Supporting Children with Medical Needs Policy 2025

JERICHO PRIMARY SCHOOL
POLICY 24

Relevant roles held and by whom (correct at the time of publishing)	
SENDCo:	**Mrs Laura Ball**
Designated Safeguarding Lead (DSL):	Mrs Penny Leck
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Approved by[1]			
Name:			
Position:			
Signed:		**Version Number:**	
Date:		**Proposed review date**[2]**:**	

REVIEW SHEET

Each entry in the table below summarises the changes to this policy and procedures made since the last review (if any).

Version Number	Version Description	Date of Revision
1	Original	August 2014
2	Amended to take into account new legislation which will allow schools to hold emergency Salbutamol inhalers for pupils diagnosed with asthma	September 2014
3	Very minor tweaks to include topical medicines where oral is mentioned and clarify the acceptance procedure for non-prescription medicines.	June 2015
4	New introductory section 'How to use this document' with formatting tips, reference to SEND Jan 2015 (updated from Jul 2014). Section 4.6 important clarification on when non-prescription medicines might be administered. Appendix A - clarification when/how decisions not to instigate IHCPs are made and that it is not just parents and healthcare professionals that can trigger an IHCP review.	November 2015
5	Updated reference DfE document '*Supporting Pupils at School with Medical Conditions, Dec 15'* resulting in only 1 change in **Section 3.1** a new bullet point about LAs, CCGs and service providers (3rd one down). **Revised Appendix B**: IHCP with space for other people involved in the development to sign if they want to or there is a need. **New Appendix C2**: a landscape version of parental consent to administer with space for a medical practitioner to sign if there is a need.	March 2016
6	Links to DfE document '*Supporting Pupils at School with Medical Conditions, Dec 15'* updated.	September 2016
7	Updated to include specific information in relation to Food Allergies and to remove some references to the school nursing service.	May 2017
8	Revised to include the use of adrenaline auto-injectors (AAIs). For ease of use and visual comfort, updated text is highlighted in green. Significant text in Section 4.10 has been updated and Section 4.11 is new. Appendices updated: B, C1, & C2. New Appendix E3.	November 2018
9	Revised to take into account the forthcoming changes to Cumbria Safeguarding Children Partnership (CSCP) which replaces Cumbria Local Safeguarding Children Board (LSCB) from 29 September 2019. Updated links to *'Guidance on the use of emergency Salbutamol inhalers in schools'* March 2015.	September 2019
10	Updated to take account of LA statutory guidance 'Ensuring a good education for children who cannot attend school because of health needs'. The addition of the updates will assist in meeting the requirements for schools to have a statutory Policy (incorporated within this Policy) for Children with health needs who cannot attend school.	November 2019
11	No legal or significant policy changes. Minor updates: S2 clearer statement of understanding about LA duties; S3.2 new example statement to choose; S4.2 new example wording on re-integration if you struggled to write something simple; S4.5 made guidance text simpler and turned it into example text with a new statement choice.	September 2020
12	No legal or significant policy changes. Major updates throughout to significantly cut content but more clearly express procedures & current good practice expected from staff. Updates to template forms to identify when a medicine is a controlled drug and requires a witness. New text in section 4.8 covering records retention. New references to new Asthma and Anaphylaxis Procedures.	November 2021
13	Reviewed as still current requiring no legal or significant policy changes. Minor content updates to reflect the separation of appendices from the main document for ease of use. Significantly updated and removed appendices include the 999 Flowchart/poster (now more useful as a poster including w3w or other options, Forms A-C3 (gender category now sex and option to add pronouns included), Forms D1 & D2 with clearer expectations,	September 2022

	Emergency Salbutamol use letter (now 3 slips to one sheet and includes an option to notify parents of a child's self-administration of their own inhaler as recommended by Asthma UK), and the Parent Invite to IHCP meeting (now includes the suggestion that parents add things to an enclosed blank IHCP to bring to the meeting). Login to www.kymallanhsc.co.uk and click on the links on the contents page to download them.	
14	Reviewed. No legal or significant policy changes required. Links updated including to the new KAHub www.kymallanhub.co.uk and added 3 advisories where, if using our **V3 model Administration of Medicines Procedures**, cuts can be made to this policy and the others referred to instead (managing medicines, Salbutamol, and AAIs) new since this policy was last reviewed by KAHSC.	September 2023
15	Updated procedures for administration and managing medication in school	Jan 2024
15	Minor amendments to take account of the new KAHSC Anaphylaxis, asthma, diabetes and epilepsy (AADE) management procedures which replace the KAHSC model Managing Asthma procedures and model Managing Anaphylaxis procedures (now withdrawn).	September 2024

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1 Definitions

For the purposes of this document a child, young person, pupil, or student is referred to as a 'child' or a 'pupil' and they are normally under 18 years of age.

Wherever the term 'parent' is used this includes any person with parental authority over the child concerned e.g., carers, legal guardians etc.

2 Statement of Intent

The governing body of Jericho Primary School has a statutory duty (under section 100 of the Children and Families Act 2014), to ensure arrangements are in place to support pupils with medical conditions.

The aim of this Policy and procedures is to ensure that all pupils with medical conditions, in terms of both physical and mental health, receive appropriate support allowing them to play a full and active role in school life, remain healthy, have full access to education including physical education, schools sports, and physical activity (PESSPA), and achieve their academic potential. It is based on the Department for Education (DfE) document *'Supporting pupils at school with medical conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England'*, will be reviewed regularly, and made accessible to pupils, parents, staff, and other adults as appropriate.

This school is committed to ensuring parents feel confident that effective support for their child's medical condition will be provided and that their child will feel safe at school.

We recognise that there are also social and emotional implications associated with medical conditions and that pupils can develop emotional disorders, such as self-consciousness, anxiety, and depression, and be subject to bullying. This policy aims to minimise the risks of pupils experiencing these difficulties.

Long-term absences as a result of medical conditions can affect educational attainment, impact integration with peers, and affect wellbeing and emotional health. This policy contains procedures to minimise the impact of long-term absence and effectively manage short-term absence.

Some pupils with medical conditions may be considered to be disabled under the definition set out in the Equality Act 2010. This school has a duty to comply with the Act in all such cases.

Some pupils with medical conditions may also have Special Educational Needs and/or Disabilities (SEND) with an Education, Health, and Care (EHC) plan in place bringing together provision to manage all of them. For these pupils, this Policy should be read in conjunction with our SEND Policy and the DfE statutory guidance document '*Special Educational Needs and Disability: Code of Practice 0-25 Years*'.

To ensure that the needs of our pupils with medical conditions are fully understood and effectively supported, we consult with health and social care professionals, pupils, and their parents.

3 Organisation

3.1 The governing body

The whole governing body and not any one person is legally responsible and accountable for fulfilling the statutory duty to make arrangements to support pupils with medical conditions in school. Governors will ensure that:

- Pupils with medical conditions can access and enjoy the same opportunities as any other pupil.
- No pupil with a medical condition is denied admission because arrangements to manage their medical condition have not been made.
- No pupil's health is put at unnecessary risk and will reserve the right not to accept a pupil into school at times where it would be detrimental to the health of that pupil or others to do so e.g., when the pupil has an infectious disease.

[1] The Governing Body are free to delegate approval of this document to a Committee of the Governing Body, an individual Governor or the Head teacher

[2] Governing Bodies, Proprietors and Management Committees free to determine – DfE recommend annually

- Work with the LA, health professionals, commissioners, and support services to ensure that pupils with medical conditions receive a full education is effective.
- Pupils are reintegrated effectively following long-term or frequent absence.
- The focus is on the individual needs of each pupil and what support is required to support them.
- Parents/carers and pupils can be confident in the school's ability to provide effective support.
- All members of staff are properly trained to provide the necessary support and are able to access information and other teaching support materials as needed.
- Policies, plans, procedures, and systems are properly and effectively implemented.

Our Lead Governor for supporting pupils at school with medical conditions is Natalie Appleton,

3.2 The Head teacher

The Head teacher has a responsibility to ensure this Policy is developed and implemented effectively with partners. They have overall responsibility for the development of IHCPs and will implement arrangements to ensure that:

- this Policy is effectively communicated and implemented with all stakeholders.
- all staff are aware of this Policy and procedures and understand their role;
- enough staff are trained and available to implement this policy, carry out the procedures, and deliver against all individual healthcare plans (IHCPs), including in emergency situations;
- staff are appropriately insured and aware of the insurance arrangements;
- recruitment needs for the specific purpose of ensuring pupils with medical conditions are properly supported are considered;
- there is a named person (usually the SENDCo) who will liaise with the LA, parents, and other professionals in relation to children with health needs;
- professional medical support is sought where a pupil with a medical condition requires support that has not yet been identified.

3.3 School staff

Every member of school staff:

- may be asked to provide support to pupils with medical conditions, including the administering of medicines, but are not required to do so;
- should consider the needs of pupils with medical conditions in their lessons or other work when managing risks or when deciding whether or not to volunteer to administer medicines;
- will receive enough training to achieve the required level of competency before taking specific responsibility for supporting pupils with medical conditions;
- will know the signs when a pupil with a medical condition needs help and what to do in response.

3.4 Pupils

Pupils with medical conditions are often best placed to provide information about how they affect them. All pupils should:

- be fully involved in discussions about their medical support needs if they have any;
- contribute to the development of their IHCP, if they need one, and follow it;
- be sensitive to the needs of all pupils with medical conditions.

3.5 Parents and carers

Parents and carers are key partners in the success of this Policy and should:

- notify the school if their child has a medical condition;
- provide enough up-to-date information about their child's medical needs;
- be involved in the development and review of their child's IHCP;
- carry out any agreed actions in the IHCP;
- ensure that they, or another nominated adult, are contactable at all times.

[1] The Governors are free to determine how to implement.
[2] The Governing Body/Board of Trustees or Proprietor is free to determine review period. (DfE recommend annually)

3.6 School nurses

The school nursing service should:

- notify school at the earliest opportunity, when a pupil has been identified as having a medical condition requiring support in school;
- support staff to implement IHCPs and provide advice and training;
- liaise with lead clinicians locally on appropriate support for pupils with medical conditions.

3.7 Integrated Care Boards (ICBs)

The role of ICBs is to:

- ensure commissioning is responsive to pupils' needs, and that health services are able to cooperate with schools supporting pupils with medical conditions;
- make joint commissioning arrangements for education, health, and care provision for pupils with SEND;
- are responsive to LAs and schools looking to improve links between health services and schools;
- provide clinical support for pupils who have long-term conditions and disabilities;
- ensure that commissioning arrangements provide the necessary ongoing support essential to ensuring the safety of vulnerable pupils.

3.8 Other healthcare professionals

Other healthcare professionals, including GPs and paediatricians should:

- notify the school nurse when a child has been identified as having a medical condition that will require support at school;
- provide advice on developing IHCPs;
- provide or signpost the provision of relevant specific support in the school for children with particular conditions, e.g., asthma, diabetes, anaphylaxis, and epilepsy.

3.9 Providers of health services

Providers of health services will need to cooperate with school, including ensuring good communication, liaising with the school nurse and other healthcare professionals, and participating in outreach training.

3.10 Local authorities

Our Local Authority (LA):

- commissions school nurses for local schools;
- promotes co-operation between relevant partners;
- makes joint commissioning arrangements for education, health, and care provision for pupils with SEND;
- provides support, advice and guidance, and suitable training for school staff, ensuring that IHCPs can be effectively delivered;
- works with the school to ensure that pupils with medical conditions can attend school full-time.

Where a pupil is away from school for 15 days or more (whether consecutively or across a school year), the LA has a duty to make alternative arrangements, as the pupil is unlikely to receive a suitable education in a mainstream school.

3.11 Ofsted

Ofsted inspectors will consider how well the school meets the needs of the full range of pupils, including those with medical conditions.

