suffering from chronic illness or allergy; or

ii) Recovering from a short-term illness and are undergoing or completing a course of treatment using prescribed medicines.

Medication will not be allowed into school except as covered by the guidelines in this document and the relevant codes of practice.

Parents/carers and doctors should decide how best to meet each child's requirements. Carefully designed prescribing can sometimes reduce the need for medicine to be taken during school hours.

To help avoid unnecessary taking of medicines at school, parents/carers should:

i) Be aware that a three-times daily dosage can usually be spaced evenly throughout the day and does not necessarily have to be taken at lunchtime; and

ii) Ask the family doctor if it is possible to adjust the medication to avoid school time doses.

Most medicines can be administered in school by the school nurses, so long as the packaging has clearly printed labels. Parents/carers should be informed that they will need to ask the pharmacist for duplicate labeled bottles in order to send medicines to school. It should be noted that duplicate containers may not be supplied free of charge - charges will be at the discretion of individual pharmacists.

Parents/carers should have access to these guidelines for reference *on the website and through dialogue with the nursing and health care team*.

Parents/carers should be made aware that the school does not keep any medication apart from paracetamol for distribution to pupils.

Parent/carers should provide the school with sufficient and up-to-date information about their child's medical needs. They may in some cases be the first to notify the school that their child has a medical condition. Parents/carers are key partners and will be involved in the development and review of their child's individual pupil school healthcare plan. They should carry out any action they have agreed to as part of its implementation, e.g. provide medicines and equipment and ensure they or another nominated adult are contactable at all times.

3. PROCEDURE FOR ADMINISTRATION OF MEDICINES IN SCHOOLS

(See Flow Chart - Appendix 2)

The following procedures are recommended as examples of best practice:

3.1 *WRITTEN INSTRUCTIONS*

All medicines that are to be **administered in school** must be accompanied by written

instructions from the parent and/or the GP.

A form is readily available to parents on request from the school nursing team, should medicines or dosage change. Each time there is a variation in the pattern of dosage, a new form should be completed *and the nurses informed*.
A care plan will be kept by the Nursing and health care team and reviewed at least annually See 'Supporting pupils at school with medical conditions' policy.

3.2 *LABELLING OF MEDICINES*

3.2.1 Rescue medication should be stored in original containers and must always indicate the child's name, dosage, expiry date.

3.2.2 It is the parents/carers responsibility to ensure that the medication is correctly labeled and in date. *The nursing team will send home stored medication at appropriate times for replacing.*

3.3 *STORAGE AND ACCESS*

3.3.1 Appropriate amounts only must be kept in secure storage but accessible in the event of emergency

3.3.2 Access to the prescribed medication must only be available to the named staff who have been appropriately trained

3.3.3 Arrangements must be agreed with the parents/carers to cater for trips off school premises

3.4 *ADMINISTRATION OF MEDICINES*

There are three general situations which apply to the Administration of Medicines in schools, these are as follows:

3.4.1 The *Pupil self-administers their own medicine of which the School is aware*

Some pupils at Ivy House School may have the capability to keep and administer their own medicine themselves. In all instances where prescribed and non-prescribed medicines are brought into school, the school must be notified on the parental consent form.

3.4.2 The *Pupil-Self Administers the medication but someone supervises the pupil*

Where the Headteacher or staff are willing to be involved voluntarily, the NHS nursing staff, employed on contract is responsible for ensuring that as a minimum safeguard self- administration of medicines that are safely stored is **supervised** by an adult. This involves ensuring:

i) Access to the medication at appropriate times. Where supervision of self-administration occurs, appropriate measures should be taken to ensure the medicine is appropriately stored to prevent any unsupervised self-administration of the medicine, as per the guidance on storage.

ii) The medication belongs to the named pupil and it is within the expiry date;

iii) A record is kept in the appropriate form noting that session was supervised but clearly indicating that medication was self-administered by pupil. These forms are supplied by the nursing team

3.4.3 A Nurse or member of the NHS team employed on the site will administer the medication following their trust rules

3.4.4 A *Named and Trained Volunteer at the School Administers the Medicine*
The school will, in this circumstance, be storing the medicines and all the points on the storage of medicines must be adhered to.

Where the Headteacher or staff are willing voluntarily to administer medication, the names of the volunteer staff must be kept up to date.