Key judgements are informed by the progress and achievement of pupils with medical conditions, alongside pupils with SEND, and also by pupils' spiritual, moral, social, and cultural development.

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4 Arrangements and Procedures

4.1 Notification that a pupil has a medical condition

When the school is notified that a pupil has a medical condition that requires support in school, the Headteacher and SENCO will be informed and will initiate the procedure described in the Flowchart: Developing an IHCP.

For a pupil starting at this school in the ordinary September intake, arrangements will be in place before they arrive and will be informed by their previous educational and/or care setting (if any).

For a pupil who joins this school mid-term or is an existing pupil with a new diagnosis, we will work to ensure arrangements are put in place within two weeks.

For pupils leaving this school to attend another educational setting, we will appropriately inform the setting they are moving to of the pupil's needs during the transition process or as soon as possible following notification by the parents or carers of the proposed move.

School does not have to wait for a formal diagnosis before providing support to a pupil because in some cases their medical condition may be unclear or there may be a difference of opinion. The Head teacher will make judgements based on all available evidence (including medical evidence and consultation with parents or carers).

4.2 School attendance and re-integration

After a period of absence though ill health, hospital education or other alternative provision there will be period of re-integration which will vary for each child, but in principle we will:

- have an early warning system to inform the LA when a child becomes at risk of missing education for 15 days in any one school year due to their health needs e.g., our regular attendance reviews informed by our knowledge of pupils' potential vulnerabilities;
- take steps to facilitate a child successfully staying in touch with school while they are absent e.g., email, newsletters, invitations to school events, approved and supervised phone, video chat or other direct contact by classmates or staff;
- plan for consistent provision during and after a period of education outside school and who/what services we have available to support us to do this - for example in what ways can we ensure the absent child can access the curriculum and materials that he or she would have used in school;
- work with the LA to set up an individually tailored reintegration plan for each child that needs one, actively seeking extra support to help fill any gaps arising from the child's absence;
- make any *reasonable* adjustments to provide suitable access for the child as required under equalities legislation.

We will also consider the emotional needs of children who require re-integration and that such re-integration may not always be as a result of an absence but could be as the result of a serious or embarrassing incident at school.

4.3 Individual Healthcare Plans (IHCP)

The school, healthcare professionals and parents or carers will agree, based on evidence, whether an IHCP is required for a pupil, or whether it would be inappropriate or disproportionate to their level of need. If no consensus can be reached, the Head teacher makes the final decision.

The IHCP is a working document that will help school effectively support a pupil with a medical condition. It will provide clarity about what needs to be done, when and by whom and aims to capture the steps which school should take to help the child manage their condition and overcome any potential barriers to get the most from their education. It will focus on the child's best interests and help ensure that this school can assesses and manage identified risks to their education, health and social wellbeing and minimise disruption.

An IHCP will cover:

- the medical condition, its triggers, signs, symptoms, and treatments;

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- the pupil's needs, including medicine (dose, side-effects, and storage) and other treatments, time, facilities (privacy, shower, sleep), equipment (glucose testing, AAIs etc.), access to food and drink (when used to manage a condition), dietary requirements, and environmental issues (dust, pollen. crowds, distance between lessons etc.);
- specific support for the pupil's educational, social, and emotional needs e.g., how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions etc.;
- the level of support needed, including in emergencies;
- whether a child can self-manage their medicine and how this can be supported;
- who will provide necessary support, their training needs, expectations of their role, and confirmation of their proficiency to carry it out effectively;
- cover arrangements for when named supporting staff are unavailable;
- who in the school needs to be aware of the child's condition and the support required;
- arrangements for written permission from parents and the Head teacher for medicines to be administered by a member of staff, or self-administered by the pupil during school hours or activities,
- arrangements for written permission from parents and the Head teacher for the school supply of emergency salbutamol or adrenaline to be administered by a member of staff, or self-administered by the pupil in an emergency during school hours or activities;
- separate arrangements or procedures required for school trips and activities e.g., risk assessments;
- where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child's condition; and
- what to do in an emergency, including who to contact, and contingency arrangements.

If a child has an emergency health care plan prepared by their lead Clinician, it will be used to inform development of their IHCP.

IHCPs are easily accessible to those who need to refer to them, but confidentiality is preserved.

IHCPs are reviewed at least annually, when a child's medical circumstances change, or following an incident, whichever is sooner. When an IHCP update is made, the SENDCo should trigger a review of associated information e.g., school insurance arrangements if it is a new medical procedure, or the asthma register recording parental consent to administer the school's emergency inhaler if consent is newly given or withdrawn.

Where a pupil has an EHCP, the IHCP is linked to it or becomes part of it.

Where a child has SEND but does not have an EHCP, their SEND should be mentioned in their IHCP.

Where a child is returning from a period of hospital education, alternative provision, or home tuition, we work with the LA and education provider to ensure that their IHCP identifies the support the child needs to reintegrate (see section 4).

4.4 Pupils managing their own medical conditions

After discussion with parents, pupils who are competent to manage their own health needs are encouraged to take responsibility for self-managing their medicines and procedures. This is reflected in their IHCP.

Where possible pupils will be allowed to carry their own medicines and relevant devices. If not, they will be able to access them quickly and easily.

If a pupil refuses to take a medicine or carry out a necessary procedure, staff will not force them to do so, but will follow the procedure agreed in the IHCP as well as inform parents. This may trigger a review of the IHCP.

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If a pupil with a controlled drug passes it to another person for use, this is a criminal offence and appropriate disciplinary action will also be taken (see the School Behaviour Policy).

4.5 Training

Any member of school staff providing support to a pupil with medical needs will receive suitable training to fulfil their role. A first-aid certificate does not constitute appropriate training for supporting pupils with medical conditions except for aspects included through specific 'bolt on' training that the provider is competent to deliver e.g., use of adrenaline auto-injectors (AAI).

Staff will not undertake healthcare procedures or administer medicines without appropriate training.

Staff training needs will be assessed through the development and review of IHCPs, on a termly basis for all school staff, and when staff leave, or a new staff member arrives.

Through training, staff will have the competency and confidence to support pupils with medical conditions and fulfil the requirements of IHCPs. It will help them understand the medical condition(s) they are asked to support, their implications, and any preventative measures that must be taken.

All staff will undergo 'whole school awareness' training on induction and regularly to be delivered at school by Health and Safety Coordinator, lead first aider and our SENCO It will cover:

- current school Policy on supporting pupils with medical conditions;
- the role of staff in implementing it;
- whether any of our pupils have been diagnosed with asthma, diabetes, anaphylaxis, epilepsy, or another medical condition they need support with, and our duty to be ready to support as yet undiagnosed pupils;
- how to spot a pupil experiencing an emergency;
- what to do in an emergency;
- how to find more information and resources.

Staff who administer simple oral or topical medicines will undergo 'administration awareness' training to be delivered at school by the lead first aider before being asked to do so. The lead first aider will have received training on how to administer medication and there will train staff appropriately. It will cover:

- an awareness of school procedures around Fabricated or Induced Illness (FII);
- whether different procedures apply in different locations and where to find the written checklist displayed in each one;
- hygiene requirements e.g., washing hands before handling medicines, using a clean measuring device for oral medicine liquids, ensuring containers are clean before they are stored again; washing hands between each pupil if administering to more than one;
- pre-administration checks e.g., having the correct record sheet and checking the medicine has not already been administered, the child's identity, child's medicine (including that the dosage, frequency etc. on any IHCP matches the prescription label), expiry date of medicine, that storage instructions have been adhered to (i.e., if it should be refrigerated that it was in the fridge) etc.;
- procedures for administration e.g., whether the child self-administers, the minimum assistance or supervision required (as described in the IHCP), what should be done with used administration devices (spoons, oral syringes, sharps etc.), what to do if something goes wrong or a child refuses a medicine etc.;
- recording procedures.

Designated staff will undergo 'specific awareness' training on induction to relevant tasks and regularly to manage a specified condition, administer complex medicines, or carry out medical procedures to be delivered by an appropriately competent healthcare professional.

We will look to ensure it covers:

- responding appropriately to a request for help from another member of our staff;
- administering the medicines or procedures;

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- recognising when emergency action is necessary;
- making appropriate records; and
- ensuring parents are informed (see links to letters and the IHCP on the contents page).

Our Health and Safety Leader records all training as necessary.

The family of a child will often be key in providing relevant information about how a child's needs can be met. If families provide specific advice they will never be relied on as the sole source of advice.

4.6 Supply staff

Supply staff will be:

- provided with access to this policy and procedures;
- informed of all relevant medical conditions of pupils they will have a responsibility for;
- covered under the school's insurance arrangements.

4.7 Managing medicines

Medicines are only to be administered at school when we have been instructed to by a relevant medical professional or a parent or carer ***and it would be detrimental to the pupil's health or school attendance not to do so.*** Such medicines can be prescription or non-prescription.

In managing the administration of medication we will adapt the following:

- We will not give pupils under 16 a medicine containing aspirin unless prescribed by a doctor.
- We will not administer herbal medication with a prescription from a doctor.
- We will gain written consent for all medication – prescription and non-prescription before administering medication.
- When administering pain relief – we will:
    - Contact parents prior to administration (where possible).
    - Check maximum dosages and
    - Check when the previous does was taken.
- We will only accept medicines that are
    - In-date
    - Labelled
    - In the original container as dispensed by a pharmacist or sold over the counter.
    - Contain instructions supplied with the medicine.
    - Pre-loaded medicines like salbutamol cannisters and adrenaline or insulin auto-injectors must still be in date but can be accepted in the dispenser rather than the packaging.
- Staff will read medication leaflet carefully so that they understand what they should do next if they have made a mistake in administering the medication e.g under/over dose.
- All medicines must be stored safely, in their original containers and in accordance with their storage instructions.
- For medicines such as inhalers, pupils must know where their medicine is at all times so that they know how to access them if needed.
- When medicines are no longer required, they are returned to parents for safe disposal.
- Sharps boxes are always used for the disposal of needles and other sharps.
- The school asthma inhaler for emergency use are stored in the **School Office** and their use is recorded. Inhalers are always used in line with medical guidance.
- The school adrenaline auto-injector(s) for emergency use are stored in the **School Office** and their use is recorded. AAIs are always used in line with medical guidance and specific training.

Controlled drugs

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The supply, possession, and administration of some medicines e.g., methylphenidate (Ritalin) are strictly controlled by the Misuse of Drugs Act 1971 and its associated regulations and are referred to as 'controlled drugs'. They will be managed as follows:

- Delivered and collected daily by a parent or carer to or from a named member of staff unless this is unreasonable or managed by agreement through a home-to-school transport provider.
- Stored in a non-portable container which only named staff members have access; however, these drugs will be easily accessible in an emergency.
- Staff can administer a controlled drug to a pupil for whom it has been prescribed and they should do so in accordance with the prescription instructions and in front of a suitable adult witness.
- A record must be kept of the administration of controlled drugs in the same way as other medicines but with the legible signature/initials of the staff administering them and the witness.

4.8 Procedure for administration and record keeping/retention

Before any medication is given, staff must ensure that written consent has been gained for all medication that will be administered.

All medication administered in school must be overseen by our two Nominated First Aiders (NFA) – Claire Nicholson and Georgia Hunter. The administration of all medication must be overseen by **2** members of staff. One must be one of our **NFA.**

School will keep a record of all medicines administered to pupils, stating what, how and how much was administered, when and by whom, with a note of any side effects experienced or refusal.

When a pupil's medicine is a controlled drug, their individual record sheets will allow for the signature of a second witness to the administration. Details of receipts and returns of the controlled drug will be accurately recorded on the administration record see **Form 1 Single Medication.**

When a pupil is given a more than one medicine e.g., pain relief and controlled drugs, it will be recorded on **Form 2- Multiple Medications.**

When a pupil is given general medication – e.g. pain relief and parents have given consent, this will recorded on the schools central **General Form (Form 3)**

To ensure that only eligible and appropriately identified pupils are given the school's emergency salbutamol asthma reliever inhaler and/or AAI, a register of such pupils will be kept in each emergency kit.