To avoid the risk of double dosing in schools, the Headteacher must clarify who is responsible for administering medications. On site this is the NHS nursing staff. Offsite it may be the school staff if trained. As an extra precaution, staff who administer medication must routinely consult the record form before any medication is given.

All staff who participate in administering medication must receive appropriate information and training for specified treatments in accordance with the code of practice. In most instances, this will not involve more than would be expected of a parent or adult who gives medicine to a child. Training should be arranged through the School Health Service, who will liaise as appropriate with those doctors responsible for the management and prescription of treatment, particularly in complex cases.

The Headteacher must ensure that all relevant staff are aware of pupils who are taking medication and who is responsible for administering the medication; and that this person should be routinely summoned in the event of a child on medication feeling unwell, as they should be aware of any symptoms, if any, associated with the child's illness which may require emergency action. Other trained staff who may be required, e.g. first-aider, should be summoned as appropriate.

The CPD (Continuing Professional Development) coordinator will keep a record of all relevant and approved training received by staff**. (CPD coordinator and school nursing staff to track training)**

Each person who administers medication must:

i) Receive a copy of these guidelines and code of practice;

ii) Read the written instructions/parental consent form for each child prior to supervising or administering medicines, and check the details on the parental consent form against those on the label of the medication;

iii) Confirm the dosage/frequency on each occasion, and consult the medicine record form to ensure there will be no double-dosing**; (school forms to be used onsite).**

iv) Be aware of symptoms which may require emergency action, e.g. those listed on an individual treatment plan where one exists;

v) Know the emergency action plan and ways of summoning help/assistance from the emergency services;

vi) Check that the medication belongs to the named pupil and is within the expiry date;

vii) Record on the medication record form all administration of medicines as soon as

they are given to each individual

viii) Understand and take appropriate hygiene precautions to minimise the risk of cross-contamination;

ix) Ensure that all medicines are returned for safe storage;

x) Ensure that they have received appropriate training/information. Where this training has not been given, the employee must not undertake administration of medicine and must ensure the Headteacher is aware of this lack of training/information.

4. INDIVIDUAL TREATMENT PLAN

For all pupils who may require individual specialised treatment, a clear treatment plan will be available. Treatment plans should be prepared by the doctor responsible for the management and prescription of treatment and should be shared with parents/carers and child's GP. The School Health Service should provide a support role in ensuring an individual treatment plan is understood and carried out in school.

In some circumstances school nurses may have a specific responsibility for an individual child's medical management in school. Appropriate information and training is available from the School Health Service to support school staff.

5. EDUCATIONAL VISITS

The administration of medicines during educational visits and other out-of-school activities requires special attention and pre-planning. The principles contained in these guidelines apply and any difficulties should be discussed with the parents/carers and child's GP/pediatrician or School Health Service. Where the facilities and supervision are provided by other than school staff, the Headteacher must ensure that adequate information is available to the organisers to ensure continuity.

6. EMPLOYEE MEDICINES

An employee may need to bring their medicine into school. All staff have a responsibility to ensure that their medicines are kept securely and that pupils will not have access to them, e.g. locker, locked desk drawer or staff room. All staff medication will be recorded onto an individual staff risk assessment.

Adequate safeguards must be taken by employees, who are responsible for their own personal supplies, to ensure that such medicines are not issued to any other employee, individual or pupil.

7. EMERGENCY AID

Where children have conditions which may require rapid intervention, parents must notify the Headteacher of the condition, symptoms and appropriate action following onset. The Headteacher may wish to discuss this with the School Health Service and onsite Nursing Team.

The Headteacher must make all staff aware of any pupil whose medical condition may require emergency aid. It is essential that all staff (including supply staff, lunchtime supervisory staff etc.) are able to recognise the onset of the condition and take appropriate action,

i.e. summon the trained person, call for ambulance if necessary etc.

Training and practical advice on the recognition of the symptoms can usually be offered by the school doctor/nurse.

All schools should devise an emergency action plan for such situations after liaising with the School Health Service. Planning should take into account access to a telephone in an emergency in order to summon medical assistance or an ambulance.

This has implications for school journeys, educational visits and other out-of-school activities.

10. UNUSUAL OCCURRENCES, SERIOUS ILLNESS OR INJURY

All parents/carers should be informed of the school's policy concerning pupils who become unwell while at school, or on authorised educational visits, trips, etc. This should be contained within the school's Information to Parents booklet (prospectus).

It is vital to have not only the pupils' home telephone numbers, but parents'/carers' daytime numbers and other emergency numbers such as those of relatives, in order to make contact. As of September 2018, all schools are required to hold a minimum of 2 emergency contact phone numbers for every child on roll.

If parents and relatives are not available when a pupil becomes seriously unwell or injured, the Headteacher may call an ambulance to transport the pupil to hospital, if appropriate.

Note: If the pupil is on medication, whether self-administered, under supervision or administered by staff, details must be provided to the emergency service, e.g. details of the written parental consent, the medicine itself and a copy of the last entry on the medication record form "Appendix 1".

11. NOTIFIABLE DISEASES

Heads should be aware of the document "A Practical Guide on the Control of Communicable Diseases for Schools and Day Nurseries" and should be available in all schools.

12. DISPOSAL OF MEDICINES

12.1 Any medication which has reached its expiry date should not be administered.

12.2 Medicines which have passed the expiry date should be returned to parents/carers for disposal. Parents should be advised that the medicines are out of date, and they will be returned home. Parents should also be advised that out-of-date medicines can be returned to the pharmacy for safe disposal out of date medicines should not be sent home with pupils.

12.3 Provision for safe disposal of used needles will require appropriate special measures, e.g. a "sharps box", to avoid the possibility of injury to others. This "sharps box" must be kept secure with no access for pupils or unauthorised persons. This should be disposed of in a safe way using a specialist licensed contractor. A "sharps box" can be found in the Nursing room on site.

13. CODES OF PRACTICE

These codes of practice have been drawn up with advice from the Health Authorities and pediatricians, both community and hospital based. Each individual code is set

out in a similar format.

It is important when receiving any written parental consent/instruction to examine and identify any variation from the detail contained in the relevant code of practice to avoid any confusion at a later date.

The codes of practice are set out in a standard format and provide:

a) Detailed guidance and sources of further information, and

b) At-a-glance “what to do” in an emergency guides where appropriate.

The codes must be readily available and within easy reach of a storage facility used for administering medicines or for providing specific treatments.

CODE OF PRACTICE

ASTHMA

1. TYPES OF TREATMENT

1.1 There are two types of treatment for asthma:

"***Relievers"***
Treatments which give immediate **relief, called** bronchodilators since they open up narrowed air passages.

"***Preventers"***
Purely **preventative** treatments, taken regularly to reduce the sensitivity of air passages so that attacks are only mild or no longer occur.

Medicines designed to prevent asthma should not be used to treat an attack because they do not have an immediate effect.

1.2 The most effective way to take asthma medicines is to inhale them. Inhaled medicines are most often given through small pressurised aerosols.

1.3 The inhaled medicine has to be taken properly otherwise the medicine may spray out into the surrounding air, never get down to the chest and therefore have no effect.

1.4 Young children and those with co-ordination problems may sometimes use a "spacer" device into which the aerosol is released and through which the medication is inhaled.

1.5 Some children use dry powder devices. Tablets and syrups are rarely given.

2. WRITTEN INSTRUCTIONS

2.1 Written instructions should clearly identify between "**relievers"** and "**preventers".** In **most** situations relievers only should need to be provided in school.

2.2 Instructions can also include details of how to help a child breathe. In an attack, asthmatics tend to take quick shallow breaths and may panic.

Some children are taught to adopt a particular posture which relaxes their chest and encourages them to breathe more slowly and deeply during an attack. If they have learnt such a technique, encourage them to use it. The emphasis should always be on the rapid provision of reliever medication.

3. LABELLING

There are several types of inhalers. It is the parent's/carer's responsibility, in consultation with the child's GP and dispensing chemist, to ensure that the inhalers are clearly labelled with the child's name and to identify the medicine as a "reliever" or "preventer". Pharmacists would not normally add this to the label and so this may appear on the label in the parent's/guardian's handwriting. This then must be checked against the parental consent form. Alternatively, parents can ask pharmacists to add this information to the label, this is the preferred option.

4. STORAGE AND ACCESS

4.1 Asthmatic children must have immediate access to "reliever" inhalers at all times.

4.2 It is not necessary to lock the inhalers away for safety reasons. Where possible, children of junior school age and above should carry their own inhalers.

4.3 Younger children should be encouraged to do so. However, some parents, after consultation with the Headteacher, may request that inhalers are kept with the supervising teacher for safe-keeping and ease of access.