When a pupil is given the school emergency inhaler or school emergency AAI, it will be recorded on the relevant general record card in the relevant it (see contents page for links to Forms E2 and E3). Parents should be informed about use of an asthma reliever inhaler using the Letter: Emergency Salbutamol Inhaler Use - see contents page for the link to a template with 3 slips to a page).

When a pupil has needed to use the school emergency AAI, parents will be informed immediately by telephone or another agreed instant communication method, and a record made.

Records relating to the administration of medicines by school staff are classed as school records as opposed to pupil records. Consent forms should be held in a separate file to the pupil file and can be held together. These consent forms should not be transferred to the next school or setting and is why they should be kept separate from the pupil personal file.

It is generally recommended that records for the administration of medicines signed by school staff should be held for 2 years from the date of the last entry on the sheet.

Individual child records of medicines administered by school staff, like Forms 1,2,3, can be securely destroyed once the child has left the school and should be held in a file separate to the pupil's personal file. Again, these administration records should not be transferred to the next or subsequent school or other educational setting.

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4.9 Emergency procedures

Medical emergencies will be handled under the school's emergency procedures.

Where an IHCP is in place, it should detail:

- what constitutes an emergency; and
- what to do in an emergency.

Pupils will be involved in age and developmentally appropriate ways in our emergency procedures e.g., fetching help or equipment, and to increase community awareness, build peer-to-peer resilience, promote leadership skills, and reduce stigma or bullying.

If a pupil needs to be taken to hospital, a member of staff will remain with the pupil until their parents or carers arrive. This may mean that they will need to go to hospital in the ambulance and may need support with arrangements for their own transport back to school or home.

4.10 Salbutamol inhalers

Asthma is a long-term condition that affects the airways (the tubes that carry air into and out of the lungs) and usually causes symptoms such as coughing, wheezing, and breathlessness. As many as 1 in every eleven children has asthma. If someone with asthma comes into contact with one of their asthma triggers, it can make their symptoms worse and even bring on an asthma attack making it difficult to breathe.

Now that the Human Medicines (Amendment) (No.2) Regulations 2014 allow (but do not require) schools to keep a salbutamol asthma reliever inhaler for use in an asthma emergency, governors have decided that keeping a supply will currently benefit pupils significantly.

This school is committed to supporting pupils who have been diagnosed with asthma and has developed separate Anaphylaxis, asthma, diabetes and epilepsy (AADE) Management procedures

In summary:

- The administration of reliever inhalers will be carried out in accordance with staff training.
- An asthma register of all pupils prescribed a reliever inhaler will be kept the school office and our emergency asthma inhaler kits and will be checked as part of initiating the emergency response.
- Where a pupil has been prescribed a reliever inhaler, this will be recorded on their IHCP with an indication of whether they can responsibly carry the device and self-administer it correctly.
- Whether use of a child's own asthma reliever inhaler should be recorded and reported to parents will be made clear in the IHCP/asthma plan.
- Consideration will be given to preventing and managing an asthma attack when planning all school activities on and off-site.
- School has 2 emergency salbutamol inhaler kits in the staff room and procedures in place to administer, maintain, and dispose of them safely.
- **Our decision to hold an emergency asthma kit does not in any way release a parent from their absolute duty to ensure that their child attends school with a fully functional inhaler containing sufficient medicine for their needs.**
- A copy of the asthma register including consent to administer the school emergency salbutamol will be held with each school asthma emergency kit.
- Designated staff will be trained in how to administer the school emergency inhaler and other staff will be trained in how to seek their help in an asthma emergency.
- Parents will be informed whenever their child has used the school emergency inhaler.

4.11 Allergens

Exposure to an allergen can cause an allergic reaction resulting in life threatening anaphylaxis where the resultant swelling can stop someone from breathing. Allergens can be found in foods like shellfish, eggs, dairy etc., objects like dye in clothing, latex etc., insect stings and bites, or in the air like pollen, dust, mould, animal dander etc.

[1] The Governors are free to determine how to implement.

[2] The Governing Body/Board of Trustees or Proprietor is free to determine review period. (DfE recommend annually)

This school is committed to supporting pupils who have been diagnosed with an allergy and has developed separate Anaphylaxis, asthma, diabetes and epilepsy (AADE) Management procedures

4.11.1 School meal and wrap around care providers

When setting up or reviewing a child's IHCP, part of the process includes appropriate information sharing, such as dietary restrictions, with the kitchen team and others. Part of the educational visits planning process written into our risk assessment is to ensure dietary needs are addressed in advance and needs shared appropriately with third party providers like residential centres.

All food handlers receive suitable training on their first day of employment and before food handling duties commence in relation to managing food allergens to include:

- cross referencing IHCPs with ingredients regularly, especially when changing products or recipes;
- handling requests for allergen information;
- properly labelling all foods they prepack;
- how cross contamination can occur and how to prevent it;
- the signs and symptoms of an allergic reaction and what to do, and who to report to should this occur.

4.11.2 Other food handlers

Other potential food handlers (food technology, classroom baking, cookery club, nursery and other staff serving snacks and treats etc.), will be made aware of information about the Major Food Allergens, so they can take it into account when planning any food-related activities for children with known allergies. Staff are also trained to be alert to signs that a child may have a previously unknown allergy or has developed a new one.

Staff or volunteers working with food in play, the curriculum, or other school activities will receive sufficient instruction on and follow the good practice outlined in Section 4.11.1 above in managing exposure to allergens.

4.11.3 Steps to reduce anaphylaxis risks

We seek the cooperation of the whole school community in implementing the following to reduce the risk of exposure to allergens.

- Bottles, other drinks, and lunch boxes provided by parents for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- If food is purchased from the school canteen, parents should check the appropriateness of foods by speaking directly to the catering manager. The child should also be taught to check allergen information with catering staff, before purchasing.
- Where we provide the food, our staff will be educated on how to read labels for food allergens and instructed about measures to prevent cross-contamination during the handling, preparation and serving of food. Examples include preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Food will not be given to food-allergic children without parental engagement and permission e.g., birthday parties, food treats.
- Trading and sharing of food, food utensils or food containers will be actively discouraged and monitored.
- Training will include that unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary allergen labelling suggesting a risk of contamination.
- Careful planning for the use of food in crafts, cooking classes, science experiments and special events (e.g., fetes, assemblies, cultural events) with adequate substitutions, restrictions or protective measures put in place (e.g., wheat-free flour for play dough or cooking), non-food containers for egg cartons.
- Careful planning for out-of-school activities such as sporting events, excursions (e.g., restaurants and food processing plants), outings or camps, thinking early about the catering requirements and emergency planning (including access to emergency medication and medical care).

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- Careful planning for on-site and off-site activities involving potential exposure to other allergens like animal dander, latex, pollen etc.

4.12 Adrenaline Auto Injectors (AAI)

Anaphylaxis is a severe and potentially life-threatening reaction to a trigger such as an allergy. It usually develops suddenly, gets worse very quickly, and can be very serious if not treated quickly with adrenaline because the resultant swelling can stop someone from breathing.

Now that the Human Medicines (Amendment) Regulations 2017 allow (but do not require) schools to keep an adrenaline auto-injector (AAI) for use in an anaphylaxis emergency, governors have decided that keeping a supply will currently benefit pupils significantly.

This school is committed to supporting pupils who have been diagnosed with anaphylaxis and has developed separate Anaphylaxis, asthma, diabetes and epilepsy (AADE) Management procedures to be followed.

In summary:

- The administration of AAIs will be carried out in accordance with professional medical guidance and staff training. Designated staff will be trained in how to administer a child's own AAI and other staff will be trained in how to seek the help of designated staff in an anaphylaxis emergency, and also what to do if they believe help will not come fast enough.
- The emergency services will be called when a reaction is severe even if the AAI has been administered or if a pupil is not diagnosed but seems symptomatic.
- Safe disposal arrangements are in place with sharps containers Staff Toilet
- An AAI register of all pupils prescribed an AAI will be supervised and located in a quiet area and will be checked as part of initiating the emergency response.
- Where a pupil has been prescribed an AAI, this will be recorded on their IHCP with an indication of whether they can responsibly carry the device and self-administer it correctly.
- Every use of a child's own AAI will be recorded and reported to parents including:
  - Where and when the reaction took place
  - How much medicine was given and by whom.
- Consideration will be given to preventing and managing an allergic reaction when planning all school activities on and off-site.
- School has 2 emergency AAI kits in Staff room and procedures in place to administer, maintain, and dispose of them safely.
- **Our decision to hold an emergency AAI kit does not in any way release a parent from their absolute duty to ensure that their child attends school with a fully functional AAI containing sufficient medicine for their needs.**
- A copy of the AAI register including consent to administer the school emergency AAI will be held with each school AAI emergency kit.
- Designated staff will be trained in how to administer the school emergency AAI and other staff will be trained in how to seek their help in an anaphylaxis emergency, as well as what to do if they believe help will not come fast enough.
- Parents will be informed whenever their child has used the school emergency AAI.

4.13 Day trips, residential visits, and sporting activities

Through development and communication of the IHCP staff will be made aware of how a pupil's medical condition might impact on their participation in educational visits, sporting, or other activities.

Before an activity takes place, a risk assessment will be conducted to identify what reasonable adjustments should be made to enable pupils with medical conditions to have equality of access. Advice is also sought from pupils, parents/carers, and relevant medical professionals.

A pupil will only be excluded from an activity if the Head teacher considers, based on the evidence, that no reasonable adjustment can make it safe for them or evidence from a clinician such as a GP states that an activity is not possible for that child.

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4.14 Other arrangements

4.14.1 Defibrillators

Sudden cardiac arrest is when the heart stops beating, and it can happen to people at any age and without warning. When it does happen, quick action (in the form of early Cardio-Pulmonary Resuscitation - CPR - and defibrillation) can help save lives. A defibrillator is a machine used to give an electric shock to restart a patient's normal heart rhythm when they are in cardiac arrest. Modern defibrillators are easy to use, inexpensive and safe and the DfE has supported a campaign to install them in schools.

This school has an Automated External Defibrillator (AED) as part of our first aid equipment outside the plant room (at the front of the building) and the community does have access to it.

We followed government recommendations in the DfE guide Automated external defibrillators (AEDs) in schools, current at the time we got it regarding the type of machine, kit, location, installation, signage, and systems of access we needed.

There is a monitoring and maintenance schedule to ensure we spot when the automatic testing detects a fault or when consumables like pads, or batteries etc. need to be replaced.

AEDs are designed to be used by someone without any specific training and by following step-by-step instructions on the device. All school staff have been given access to the instructions and an appropriate briefing on our procedures for using the AED.

The emergency services will always be called where an AED is used on a person or requires using.

The local NHS and ambulance service have been notified of its location.

4.15 Unacceptable practice

While it is essential that all staff act in accordance with their training, in any given situation they should be confident in using their discretion and judging each case on its merits with reference to a child's IHCP. It is not however, generally acceptable practice at this school to:

- prevent children from easily accessing their inhalers and medicine and administering their medicines when and where necessary;
- assume that every child with the same condition requires the same treatment;
- ignore the views of the child or their parents; or ignore medical evidence or opinion, (although staff will be supported to appropriately challenge this where they have genuine concerns);
- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans;
- if the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable;
- penalise children for their attendance record if their absences are related to their medical condition e.g., hospital appointments;
- prevent pupils from drinking, eating, or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively;
- require parents, or otherwise make them feel obliged, to attend school to administer medicine or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs; or
- prevent children from participating or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g., by requiring parents to accompany the child.