4.4 Inhalers should be taken to swimming lessons, sports, team games and on educational visits and used accordingly.

5. ADMINISTRATION OF MEDICINES

5.1 Self-administration is the usual practice. Staff need to be aware of possible over- use of inhalers and the Headteacher should inform parents/carers as appropriate.

5.2 In circumstances where staff assist a pupil to use an inhaler, the individual treatment plan, where one exists, should be followed. A record should be made in the **School Medicine Record Form - Appendix 1**.

5.3 Staff involved in helping a child during an attack should:

- stay calm
- do things quietly and efficiently
- speak reassuringly and listen carefully
- ensure access to "reliever" inhaler
- be aware of any specific relaxation techniques which may assist.

6. OVERDOSE/MISUSE

6.1 No significant danger to health results from occasional overdose/misuse of inhalers. Staff, however, should be vigilant for inhaler abuse as there is evidence nationally that children are selling use of their inhalers to friends in the mistaken belief that it will induce some sort of high.

6.2 "INTAL" capsules are not harmful if swallowed.
Other capsules, e.g. "VENTOLIN" will have no side effects UNLESS MORE THAN 10 ARE SWALLOWED.

6.3 In all suspected cases, note the School Medicine Record and note the action taken to seek medical advice and advise parents.

7. FURTHER INFORMATION

7.1 Further advice and guidance can be obtained from:
(1) The Local School Health Team
(2) Community Child Health
(3) The author of an Individual Treatment Plan, if one exists, for a specific child

THE ASTHMA ATTACK - WHAT TO DO

Ideally, there should be a school plan of action for asthma attacks. If you do not have a

plan of action, follow the advice below.

If an asthmatic pupil becomes breathless and wheezy or coughs continually:

1. **Keep calm.** It's treatable.

2. **Let the pupil sit down** in the position they find most comfortable. Do not make them lie down.

3. **Let the pupil take their usual reliever treatment -** normally a blue inhaler.
If the pupil has forgotten their inhaler, and you do not have prior permission to use another inhaler:

- Call the parents/carers
- Failing that, call the family doctor
- Check the attack is not severe - see below

4. **Wait 5-10 minutes.**

5. **If the symptoms disappear,** the pupil can go back to what they were doing.

6. **If the symptoms have improved,** but not completely disappeared, call the parents and give another dose of inhaler while waiting for them.

7. If the normal medication has had **no effect,** see severe asthma attack below.

WHAT IS A SEVERE ASTHMA ATTACK?

Any of these signs mean severe:

- Normal **relief medication does not work** at all.
- The **pupil is breathless** enough to have difficulty in talking normally
- The **pulse rate is 120 per minute** or more.
- **Rapid breathing** of 30 breaths a minute or more.

HOW TO DEAL WITH A SEVERE ATTACK

Either follow your school protocol or:

1. **Call an ambulance or the family doctor** if they are likely to come immediately.

2. Get someone to **inform the parents.**

3. **Keep trying with the usual reliever inhaler every 5/10 minutes and** don't worry about the possibility of overdosing.

If the pupil has an emergency supply of oral steroids (prednisolone, prednesol), give them the stated dose in accordance with the parental consent form and individual treatment plan (if one exists).

CODE OF PRACTICE

ANAPHYLAXIS
(ALLERGY SHOCK SYNDROME)

This code of practice only applies when the acute allergic condition is known and notified to the school. The condition is extremely rare and will only affect a few pupils within the City. It commonly occurs in response to certain foodstuffs, particularly peanuts, but can occur in response to wasp stings.

1. TYPES OF TREATMENT

The treatment may involve all three of the treatments below or any combination of them, dependent on the type and severity of the reaction. At all times the individual treatment plan must be consulted.

1.1 An **anti-histamine** may be prescribed according to the severity of the reaction.

1.2 Use of an **adrenaline inhaler** may be prescribed if respiratory symptoms appear.

1.3 An **adrenalin** injection "should be immediately administered" as a life-threatening situation develops quickly.

Immediate emergency medical aid should be called in all cases, informing the doctor/ ambulance service of the acute allergic reaction.

2. WRITTEN INSTRUCTIONS (INDIVIDUAL TREATMENT PLANS)

2.1 An Individual Treatment Plan must be drawn up by the Consultant Paediatrician or the General Practitioner.

2.2 In addition to the written instructions, a form of indemnity must be signed by the parents which would indemnify staff in respect of their agreeing to undertake the task of administering an adrenalin injection where an acute allergic condition is known. (Copy attached.)

2.3 The parent/carer must agree in writing to be responsible for ensuring that the school is kept supplied with injections which are "in date".

2.4 The parent/carer is responsible for providing the school with names and telephone numbers of persons who can be contacted in a matter of emergency.

2.5 The Headteacher, through the employer, must ensure appropriate training is given to staff. The School Health Service, following consultation with the prescribing pediatrician, is responsible for arranging the appropriate information and training for a minimum of two responsible people who have volunteered to administer adrenalin. It may be necessary for the Headteacher to arrange for the teachers and other staff in the school to be briefed about a pupil's condition and about the arrangements contained in the written instructions. If there are no volunteers to administer the medication, then an ambulance must be called should a child suffer a reaction.

2.6 The instructions may include detailed arrangements for meals and that steps are taken to ensure that the pupil does not eat any food other than items prepared/approved by

the parents/carers as far as is reasonably practicable.

2.7 Appropriate arrangements must be agreed with parents/carers for provision and safe handling of medication during educational visits away from the school.

2.8 For each child the symptoms which indicate the onset of an acute allergic reaction may be different. It is the parents'/carers' responsibility to ensure, in conjunction with the GP, that the list of symptoms which indicate onset are notified to the school within the written instructions.

2.9 In the event of the child showing any of the physical symptoms, staff are instructed to follow the agreed emergency procedure.

2.10 The instruction must clearly indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor/carers.

2.11 If adrenalin is administered, then the emergency services/hospital must be informed of the dose administered.

3. LABELLING

3.1 All syringes must be clearly labeled with the child's name and identify the medicine clearly.

4. STORAGE AND ACCESS

4.1 As the medication is required immediately, the adrenalin injection should be available to the responsible persons at all times, including educational trips/visits etc. It would be inappropriate to have the medication in a locked storage cabinet with limited access as any delay in administering the adrenalin is unwarranted. Where appropriate, e.g. school trips, games, cross-country runs etc., the pupil should have ready, or immediate access to the medication.

4.2 The location and access to a second syringe which may be provided as a reserve should be clearly known to the responsible persons.

5. ADMINISTRATION OF MEDICINES

5.1 The syringe carries a small needle which only needs to be placed against an area of fatty tissue before the plunger is depressed, e.g. side of the thigh. If a second injection is administered, it must be in different site on the thigh.

5.2 Although the administration of injections is considered to be a matter for medical staff, the advice is that this process can be carried out with confidence after appropriate training. Training would be provided by the School Health Service and legal liability assured by the LA.

6. OVERDOSE/MISUSE

6.1 The adrenalin must only be used for the "named" pupil/child.

6.2 Any injection held in reserve must not be administered to another child - even if

symptoms similar to an acute reaction are presented.

6.3 An acute reaction not previously known must only be dealt with as a medical emergency and no medication administered.

FORM OF INDEMNITY

In consideration of staff at

…….. School agreeing to administer an injection of adrenalin to

…… (Full name of child).

By means of …….

in the event of the said child suffering from an anaphylactic reaction.

We……the parent(s)/guardian(s) of the child (named above), hereby indemnify Derby City Council, its servants or employees against all proceedings, costs, liabilities and damages incurred as a result of any injury or damage caused to the named child by the administration of an injection of adrenalin, provided always that this indemnity shall not include injury resulting from or caused by or materially attributable to the negligence Derby City Council, its servants or employees or the failure of the Derby City Council to perform their common law or statutory duties and liabilities.

Signed.....Parent(s)/Guardian(s)

Dated ……

Address:

Telephone (Day time) …….

Emergency Contact number…….

CODE OF PRACTICE

TREATMENT OF PROLONGED SEIZURES AND USE OF RECTAL DIAZEPAM (Valium)

Epilepsy is a tendency to have recurrent seizures and there are many different types of seizure.

When a person has continuous major convulsive seizures, this is known as status epileptics. This can cause irreversible brain damage and eventually death if untreated. The individual treatment plan will give more details.

When a child or young person has a convulsive seizure lasting longer than 5mins or 2 seizures together without recovery between - the child needs medication to stop the seizure (rescue medication). If the child doesn't have rescue medication available, an ambulance needs to be called.