4.16 Insurance

School staff who agree to support pupils at school with their medical conditions and administer medicines are appropriately insured by the local authority to do so when they are acting in accordance with our policies and their training given the circumstances they faced at the time. The Insurance Policy wording is available on request from our school office.

[1] The Governors are free to determine how to implement.

[2] The Governing Body/Board of Trustees or Proprietor is free to determine review period. (DfE recommend annually)

The Insurance Policy provides liability cover relating to the administration of medicines and any required healthcare procedures as identified through the IHCP process.

Every IHCP review must consider whether current insurance arrangements remain compatible with any identified changes required. A significant change, for example an entirely new medical procedure required, will be checked as compatible with current insurance arrangements direct with the school's insurers. If current insurance is inadequate for the new procedure additional insurance will be arranged.

4.17 Complaints

If parents or pupils are unhappy with the support provided they should discuss their concerns directly with Laura Ball our Special Educational Needs Coordinator or Penny Leck our Health and Safety Leader.

If this does not resolve the issue, they can make a formal complaint through the normal school complaints procedure https://www.jericho.cumbria.sch.uk/policies/ .

If the issue remains unresolved, the complainant has the right to make a formal complaint to the DfE.

[1] The Governors are free to determine how to implement.

[2] The Governing Body/Board of Trustees or Proprietor is free to determine review period. (DfE recommend annually)

PROCEDURES FOR THE ADMINISTRATION OF MEDICATION

Relevant roles held and by whom (correct at the time of publishing)	
SENDCo:	Mrs Laura Ball
Designated Safeguarding Lead (DSL):	Mrs Penny Leck
First Aid / Medication Leads	Mrs Claire Nicholson / Miss Georgia Hunter

[1] The Governors are free to determine how to implement.

[2] The Governing Body/Board of Trustees or Proprietor is free to determine review period. (DfE recommend annually)

REVIEW SHEET

Each entry in the table below summarises the changes to these procedures made since the last review (if any).

Version Number	Version Description	Date of Revision
1	Original	February 2023
2	March 2023: New section on records and retention referring staff to Supporting Pupils… Policy.	March 2023
3	New section on different types of medicines including herbal remedies and policy decisions on some e.g., no aspirin for U16s without a prescription.	September 2023
4	Clarification in Section 4 on parental consent to administer & receiving procedures for long-term or life-long emergency medicines e.g., adrenalin, salbutamol, insulin & buccal midazolam. Updated form finding references in Section 9.	September 2024
5		
6		
7		
8		
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10		

1. Purpose

This procedure provides the process for administering medicines to pupils when they are attending school or during school-related activities, in accordance with the advice of the pupil's prescribing medical practitioner or as an emergency response. Having clear, documented procedures to manage the administration of medicines facilitates safe systems of work that ensure pupil and staff safety and supports this school in meeting legislative requirements under Section 100 of the Children and Families Act 2014, the Medicines Act 1968, the Misuse of Drugs Act 1971, and workplace health & safety laws.

Pupils will be treated as individuals with due consideration given to their age, beliefs, opinions, experience, ability, cultural needs, and any other factors important to them such as preserving their dignity and privacy.

For more information about our arrangements to support pupils with medical needs and how we manage the emergency administration of adrenaline, salbutamol, insulin, and buccal midazolam see our] policy on Supporting Pupils at School with Medical Conditions and our procedures for managing anaphylaxis, asthma, diabetes, and epilepsy

2. Who can administer medicines

Only staff who have been trained and assessed as competent can undertake the administration of medication at Jericho Primary School. At Jericho we have two nominated first aiders (NFA) who take the lead and oversee all administration of Medication. These are Claire Nicholson and Georgia Hunter. All administration must be overseen by 2 staff members, at least one must be a NFA. We will administer the following:

- topical medicines
- ear, eye, or nasal drops
- inhalers or other respiratory aerosol devices
- oral medicines (and additionally assessed for controlled drugs administration)
- invasive medicines e.g., adrenalin auto-injectors or other injection/intravenous devices, suppositories, or pessaries,
- personal oxygen supplies.

Staff administering a medicine need an understanding of what it is for, what the normal dosage is, precautions required such as "take with food", contra-indications to be aware of such as the effects of taking another drug that interacts with the medicine, and how to look for and report possible adverse effects (sometimes called side effects) the pupil may experience, including changes which may mean a pupil's clinicians should review their prescription.

If necessary, staff should seek advice from the prescriber, or a pharmacy professional if they have an issue with any checks they have carried out or if they are unsure what to do when administering a medicine. This is important for **all** medicines but is particularly important for those like insulin where a Boehringer Mannheim (BM) blood check must be carried out first and the results may affect the administration.

3. Types of medicine

3.1. Prescription

Prescription medicines are strictly controlled by law and can only be taken by the person they were prescribed for. It is both dangerous and illegal for anyone to take a medicine prescribed for someone else or to give a person someone else's prescription medicine.

This is also why schools and childminders must have written parental consent to administer medicines to anyone in their care who is under the age of 16.

We have strict guidelines on how we accept prescription medicines to avoid receiving the wrong one. Staff take particular care when a child shares the same name or same first name initials as someone else that they live or come into contact with where their medicines might be confused. There is also more than one check during administration that should ensure the medicines of a parent and child cannot be confused and an adult (over)dose be administered accidentally.

3.2. Non-prescription

It is appropriate for over-the-counter medicines to be administered by a member of staff in the nursery or school, or self-administered by the pupil during school hours, following written permission by the parents.

However, every school has a statutory duty to protect the physical and mental health of pupils. This can include administering prescription or OTC medicines but also not administering them where there are significant health or safeguarding concerns.

All staff who administer medicines are trained to recognise and handle safeguarding concerns involving potential Fabricated and Induced Illness (FII). Any member of staff who has concerns about a potential case of FII must report it immediately to the DSL.

We will not administer Herbal or homeopathic remedies.

3.3. Policy decisions on some medicines

In line with national guidance, we have made several policy decisions on the administration of some medicines to pupils as follows.

Pupils under 16 must not be given prescription or non-prescription medicines without their parent's written consent, except when it has been prescribed without parents' knowledge. We will encourage the pupil to involve their parents while respecting their right to confidentiality.

Pupils under 16 must not be given a medicine containing aspirin unless prescribed by a doctor.

Pain relief must not be administered without first checking maximum dosages and when the previous dose was taken. Every effort will be made to contact parents prior to administration, where necessary, to check this and to inform them that pain relief will be given.

The repercussions of staff administering an underdose or overdose of a pupil's medicines to them should be identified from the patient information sheets that come with them and be specifically drawn to the attention of staff to include what they should do next if they are worried a mistake has been made.

We will not administer medicines covertly.

4. Receiving medicines

Medicines can only be received in school as agreed in each Individual Health Care Plan (IHCP) or as detailed in a Parental Consent to Administer Medicines Form.

Medicines must be hand delivered to the school office to a member of our administration team.

It is school policy only to accept the minimum quantity of a medicine necessary in school at any one time. This might require a daily delivery to school or monthly (no more than 20 school days' worth) depending on our risk assessment and what is reasonable. Sometimes a medicine must come to school and go home daily e.g., a refrigerated antibiotic oral liquid suspension.

Staff receiving medicines must check:

- There is explicit and valid written **parental consent** for the administration of this medicine to this pupil. If not, provide the appropriate form and check it *before* accepting the medicine.
- The name of **the pupil** on the prescription label (or written by parents or carers on the non-prescription medicine container) and/or the consent form match.

- The name of **the medicine** on the prescription label, and consent form, and packaging, and inside the packaging e.g., on the blister pack, bottle etc., all match, especially the strength of the medicine.
- **The expiry date** of the medicine has not passed. If the medicine is already open and it expires *before* the expiry date once opened (many oral liquid antibiotics, eardrops, and eyedrops):
  - check that the date it was first opened has been written on the container (if not ask for the date of opening to be written on it now)
  - check that the medicine is not past its safe administration window (often 28 days from opening - look at the packaging or Patient Information Leaflet for information).
- If the pupil has **any allergies** that might affect or be affected by the medicine, or if they have had an adverse reaction to the medicine in the past.
- The prescription or **other directions** for administration are unambiguous and include as appropriate the name, form (or route of administration), strength, timing, and frequency of dose of to be administered, course start and finish dates and, where possible, the manufacturer's Patient Information Leaflet detailing known adverse effects and other important information.
  - Raise *any* ambiguities or concerns regarding the directions for administration of the medicine with parents or (sometimes and) the prescriber, or a pharmacy professional without delay.
  - Check that all necessary calculations have been done and the medicine is ready for administration e.g. packaging for an oral liquid suspension contains a suitable 5ml medicine spoon, oral syringe, or measuring cup. If a half tablet is required, check the tablets are already cut in half.
- Any specific **storage requirements** have been and will be reasonably maintained i.e., make sure medicines are put in the secure medical cabinet or fridge as soon as possible after receiving them.

Once checks have been done and the medicine is accepted, the office staff should ensure:

- the correct completed form is passed to Claire Nicholson (EYFS/KS1) or Georgia Hunter (KS2)
- the medicine is put away as soon as possible in the secure medicines store, and

Sometimes, there are limited exceptions to this receiving procedure, usually for long-term or life-long medical conditions that may require emergency medicines such as:

- adrenaline auto-injectors (AAI for anaphylaxis),
- salbutamol reliever inhalers (or terbutaline for asthma), and
- insulin injectors/pumps (for diabetes).

This is because when we become aware that a pupil may need us to administer these emergency medicines, we write to parents and carers explaining the support we offer and our expectations e.g., that they provide their child with 2 or more doses as recommended by their clinician **and** a spare device/dose that we hold onto during term-time only. We also complete, with the family (and clinicians if appropriate), an IHCP which records parental consent and detailed information about the medical condition and medicines.

Rather than repeatedly recording the bringing from and returning to home of these emergency medicines and spares, we will follow it up as a potential safeguarding concern if the doses and spare are **not** provided as agreed and recorded during the IHCP development process.

Buccal midazolam (for epilepsy) is not in the above list because it is a controlled drug, and receipt in school and return to the family must be witnessed and accounted for in a written record. Form 2 Multiple and Long Term Medicaiton can be used for this purpose and will last a child almost 3 years of half-termly drug receipts and returns.

If we develop concerns about poor management of a child's medical condition that could result in a life-threatening emergency, or if we feel there is a harmful pattern of behaviour developing where the medicines are not brought to school or not replaced when expired, we might adapt Form 2 or develop another systematic way to record the receiving as well as administering of their emergency medicines.

A medicine must be returned to parents or carers:

- daily when it is a bottle of oral liquid suspension and the pupil needs to take it at home
- when it has expired
- when the packaging is damaged or improperly sealed
- when the medicine has been split and there is no way to store it safely, securely or hygienically, or
- when the course of treatment has ended.

Parents must collect all medication from the school office at home time or from the after-club play leader, if using our wrap around care. If the medicines are not collected, parents can try to contact school staff and can be given the medication by alternative staff members with the agreement of a member of the Senior Leadership Team. If the medicine is not collected it will remain in the recommended storage.

Staff returning medicines to parents and carers must ensure that any relevant tracking record is completed e.g., the signature sheet for the receipt and return of controlled drugs.

5. Refusing administration

Pupils can refuse the administration of medicines for a variety of reasons.

If a pupil refuses a medicine, staff must NEVER force them to take or use it. Parents must be contacted and a senior leader informed.

We will not administer medicines covertly.

6. Administering medicines

These procedures seek to ensure we achieve the five "rights" to the safe administration of medicines.

- Right person that we hold the right consent to administer to,
- Right medicine,
- Right dose,
- Right time,
- Right records.

All medicines

The nominated first aider who has been trained and assessed as competent to do so will administer medication in line with the following procedures.

If they are unsure what to do at any stage when following this procedure or if the information checked does not match with expectations, they must ***STOP***, not administer the medicine, and refer to a senior leader for advice before proceeding.