There are 3 types of rescue medication – **Buccal Midazolam,** Rectal Diazepam and Rectal Paraldehyde (rarely used)

1. TYPES OF TREATMENT

1.1 Administration of prescribed rescue medication

1.2 Use of prescribed anti-convulsants (given regularly at home twice a day)

2. WRITTEN INSTRUCTIONS

2.1 There will be a written care plan describing the seizures and what to do in the event of a seizure occurring, if rescue medication prescribed the dose will be recorded

2.2 If rescue medication needs to be given the careers/staff will be taught how to use it by a health professional

2.3 Parents/carers are asked to inform the school of seizures and rescue medication given outside school hours

3. LABELLING

3.1 Medication should be stored in original containers and must **always** indicate the child's name, dosage, date of issue and expiry date.

3.2 It is the parents'/carers' responsibility to ensure that the medication is correctly labeled in consultation with the dispensing chemist.

4. STORAGE AND ACCESS

4.1 Appropriate amounts only must be kept in secure storage.

4.2 Access to the prescribed medication must only be available to the named volunteers who have been appropriately trained.

4.3 Any movement in and out of storage must be signed for in the Drugs Record Book.

4.4 Arrangements must be agreed with the parents/carers to cater for trips off school premises.

5. ADMINISTRATION

5.1 Only in accordance with specific **instructions** and protocols received from the paediatrician.

5.2 Ideally, a minimum of two volunteer members of staff should be trained so cover can be provided should one be away. During the administration, a second person should be present to provide witness support to the person administering the medication. The training must:

5.2.1 include aspects of storage of the drug and completion of records;

5.2.2 be updated annually;

5.2.3 eradicate all "as and when" decisions, and each case must include clear protocols for the timing of events in sequence.

5.3 Details of all training must be kept in a file specifically for the purpose.

5.4 Maximum privacy should be ensured during the administration of rectal diazepam and where appropriate the views of the pupil regarding the use of rectal diazepam in schools should be sought.

5.5 The time, date and duration of seizures (or the onset of symptoms) must be logged with details of action taken. The time lapse between calling for and arrival of an ambulance will be noted.

5.6 Any staff and prescription changes indicate a need for a review of the instructions and procedures for administering the medication.

6. OVERDOSE/MISUSE

6.1 Details to be provided by medical adviser (consultant paediatrician), to include any specific health and safety (COSHH) requirements, as per individual child.

7. FURTHER INFORMATION

7.1 Procedures to be adopted during a seizure e.g. removal from class/being placed in recovery position etc., to be confirmed in individual treatment plans/instructions as advised by the consultant pediatrician. Each child has a care plan to follow

CODE OF PRACTICE

DIABETES IN SCHOOLS

Type 1 Diabetes Management in School

Type 1 Diabetes Mellitus occurs with a lack of insulin to utilise glucose effectively. Children with Type 1 Diabetes Mellitus manage this condition with subcutaneous insulin and are at risk of high and low blood sugars which may make them unwell.

1. TYPES OF TREATMENT

Insulin is given subcutaneously in designated areas of the thigh, buttock and tummy. Patients are also advised to eat a healthy diet and regularly exercise as with any young child. Treats can be given in moderation following a main meal with insulin injections.

The three main diabetes regimens are:

- Twice daily premixed insulin (BD)
- Multiple injections of insulin (MDI)
- Continuous subcutaneous insulin infusion (Pump Therapy)

Twice Daily Insulin Regimen

Injections are given before breakfast and before evening meal. The child/ Young person will require mid-morning and mid afternoon snack as discussed with their individual care plans.

Multiple Injections of Insulin (MDI) or Basal Bolus Regimen

MDI is designed to copy normal insulin production. An injection of fast acting insulin is given via a pen device before each meal (bolus) and one injection usually later in the evening is given as basal insulin. The fast acting insulin should be given within 10 minutes of eating.

The child/ Young person will require carbohydrate free snacks when applicable with school policy as discussed with their individual care plans.

Continuous Subcutaneous Insulin infusion (Pump Therapy)

Pump therapy is another way of administering basal insulin continuously and give a bolus of insulin with all foods that contain carbohydrate. It is attached to the body through tubing and a cannula. It requires 2-3hrly blood sugar testing and can increase risk of the life threatening condition- ketoacidosis if not appropriately managed

Insulin Regimens and monitoring

Most children/young people will require some supervision when monitoring their blood glucose levels in the event of requiring any emergency treatment or advice. Some children/ young people will require supervision of the insulin dose given or depending on age and maturity they may require trained school staff to administer the injection.