Preparation

1. At all times there must be 2 members of staff who administer medication. 1 member of staff must be the nominated first aider. The other must be a witness. They must both agree the checks made, watch the dose being measured, and the medicine being taken, and to legibly sign the records.
2. All medications should be administered in the staff room where medication is stored.

Administration

3. Thoroughly **wash and dry hands** and any necessary equipment e.g., medicine spoon, oral syringe, measuring cup, glass, tablet cutter.
4. If required, undertake other **preparations or infection control** procedures such as, preparing other necessary equipment, safely donning fresh Personal Protective Equipment (PPE) if needed in the circumstances.

5. Ensure **only ONE medicine is administered at a time**

Establish the SIX RIGHTS of medicines administration

1. **Right pupil** – Check the pupil's identity and their IHCP for important information such as valid parental consent to administer *this* medicine to *this* pupil, whether self-administration has been assessed and agreed, is not agreed, or if agreement is being worked towards and further assessment is required, their allergy status, any preferred method of administration if there are options, whether they might refuse the medicine, adverse effects they have experienced before to be alert to etc.

2. **Right medicine**

   - Check the person's name on the prescription medicine label or the non-prescription medicine label written by parents or carers matches the pupil's name. Be vigilant in checking the date of birth of the patient on prescription labels with the pupil's when a parent or carer shares the same name as the pupil and the adult's prescription may have been handed to school in error.

   - Check the name of the medicine on the prescription label matches the name of the medicine in the IHCP and in the administration record, and that the name of the medicine on the external packaging *and* the blister pack or container inside also matches. Double check that the strength of the medicine matches to ensure it has not been mixed up with a much stronger version. This can happen when an adult in the household with the same name takes the same medicine and the wrong blister pack or container has been put back in the wrong packaging at home.

   - Check the physical state of the medicine, packaging, and labelling, noting ready to report any significant damage such as a pierced blister pack or cracked pill container, that the expiry date has not passed, and whether storage had been suitable i.e., it was in the fridge if it requires refrigeration. When a medicine has a different expiry date once opened, commonly eye, ear, or nasal drops and sprays, and most oral liquid suspensions, the date of opening should be written on the bottle and packaging where possible. Consult the packaging or Patient Information Leaflet for the expiry period from opening which is often 28 days but can be less so it must be checked. It is not good practice to calculate the expiry date from the date of opening and write it on the medicine in case it is confused for the opening date.

   - Check the amount of medicine available is as expected and note how much will be left after administration. If there appears to be too much medicine available or not enough, ***STOP***, do not administer the medicine yet. Re-check the records and the medicine store and refer to senior leader first if still unsure whether there has been a previous missed dose or if the due dose has already been taken *before* administering *this* dose of the medicine. Missing medicines, especially controlled drugs must be recorded to a senior leader immediately.

3. **Right dose** – Check that the required dose matches all the relevant medicine-related records and any special instructions on the dispensing label e.g., "not to be given with milk or antacids" or "to be taken with food" etc. and take appropriate action.

   NEVER dispense a medicine (take it from its original container) and give it to another member of staff, unless it will remain in sight the whole time and you and the witness can see the pupil take it.

4. **Right time** – Check against the IHCP and the administration record that this medicine is for this pupil, that they are due to have it *now*, the dose they should be having, the normal frequency etc., that nothing has changed, and that the pupil has not already had it.

   Giving a medicine too late or too early can have serious consequences for the way the medicine works and on the health or wellbeing of the pupil. This can include occasions when the timing of a dose interferes with how it should be taken, for example offering a pupil their medicine after lunch when it must be taken on an empty stomach. If a previous dose was too recent, there is also a danger of toxicity.

5. **Right records** –

   - Record on the administration record details of the medicine given, or that it was offered and refused, or that administration went wrong in some other way (see above).

- Record any other issues and trigger any action necessary e.g., notification to parents of insufficient pre-cut tablets.
- Ensure any witness to the procedure has signed the administration record.

7. Disposing of medicines

Our school policy is to return all unused medicines to parents and carers for proper disposal by them when necessary.

8. Records and retention

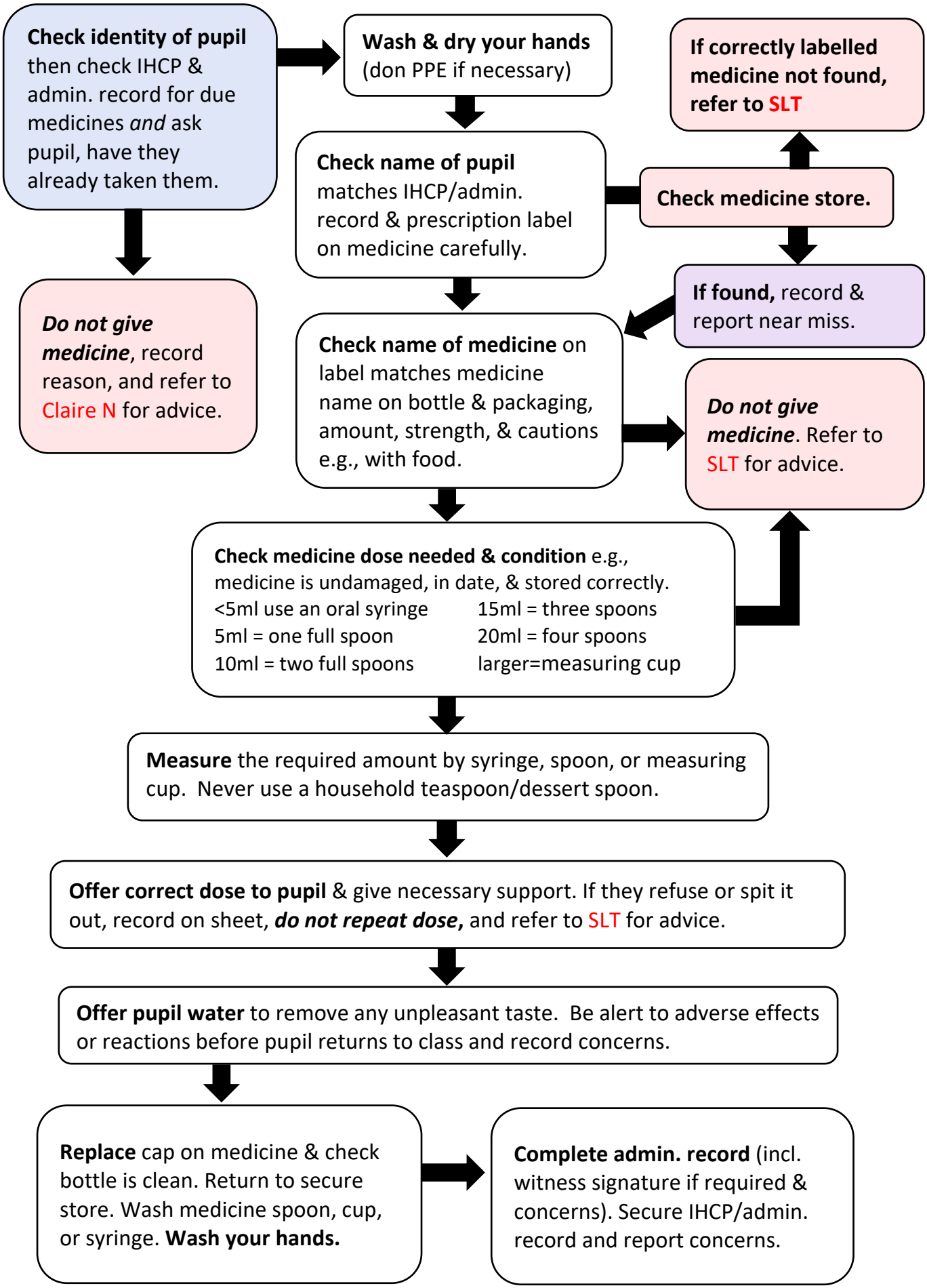
School will keep a record of all medicines administered to pupils, stating what, how and how much was administered, when and by whom, with a note of any side effects experienced or refusal.

When a pupil's medicine is a controlled drug, their individual record sheets will allow for the signature of a second witness to the administration. Details of receipts and returns of the controlled drug will be accurately recorded on the administration record see **Form 1 Single Medication.**

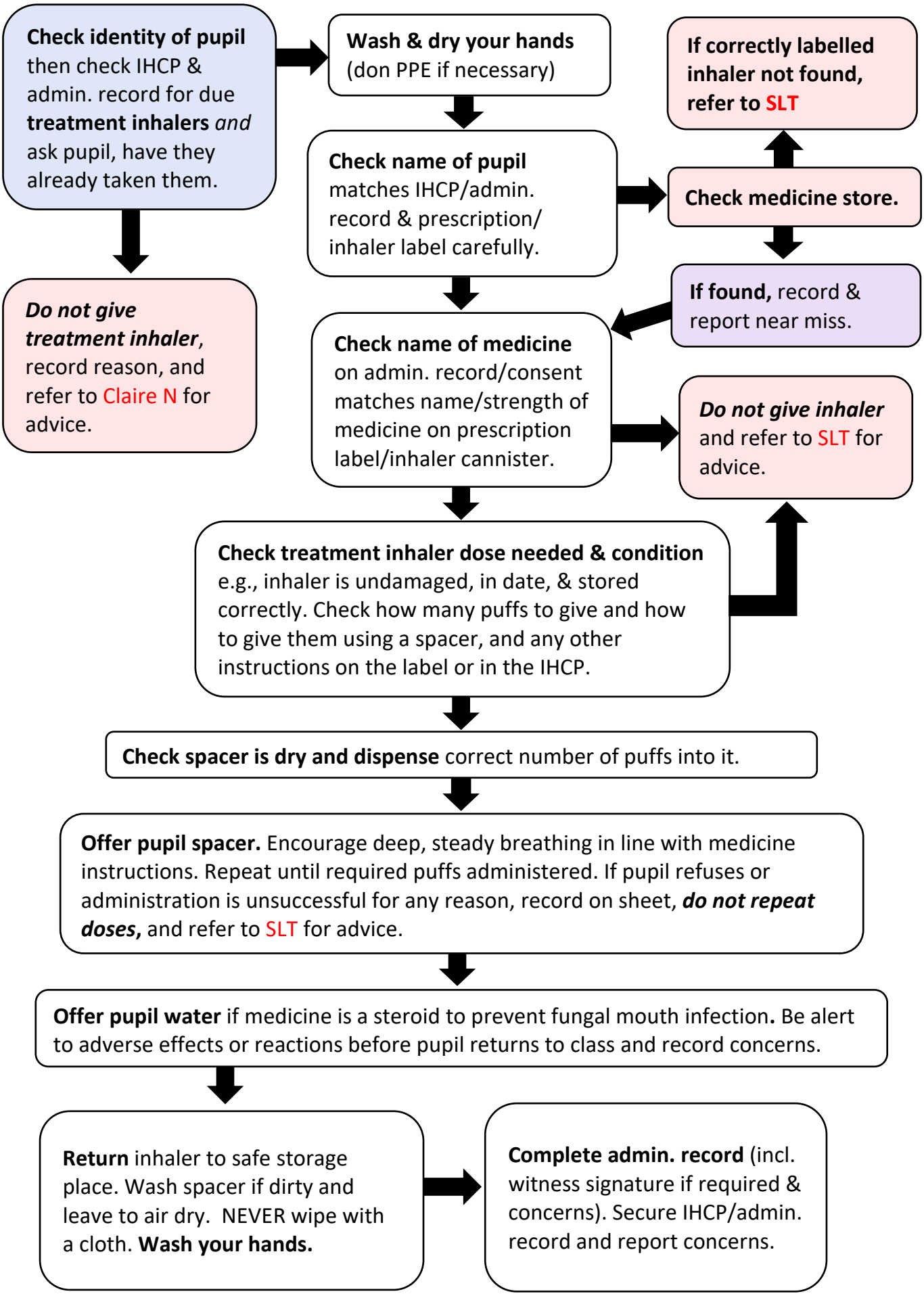
When a pupil is given a more than one medicine e.g., pain relief and controlled drugs, it will be recorded on **Form 2- Multiple Medications.**

When a pupil is given general medication – e.g. pain relief and parents have given consent, this will recorded on the schools central **General Form (Form 3)**

Administering Oral Liquids (by mouth) Flowchart



Administering Treatment Inhalers Flowchart



Administering Eyedrops Flowchart

Check identity of pupil then check IHCP & admin. record for due eyedrops *and* ask pupil, have they already had them.