All insulin regimens require the child/young person to monitor blood glucose and blood ketone levels and for staff to be aware of signs, symptoms and treatment of Hypoglycaemia (low blood sugars) and Hyperglycaemia (high) blood sugar levels as written in the individual care plans.

Hypoglycaemia (Low blood sugar levels)

Hypoglycaemia is when the blood glucose level falls below 4mmol/l

Each child is encouraged to carry their own equipment to deal with a low blood sugar however an emergency box supplied by parents to school is also advised. The emergency box should contain, glucose drinks, glucose tablets, glucogel and starchy carbohydrate snacks

Can occur regularly due to:

- Not enough carbohydrate eaten with insulin
- Late carbohydrate
- Too much insulin
- Exercise
- Change in routine
- Poor injection technique or lumpy injection sites

Signs and Symptoms of Hypoglycaemia are:

- Hungry
- Pale
- Shaky
- Dizzy
- Confused
- Difficulty concentrating
- Blurred vision
- Headache
- Odd behaviour, Poor judgement
- Slurred speech
- Lack of co-ordination

Mild

Pupil requires supervision but can take instruction for necessary treatment

- **Glucose appropriate for weight and blood glucose level**
- **(See individual Hypoglycaemia care plan)**

Moderate

Pupil is conscious however requires intervention from a supervising adult

- **Glucogel gel as directed by care plan**

Severe

Pupil is semi-conscious or unconscious and requires emergency intervention

- **Glucagon Injection**

Follow up treatment

BD/MDI - Young people using any of these regimes require starchy carbohydrate following treatment with glucose. If a meal is due they do not require this extra carbohydrate.

Hyperglycaemia (High blood sugar levels)

In children who are unwell a blood ketone test is required, particularly if blood glucose levels are above 11mmol/l. A blood ketone level should be 0.0mmol/l any blood ketone level above 3mmol/l means the child is at risk of Ketoacidosis

Danger signs of ketoacidosis to look for:

- Vomiting
- Abdominal pain
- Lethargy
- Confusion
- Fast breathing

Any signs of ketoacidosis dial 999

Please be aware many children/young people with Type 1 Diabetes may have blood glucose above 11mmol/l however not necessarily have blood ketones. As long as the child/young person remains generally well it will not affect their health in the short term. Their concentration level however with a high blood glucose may be altered. Regular blood glucose testing will be required and encouraging the child to drink water will prevent any dehydration

If symptoms of ketones are present (see individual care plan) seek advice from the parents or hospital medical team immediately.

If the child has a high blood sugar with no ketones present a correction bolus of fast acting insulin can be given if directed by parent's/ health care professional or an individual care plan.

Blood Glucose and Ketone Testing
The child/young person should have access to their blood testing equipment at all times. This equipment may include sharps and should be addressed on the care plan if necessary.

2. WRITTEN INSTRUCTIONS

Individual Care plans will be provided by the Derbyshire Children's Hospital Diabetes Team and completed by Parents. The care plans provided include:

- Blood glucose testing
- Injecting insulin (If applicable)
- Management of Hypoglycaemia and recommended emergency supplies
- Management of hyperglycaemia and blood ketone testing
- Giving a correction bolus (If applicable)

3. LABELLING

All emergency equipment should be labelled with the child/young persons' name.

4. STORAGE AND ACCESS

Diabetes medical equipment should be kept with the child/young person at all times and spare medical equipment stored in a clearly identified area. Any spare insulin or glucagen hypokit will need to be stored in a fridge according to manufacturer's guidance.

Every child with diabetes in school should be allowed free access to toilet facilities and unlimited access to drinking water within the classroom

5. ADMINISTRATION OF MEDICINES

It is advised that all schools, document any blood glucose/ketone levels and insulin given and by whom. This can be accessed through Managing Medicines in School and Early Years setting (Department of Health) or Derbyshire Children's Hospital insulin administration form accessed through the diabetes nursing team.

CODE OF PRACTICE

CONTINENCE MANAGEMENT
THE USE OF CLEAN INTERMITTENT CATHETERISATON (CIC)

INTRODUCTION
There are many causes of incontinence in children and therefore the management will vary. Every child requires individual assessment.