Wash & dry your hands (don PPE if necessary)

Check name of pupil matches IHCP/record sheet & prescription label on eyedrops carefully.

Check medicine store.

If correctly labelled eyedrops not found, refer to SLT

If found, record & report near miss.

Do not give eyedrops, record reason, and refer to Claire N for advice.

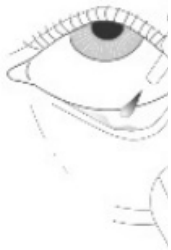
Check name of eyedrops on label matches name of eyedrops on packaging, amount left, strength, and any cautions e.g. may sting

Do not give eyedrops & refer to SLT for advice.

Check eyedrop dose needed & condition e.g., bottle is undamaged, in date (incl. from date opened - usually 28 days), stored correctly, how many drops to give, and any waiting time. **Shake bottle well.**

Support pupil to or administer eyedrops. Avoid touching eyes with nozzle, ask pupil to bend head slightly backwards & pull gently on lower eyelid (or use your thumb). Squeeze bottle to release drops required, release eyelid, and ask pupil to blink & wipe excess with tissues. If they refuse the dose, record, and refer to SLT.

WAIT 5 mins between doses and use multiple eyedrops in order,
1. Aqueous solutions (chloramphenicol) **2.** Drops which sting (atropine)
3. Suspensions (dexamethasone) **4.** Eye ointments (Lacrilub)



Allow pupil's eyes to adjust before returning to class, Be alert to adverse effects or reactions before pupil returns to class & record concerns.

Replace lid on bottle, check it is clean & date bottle if first opened today. Return to secure store. Dispose of used tissues. **Wash your hands.**

Complete admin. record (incl. witness signature if required & concerns). Secure IHCP/admin. record and report concerns. **WAIT 5 MINUTES BEFORE APPLYING DIFFERENT EYEDROPS**

Administering Eardrops Flowchart

Check identity of pupil then check IHCP & admin. record for due eardrops *and* ask pupil, have they already had them.

Wash & dry your hands (don PPE if necessary)

Check name of pupil matches IHCP/record sheet & prescription label on eardrops carefully.

Check medicine store.

If correctly labelled eardrops not found, refer to SLT

If found, record & report near miss.

Do not give eardrops, record reason, and refer to Claire N for advice.

Check name of eardrops on label matches name of eardrops on packaging, amount left, strength, and cautions e.g. may sting. Warm gently for 30 mins to room or body temperature.

Do not give eardrops & refer to SLT for advice.

Check eardrop dose needed & condition e.g., bottle is undamaged, in date , (incl. date opened - usually 28 days), stored correctly, how many drops to give, and any waiting time. **Shake bottle well.**

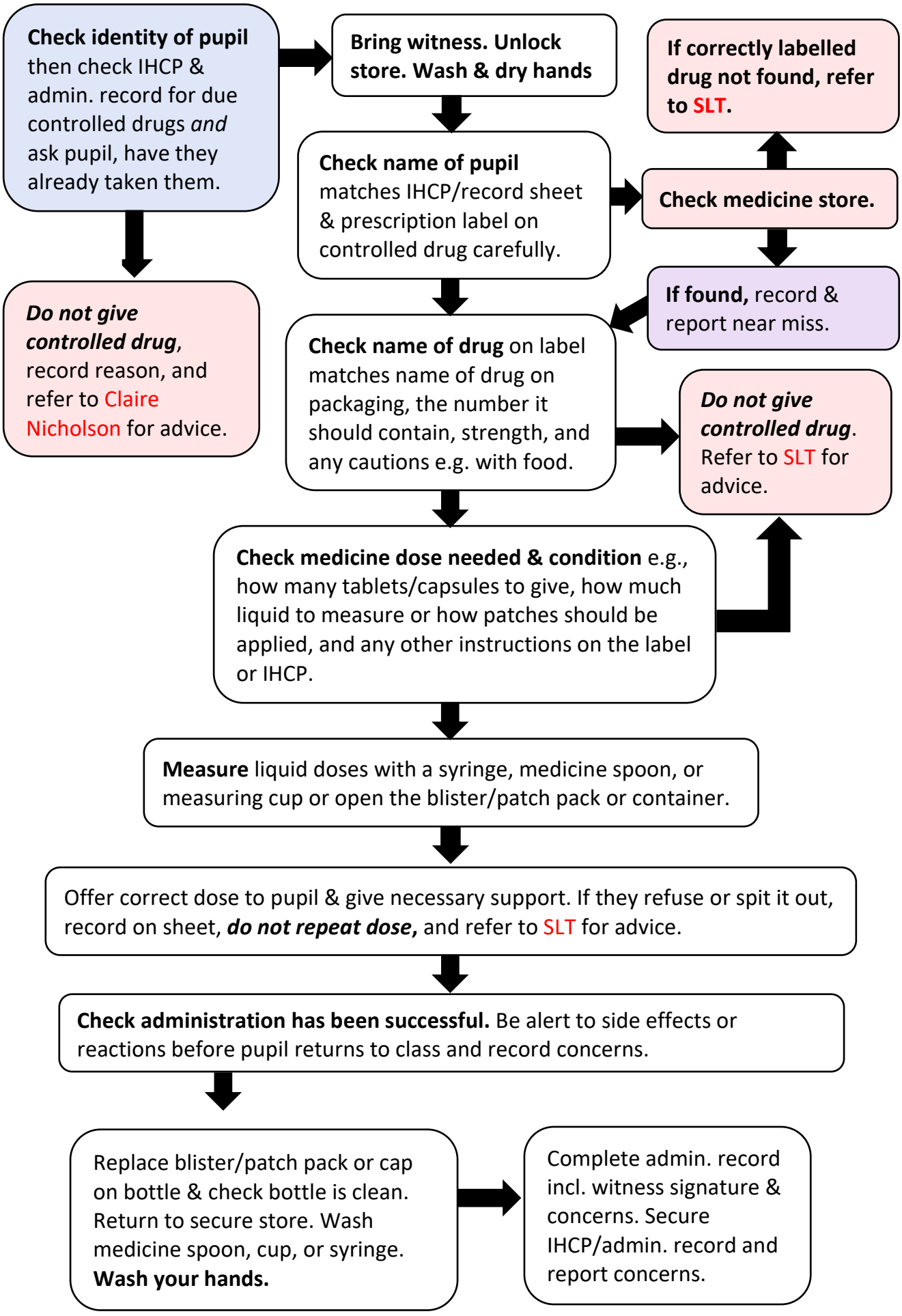
Support pupil to or administer eardrops. Ask pupil to lie or sit with head tilted so affected ear is uppermost, and gently pull lobe back & down (young child) OR upper ear back & up (older child/adult) or use your free hand to. Squeeze bottle to release drops required into straightened ear canal, gently push ear flap into canal to encourage drops to pass down, release ear. If they refuse the dose, record, and refer to SLT.

Ask pupil to hold stay in position for up to 5 mins before getting up and wiping any excess with tissues & record side effects, reactions, or concerns.

Replace lid on bottle, check it is clean & date bottle if first opened today. Return to secure store. Dispose of used tissues.
Wash your hands.

Complete admin. record (incl. witness signature if required & concerns). Secure IHCP/admin. record and report concerns. **WAIT 5 MINUTES BEFORE APPLYING DIFFERENT EARDROPS**

5 Controlled Drugs Admin. (all forms) Flowchart



ANAPHYLAXIS, ASTHMA, DIABETES AND EPILEPSY MANAGEMENT PROCEDURES

JERICHO PRIMARY SCHOOL
POLICY 24 ON

Approved by			
Name:			
Position:			
Signed:		**Version Number:**	**1**
Date:		**Proposed review date:**	

Review Sheet

Each entry in this table summarises the changes to these procedures made since the last review (if any).

Version Number	Version Description	Date of Revision
1	New procedures merging the existing Anaphylaxis Procedures (V3 June 2024) and Asthma Procedures (V5 Nov 2023) and including new information about diabetes and epilepsy to create a single resource of practical information for staff on how to manage the conditions and respond to an emergency in line with their training.	September 2024
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Contents

Posters A & B: How to recognise a mild to moderate allergic reaction and what to do.

Benedict Blythe Foundation – Schools Allergy Code

Posters C & D: How to recognise an asthma attack and what to do.

Find all parental consent and medicines administration record cards and sheets, all individual healthcare plan (IHCP) templates, a customisable invitation to parents and carers to help develop the IHCP, and notification letters e.g. for salbutamol use

1 Introduction

These procedures have been developed to support staff who are implementing our *'Medical Needs Policy – Policy Number 024.*

This appendix covers the four most common severe and life-threatening health conditions that a pupil might have or develop in childhood - anaphylaxis, asthma, diabetes, and epilepsy. It summarises the basic information all staff receive during induction about the conditions, the risks that may need to be understood, measures that may be necessary to control risks, roles and responsibilities, and what to do in an emergency.

1.1 Anaphylaxis

Anaphylaxis is a serious and often sudden allergic reaction, requiring emergency treatment. It occurs when the body's immune system wrongly identifies a food or other substance as a threat. Reactions usually begin within minutes and rapidly progress but can occur up to 2-3 hours later.

Allergic reactions are caused by the sudden release of chemicals, including histamine, from cells in the body. The release is triggered by the reaction between the immune system antibodies (called Immunoglobulin E or IgE) and the food or substance (known as an allergen) it has been exposed to.

The body will have been exposed to the allergen on a previous occasion, although the person may not have been aware of this at the time. On that earlier occasion, the allergen was wrongly identified as a threat and antibodies were made against it, which means that on the next exposure, a serious reaction may occur.

The mechanism is so sensitive that sometimes even tiny amounts of the allergen can cause an allergic reaction. Common allergens that can trigger anaphylaxis are:

- foods (e.g., cereals containing gluten, sulphites/sulphur dioxide (preservatives), celery, crustaceans, egg, fish, lupin, milk, mustard, molluscs, tree nuts, peanuts, sesame, soya);
- insect stings (e.g., bee, wasp);
- medications (e.g., antibiotics, pain relief such as ibuprofen);
- latex (e.g., rubber gloves, balloons, swimming caps).

In the skin, this causes an itchy rash, swelling and flushing. Anaphylaxis involves difficulty in breathing or affects the heart rhythm or blood pressure. Any of the ABC symptoms may lead to collapse and unconsciousness and, on rare occasions, can be fatal.

AIRWAY - - - - - - swelling in the throat, tongue or upper airways (tightening of the throat, hoarse voice, difficulty swallowing)

BREATHING - - - sudden onset wheezing, breathing difficulty, noisy breathing

CIRCULATION - - dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness

The severity of an allergic reaction can be influenced by a number of factors including minor illness (like a cold or other infection), poorly controlled asthma, exercise just before or after contact with the allergen, hay fever, stress, aspirin/ibuprofen and, in the case of food, the amount eaten. It is very unusual for someone with food allergies to experience anaphylaxis without actually eating the food: contact skin reactions to an allergen are very unlikely to trigger anaphylaxis in most people with the condition.