LARNING, EMOTIONAL AND BEHAVIOURAL DIFFICULTIES
Bladder and bowel control are a function of physical, intellectual and social development, therefore children with Learning difficulties or emotional and behavioral difficulties may be incontinent. These children will require: -

1. Full assessment by a continence adviser.

2. A toileting regime designed to accommodate the demands of the school day.

3. A positive rewarding approach.

NEUROPATHIC BLADDER AND BOWEL
The commonest cause of neuropathic bladder in children is spina bifida, but may be caused by a range of other conditions. Bladder and bowel function is disrupted by abnormal development of the nerve supply and can only rarely be cured by treatment. However, medication, surgery and specialist techniques can usually achieve a reasonable level of continence. To achieve social control requires very careful assessment by the continence adviser and doctors and a specific care plan implemented by children, parents and care staff. Such a care plan should be designed to achieve continence, encouraging as much independence as possible and respect for the child's dignity and privacy.

Associated problems which may affect the management of continence in schools.

1. MOBILITY
Many children with spina bifida have mobility problems. They need toilet facilities which are accessible, private and secure and may need help with transfer from wheelchair to toilet etc. or full support

2. DEXTERITY
Hand function, co-ordination and perception are often poor in children with spina bifida.

3. HYDROCEPHALUS
All children with spina bifida have a degree of hydrocephalus, with a possible resultant effect on Learning ability, concentration and numeracy. Such problems may be highly specific and easily masked by the child's open, chatty personality.

All children will require: -

1. Regular medical and nursing supervision
2. Private and accessible toilet facilities
3. Accessible cupboard to store equipment
4. Disposal facility for soiled pads and catheters
5. Assessment of welfare support needs
6. Independence training plan
7. Access to specialist counselling as and when required

1. TYPES OF TREATMENT

1.1 *REGULAR TOILETING*

Planned usually to coincide with breaks in the school day. Children may, however, require more frequent toileting to achieve specific short-term gains in agreement with school staff. Bowel continence can usually be managed at home.

1.2 *MEDICATION*

Anticholinergenics, e.g. Oxybutynin, may require administration as regular treatment. Most children will not require this during the school day.

1.3 *CATHETERISATION (CIC)*

This is a clean (usually not sterile) procedure and can be performed on a changing bed or in a chair.

2. WRITTEN INSTRUCTIONS

2.1 There must be a written care plan on every child drawn up by a continence adviser/ community paediatric nurse in conjunction with the consultant pediatrician or surgeon. The care plan should be reviewed at last annually.

2.2 The instructions must be approved and signed by the parents/carers and health professional responsible.

2.3 At last two persons should be trained to perform and supervise CIBC. Training could be available from the school health service or voluntary agency continence adviser (ASBAH Association for Spina Bifida and Hydrocephalus). Training should only be given by professionals.

2.4 Specific consideration needs to be made for education visits out of school to ensure pupils are not disadvantaged from lack of trained staff.

3. LABELLING

All equipment and catheters should be labelled for the sole use of the child.

4. STORAGE AND ACCESS

4.1 All equipment should be stored in a cupboard easily accessible to child and carer during catheterisation.

4.2 Toilet facilities must be easily accessible to the children with the advice of continence adviser and occupational therapist and be of sufficient size to allow procedures to take place easily but with sufficient privacy to preserve dignity and independence.

4.3 Facilities should be clean, secure, and private and, if not for sole use, be accessible as required.

4.4 Large schools need to consider the need for more than one facility to allow the child access to all facilities on site and access to the curriculum. Clearly this is essential for split-site schools.

5. ADMINISTRATION OF PROCEDURE

5.1 At least two suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave. Training should be provided by a nurse either through the School Health Service or voluntary agencies (e.g. ASBAH).

5.2 It is the role of the school to supervise and support rather than carry out procedures wherever possible to aid the independence of the child.

5.3 The child will require ongoing supervision. Skills may appear to have been lost during extended holidays, but increased levels of supervision early in the term to aid settling in should restore efficiency.

5.4 Staff inset training should be updated by School Health or ASBAH at regular intervals.

5.5 Staff will require additional training in lifting and handling for children with additional mobility problems

Appendix 1

Date												
Time given												
Teacher Initials												

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USE OF MEDICATION IN SCHOOL **Appendix 2**

This flow chart should be used in conjunction with the accompanying text in the guidance document which gives more information on each section.