In severe cases, the allergic reaction can progress within minutes into a life-threatening reaction. Administration of adrenaline can be lifesaving, although severe reactions can require much more than a single dose of adrenaline. It is therefore vital to contact Emergency Services as early as possible. Delays in giving adrenaline are a common finding in fatal reactions. Adrenaline should therefore be administered immediately, at the first signs of anaphylaxis.

According to Allergy Training for Schools | Anaphylaxis UK, up to 5% of children in the UK have a food allergy. However, the majority of allergic reactions to food are not anaphylaxis, even in children with previous anaphylaxis. Most reactions present with mild-moderate symptoms, and do not progress to

anaphylaxis. Fatal allergic reactions are rare, but they are also very unpredictable. In the UK, 17% of fatal allergic reactions in school-aged children happen while at school.

1.2 Asthma

Asthma is a long-term lung condition. It affects the airways (breathing tubes) that carry air in and out of the lungs. causing them to become swollen (inflamed). This makes the airways narrower so less air gets into and out of the lungs.

According to What is asthma? | Asthma + Lung UK (asthmaandlung.org.uk), it is a common condition. In the UK, 5.4 million people have asthma - about 8 in every 100 people.

People with asthma can get symptoms like wheezing, breathlessness, a cough or a tight chest. Sometimes symptoms can get worse quickly. This is an asthma attack.

Symptoms can be triggered by things like exercise, allergens or changes in weather. There are lots of potential triggers and everyone with asthma will have their own set.

At the moment there is no cure for asthma, but most people can control their symptoms well with asthma inhalers and other medicines when they use them as prescribed. Some people may not have symptoms for weeks or months at a time.

When asthma is not well controlled, or for people with severe asthma, attacks happen more often and are more severe and can be life-threatening. Sadly, four people die every day in the UK because of asthma attacks and 2 out of 3 asthma deaths are preventable.

Having frequent asthma attacks can also make asthma worse over time because they can cause scarring in the airways (sometimes called 'airway remodelling') which makes them narrower. Someone with scarred and narrow airways is more likely to have worse symptoms more often.

Most people with asthma who get the right treatment (and take it correctly) and who understand how to manage their symptoms and control their exposure or reaction to triggers, are able to get on with what they want to do in life.

1.3 Diabetes

There are two main types of diabetes:

Type 1 diabetes causes a person's blood sugar to become too high because the body can't make a hormone called insulin.

Type 2 diabetes is high blood sugar levels due to the body not making enough insulin, or the insulin it makes doesn't work properly, known as insulin resistance.

Other types of diabetes include **gestational diabetes**, which some women may go on to develop during pregnancy, **type 3c**, **MODY**, and Latent Autoimmune Diabetes in Adults (**LADA**) (see What is diabetes? | Getting to know the basics | Diabetes UK for more information).

Fewer than one in 10 people in the UK who have diabetes have type 1. The exact causes are not known. Although it's often diagnosed in childhood, people can develop type 1 diabetes at any age and are at higher risk if their mother, father, brother or sister has it.

Insulin is the main treatment, delivered by injection or an insulin pump. Checking and managing blood sugar levels is important to help reduce the risk of serious short or long-term health problems called **chronic diabetes complications** (eye, foot, heart or kidney problems, stroke, nerve damage, gum disease).

Acute diabetic complications can happen at any time and may lead to chronic, or long-term, complications.

- Hypos – when blood sugars are too low.
- Hypers– when blood sugars are too high.
- Hyperosmolar Hyperglycaemic State (HHS)– a life-threatening emergency that only happens in people with type 2 diabetes brought on by severe dehydration and very high blood sugars.

- Diabetic ketoacidosis (DKA) – a life-threatening emergency where the lack of insulin and high blood sugars leads to a build-up of ketones which makes the blood acidic.

Symptoms of type 1 diabetes are known as the 4 Ts, but can also include genital itching or thrush, cuts and wounds that take longer to heal, and blurry eyesight:

- **T**oilet – going for a wee more often, especially at night.
- **T**hirsty – being constantly thirsty and not being able to quench it.
- **T**ired – being incredibly tired and having no energy.
- **T**hinner – losing weight without trying to or looking thinner than usual.

Symptoms for type 2 diabetes in children and young people are the same as those above but may be more obvious. Type 2 diabetes in children is much less common than type 1. Risk factors include a family history of type 2 diabetes, ethnicity and obesity or being overweight.

There is no cure for type 2 diabetes but by losing weight some people can go into remission. This means their blood sugar stays at normal levels and they won't need to take any medicine for it.

Warning signs of a hypo can include, feeling shaky, sweating, hunger, tiredness blurred vision, lack of concentration, headaches, feeling tearful, stroppy or moody, or going pale.

Diabetic Ketoacidosis (DKA) is a serious condition that affects people with type 1 diabetes, and occasionally those with type 2 diabetes (although they are more likely to be affected by HHS). When there is severe lack of insulin in the body, it can't use sugar for energy and starts to use fat instead. When this happens, chemicals called ketones are released. If left unchecked, ketones can build up and make the blood acidic.

In someone already diagnosed with diabetes, the causes can include:

- being ill e.g., with a chest infection, flu, Urinary Tract Infection (UTI)
- high blood sugar levels caused by a growth spurt or puberty
- not taking insulin or missing doses
- surgery or an injury
- high blood sugar caused by menstruation.

The signs of DKA include:

- high blood sugar levels
- being very thirsty
- needing to pee more often
- feeling tired and sleepy
- confusion
- blurred vision
- stomach pain
- feeling or being sick
- sweet or fruity-smelling breath (like nail polish remover or pear drop sweets)
- passing out.

Sometimes, especially in children, there isn't an obvious trigger. Early signs of DKA can be treated with insulin and fluids if recognised quickly. If not, hospital treatment is required.

1.4 Epilepsy

Epilepsy is a neurological condition that affects the brain, causing repeated seizures, sometimes called "fits". Anyone can have a one-off seizure, but it doesn't always mean they have epilepsy. People are usually diagnosed with epilepsy if their doctor thinks there's a high chance they could have more seizures.

Electrical activity is happening in the brain all the time, as the cells there send messages to each other. A seizure happens when there is a sudden burst of intense electrical activity in the brain. This causes a temporary disruption to the way the brain normally works. The result is an epileptic seizure.

There are many different types of seizure. What happens to someone during a seizure depends on which part of their brain is affected, and how far the seizure activity spreads.

During some types of seizure, the person may remain alert and aware of what's going on around them, but have unusual sensations, feelings or movements. With other types, they may lose awareness and behave oddly, or go stiff, fall to the floor and jerk. Some people only have one type of seizure, and some people have more than one type.

When an epileptic seizure starts in one side of the brain, it's called a **focal** seizure. The person can be fully aware of what's happening around them, even if they can't move or respond. It's called a focal impaired awareness seizure when the person's awareness is affected during the seizure. Doctors may also use the words motor, where the main symptoms involve muscle activity, such as jerking, muscles becoming limp (loss of muscle tone) or repeated movements, or non-motor where the main symptoms don't involve muscles but include things like changes in emotions, thinking and sensation, to describe focal seizures.

Most focal aware seizures are short, lasting between a few seconds and two minutes. Focal impaired awareness seizures usually last between one and two minutes but may be shorter or longer for some people.

When a seizure has a generalised onset affecting both sides of the brain from the start, this is called a generalised **tonic-clonic** or bilateral convulsive seizure. Some seizures start in one side of the brain and then spread to affect both sides. When this happens it's called a focal to bilateral tonic-clonic seizure.

There are 2 phases in a tonic-clonic seizure: the 'tonic' phase, followed by the 'clonic' phase.

During the **tonic phase**, the person loses consciousness, all their muscles go stiff, and if they're standing, they fall to the floor, air might push past their voice box, which can make a sound like crying out, and they may bite down on their tongue or the inside of their mouth.

During the **clonic phase**, their limbs jerk quickly and rhythmically, they may lose control of their bladder and/or bowels, and their breathing may be affected, causing a blue tinge around the mouth.

Most tonic-clonic seizures last between one and three minutes. If a tonic-clonic seizure lasts longer than five minutes, this is called status epilepticus and may need emergency medical treatment.

Status epilepticus happens when a seizure doesn't stop in the usual time, or when someone has seizures one after another without recovering in between. It is a medical emergency that can happen with any type of seizure.

Convulsive status epilepticus is when a tonic-clonic seizure lasts for 5 minutes or more, or one follows another without the person regaining consciousness in between. If either of these things happen, the person needs urgent treatment to stop the status before it causes long-term damage. If convulsive status epilepticus lasts for 30 minutes or longer it can cause permanent brain damage or even death.

Non-convulsive status epilepticus is when a non-convulsive seizure, such as an absence or focal impaired awareness seizure, lasts too long. These can be harder to spot because the signs and symptoms can be less obvious. For example, someone who is in absence status or focal impaired awareness status may appear confused and less responsive than usual or have changes to their speech or behaviour for no clear reason.

Some people are prescribed emergency medicine to treat status epilepticus, usually buccal midazolam given by plastic syringe, between their gums and cheek (sometimes rectal diazepam or, for some children, rectal paraldehyde.

Absence seizures are a type of generalised onset seizure, affecting both sides of the brain from the start.

During a **typical absence** seizure, the person will suddenly stop what they are doing for a few seconds but will not fall. They might appear to be daydreaming or 'switching off' and people around them might not notice. Their eyelids might flutter and they might have slight jerking body or limb movements. In longer absences, they might have some short, repeated actions, they won't know what is happening around them and can't be brought out of it.

One typical absence lasts less than 10 seconds. Some people have hundreds of absences a day, often in clusters, one after another, and they are often worse when they are waking up or drifting off to sleep.

Atypical absences are similar to typical absences, but they last longer (up to 30 seconds), and they start and end more slowly. The person might be able to move around, but their muscles might go limp or 'floppy', appearing clumsy. They may be able to respond to someone during an atypical absence seizure.

People who have atypical absences usually have learning disabilities or other conditions that affect the brain.

After someone has a seizure, it can take a while for their brain to fully recover and they may feel confused.

Epilepsy can start at any age and some types last for a limited time, but for many people, epilepsy can be a life-long condition.

2 Rationale

Jericho Primary School recognises the important part that nurseries, schools, and other settings play in helping children and young people with AADE manage their medical condition well to achieve good health, active learning, and personal independence.

We recognise that some pupils may need time off school or suffer disturbed sleep due to their health which can leave them feeling ill, tired, irritable, and struggling to concentrate or catch up at school.

These procedures centre on the safeguarding of pupils diagnosed with AADE but include principles adaptable to managing other serious health concerns that can lead to pupils experiencing similar struggles.

This school welcomes all pupils, including those who have AADE, and encourages them to achieve their full potential in all aspects of school life by providing a positive educational environment, procedures to control the risks and prevent and manage emergencies, and well-trained staff to implement them.

So that pupils diagnosed with AADE can be fully integrated into school life, we will:

- ensure they can and do participate fully in all aspects of school life, including P.E., design technology, science, arts, drama, educational visits, and other extended school activities by understanding the severity of a pupil's condition and their triggers, assessing the risks and implementing control measures to try to reduce them, and by having sound emergency management procedures;
- have arrangements in place to ensure that those with emergency medicines can get immediate access to them at all times;
- keep a record of all pupils diagnosed with anaphylaxis who have an Adrenalin Auto-Injector (AAI Register) or asthma who have a reliever inhaler (Asthma Register), or diabetes, or epilepsy, and have an Individual Health Care Plan (IHCP) in place for the pupils who need one;
- ensure that the whole school environment, including the physical, social, sporting, and educational environment, is as favourable to them as to their peers without the condition;
- ensure there is an area of school that allows for adequate privacy (and supervision if necessary) where pupils who know they are becoming unwell can go to use their emergency medicines if they are uncomfortable doing so in front of others;
- ensure that all staff and other adults working in the school and who come into contact with pupils with AADE know what the conditions are, what risks are relevant to their work, how to best control them, how to recognise symptoms, and what to do in an emergency;
- ensure all pupils understand AADE so they can support their peers and avoid the stigma sometimes associated with these conditions. This might include how to recognise symptoms and what to do if they think it's an emergency when pupils are old or mature enough and are without close adult supervision;
- take steps to ensure that pupils are not being bullied because of their medical conditions and apply our anti-bullying procedures to prevent it;
- work in partnership with all interested parties including the governing body, all school staff and other adults, the school or community nurse, parents and carers, other relevant employers of adults working in the school (e.g., cleaning and catering staff), the local health protection team, and pupils to ensure these procedures are implemented and maintained successfully.

3 Managing pupils' emergency medicines

Pupils who have emergency medicines need immediate access to them and are encouraged to carry them as soon as their parent or carer, GP, and teachers agree they are mature enough and their peers would

not be at risk. The medicines of children who are not capable of carrying them safely themselves are kept in their classroom. Spare inhalers and epi-pens are kept in the school office.

It is explained to all staff as part of their induction that any child who appears to need and/or has asked for their emergency medicine should be given it immediately and what procedure they must follow.

We ask all parents and carers to ensure they equip their child with the minimum doses that their medical practitioner advises them to carry (usually two or more) clearly labelled with their child's name. We will also ask for a clearly labelled spare that can be kept in a suitable location in school, during term time only, in case the pupil's own runs out, or is damaged, lost, or forgotten.

It is the responsibility of parents and carers to ensure the medicines their child carries have not expired and that the spare provided will last for the entire half term, or they have a plan to replace it. We do not check the expiry dates of children's personal medicines periodically.

If it comes to the attention of staff through their normal duties that a medicine has expired or will expire soon, we will inform a parent or carer and ask them to take it home and provide a replacement.

Teachers are not required to administer emergency medicines to pupils, however many staff at this school are trained and willing to administer, supervise or provide other support to a pupil able to self-administer.

School staff who agree to administer medicines are insured by the local authority to do so when they are acting in accordance with our policies and their training given the circumstances they faced at the time.

Parents and carers will be informed about every use of an emergency medicine on their child.

4 Procedures for the administration of emergency medicines

4.1 Arrangements

The procedure for obtaining and using a pupil's own emergency insulin, buccal midazolam, AAI or inhaler and the school emergency AAI or inhaler are similar with slight variations affecting certain staff e.g., where the easily accessible but secure place pupils' own medicines are kept if they cannot carry them, the nearest spare to their work area etc.

The school emergency AAI or inhaler kit should only be used on a pupil where both medical authorisation and written parental consent have been provided. The pupil having their own prescribed AAI or inhaler is the simplest form of evidence for medical authorisation.

This can also include children at risk of anaphylaxis who have a medical plan confirming this, but who have *not* been prescribed an AAI. In such cases, specific consent for use of the spare AAI from both a healthcare professional *and* parent or carer must be obtained. They can use the template medical plan available from the British Society for Allergy and Clinical Immunology (BSACI) and give us a copy, so we can follow it in an emergency.

A pupil who has been prescribed an inhaler for their asthma which contains an alternative reliever medicine to salbutamol (such as terbutaline), should still use the school salbutamol inhaler if their own inhaler is not accessible and consent is held – it will still help to relieve their asthma symptoms and could save their life.

All children with a diagnosis of an allergy and anaphylaxis should have a written Allergy Management Plan. BSACI produces three Paediatric Allergy Action Plans - BSACI, one for each manufacturer currently authorised to supply AAIs in the UK. We will use the relevant one or our IHCP template, whichever provides the clearest emergency action plan.

In an emergency which resembles anaphylaxis in a pupil who has not been prescribed their own AAI and who does not have a medical plan that indicates school should administer the school emergency AAI kit either, these rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations, the member of staff administering the AAI, in an emergency and acting under medical instruction, does not need to have had any specialist training.

All children with a diagnosis of asthma should have a written Child asthma action plan (asthmaandlung.org.uk) which they complete with the help of their GP, community nurse and family, which we can use to inform the school IHCP and create an emergency action plan.

Salbutamol inhalers are intended for use where a child has asthma. The symptoms of other serious conditions and illnesses, including allergic reaction, hyperventilation, and choking from an inhaled foreign body can be mistaken for those of asthma, and the use of the emergency inhaler in such cases could lead to a delay in the child getting the treatment they need.

In an emergency which resembles symptoms of asthma in a pupil who has not been prescribed a reliever inhaler and who does not have a medical plan that indicates school should administer the school emergency salbutamol either, the rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations the member of staff administering it, in an emergency and acting under medical instruction, does not need to have had any specialist training.

Staff will supervise or otherwise support a pupil who is able to self-administer their own or the school emergency AAI or inhaler, or they will administer it for pupils who are unable to self-administer it in accordance with their training and **Poster A** - 'How to recognise a mild to moderate allergic reaction'; and **Poster B** - 'Signs of anaphylaxis and what to do', or **Poster C** – 'How to recognise an asthma attack'; and **Poster D** - 'What to do in the event of an asthma attack'.

All children with a diagnosis of Type 1 diabetes should have an NHS Diabetes UK/NHS Individual Health Care Plan (Type 1), which they complete with the help of their GP, community nurse and family. We will use it to help us make reasonable adjustments to facilitate prescribed medical care to allow a child to participate in education on the same basis as their peers.

Children with a diagnosis of Type 2 diabetes should have a school IHCP drawn up for them to describe the specific support they need to avoid or manage the risks of becoming hypo or hyper-glycaemic.

Trained staff will supervise or otherwise support a pupil who is able to carry out their own BM checks and administer their own insulin and they will do it for pupils who are unable to.

All children with a diagnosis of epilepsy should have a written Care Plan (epilepsy.org.uk). It's an agreement between the person with epilepsy, their healthcare professional, and where appropriate, their parents or carers. The care plan should say how to tell if they are in status epilepticus and what to do. It should also include details of any emergency medicine that has been prescribed, who is trained to use it and when to give it. We will use it or our IHCP template, whichever will help us provide the best support for the child at school.

These plans must be easily available to staff, especially trained staff who may need to refer to them in an ongoing emergency.

4.2 Summary of emergency action - Anaphylaxis

1. Establish that the pupil in difficulty is experiencing an allergic reaction as far as possible and try to keep them calm. Once it has been established that administration of an AAI is required, **call for an ambulance unless to do so would delay treatment.**
2. Lie the pupil flat with legs raised (or sit them up if having breathing problems).
3. Establish the pupil's identity and the correct action to take (posters A and B).
4. Obtain the child's AAI, the child's spare AAI, and/or the school emergency AAI if required.
5. Check the AAI to be administered is correct, not expired, and will be given at the right dose in the right way.
6. Administer or support self-administration of the AAI in accordance with posters A and B **and call for an ambulance**.
7. Record the administration (see Form E3: Record Card Adrenalin Administration).
8. Inform parents or carers as soon as possible after an ambulance has been called.

If a pupil is having more frequent or more severe allergic reactions to their triggers, we will review the IHCP and inform their parents/carers. The pupil might need to see their GP for a review after which we might also need to review their IHCP with them and their parents.

4.3 Summary of emergency action - Asthma

1. Establish that the pupil in difficulty is experiencing an asthma attack as far as possible and try to keep them calm.
2. Establish the pupil's identity and the correct action to take i.e., whether appendices C and D should be followed or the pupil's individual S/MART Plan i.e., their Maintenance and Reliever Therapy plan (using only one combination preventer/reliever inhaler – app enabled smart inhalers are not available in the UK yet).
3. Obtain the child's inhaler (and spacer), the child's spare inhaler, and/or the school emergency inhaler and spacer if required.
4. Check the medicine to be administered is correct, not expired, and will be given at the right dose in the right way i.e., whether a spacer is used or there is a S/MART Plan.
5. Administer or support self-administration of the reliever inhaler in accordance with the posters/advice or the pupil's S/MART Plan and/or the pupil's ACP/IHCP **and call for an ambulance if necessary**.
6. Record the administration of the school asthma kit on Form E2: Record CARD Emergency Salbutamol Use or Form E2: Record SHEET Emergency Salbutamol Use which should be inside the kit. If there are privacy or confidentiality issues or a child's asthma is not well-controlled, use of the school asthma kit and the child's own personal supplies can all be recorded together on Form E2: Record SHEET Personal Salbutamol Use.
7. Inform parents or carers as agreed or as soon as possible if an ambulance has been called.

If a pupil appears to be using their reliever inhaler more often than expected according to the needs outlined in their ACP/IHCP, we will inform their parents or carers. We might need to review the child's plan with them, or the child might need to see their GP or a community asthma nurse for an asthma review after which we might also need to review their child's plan with the family.

4.4 Summary of emergency action - Diabetes

1. If the pupil is conscious, obtain the reading from the Continuous Glucose Monitor (CGM) if they wear one **or** ensure, supervise or help the pupil in difficulty test their blood glucose levels to establish whether they are hypo- or hyper-glycaemic - keep yourself and them calm.
2. If the pupil is convulsing, clear the area so they don't hit anything and hurt themselves or if they are unconscious, put them in the recovery position **and call for an ambulance** - then follow the IHCP.

If the pupil is having a **hypo** do not leave them alone and don't make them go anywhere. Follow steps 3-8:

3. Obtain the IHCP first to find out how much is needed and offer the pupil the right amount of something sugary to eat or drink, like Lucozade, a non-diet soft drink, glucose tablets or fruit juice.
4. After 10–15 minutes, check the blood glucose level again. If the level is still low, repeat step 2.
5. Check the blood glucose level again after another 20–30 minutes to make sure that they have returned to normal.
6. Check the IHCP again to see if the pupil will need a follow-on snack after treating a hypo, such as a piece of fruit, biscuits, cereal bar, small sandwich or the next meal if it's due and make sure they get it.
7. Record this administration in the pupils' Diabetes log book – see appendix A
8. Inform parents or carers in the agreed ways.

If the pupil is having a **hyper** - follow these steps 3-8:

3. Obtain the IHCP first to find out when the pupil needs insulin and how to give it.

4. Establish if blood sugar levels have only been high for a short time and if another course of action is more appropriate than giving insulin such as drinking water and exercising to bring levels down.
5. If they need extra insulin, ensure, supervise or help the pupil in difficulty administer their insulin and encourage them to drink sugar-free fluids.
6. Follow the IHCP with regard to testing for ketones in the blood or urine, and when a pupil might need to go to hospital. **Call for an ambulance if necessary.**
7. Record insulin administration in the pupils' Diabetes log book – see appendix A
8. Inform parents or carers in the agreed ways or as soon as possible if an ambulance has been called.

If a pupil is having more frequent or more severe hypos or hypers, we will review the IHCP and inform their parents/carers. The pupil might need to see their GP for a review after which we might also need to review their IHCP with them and their parents or carers.

4.5 Summary of emergency action – Epilepsy

1. Stay calm, note the exact time the seizure began, and **prepare** to administer the emergency medicine and call an ambulance if it becomes necessary e.g. radio, phone, or send a reliable individual to relay information for action to an appropriate person.
2. Protect the pupil from injury (remove harmful objects from nearby) and stop others crowding around them (where possible move others away from the area) – NEVER move them unless they are in immediate danger e.g. on stairs, in the road etc. and then only with proper regard for your own safety.
3. Cushion their head (with a folded jumper, a cushion etc.) to reduce the chance of head injury.
4. Do not restrain them in any way and never put anything in their mouth – allow the seizure to happen.
5. Place them in the recovery position when the convulsions have stopped and check their breathing is returning to normal.
6. If the seizure lasts more than 5 minutes (status epilepticus) **OR** it lasts 2 minutes longer than is normal for them or another time period recorded in the pupil's IHCP or Epilepsy Care Plan **OR** the pupil has one after another without recovering, administer the emergency medicine and **call for an ambulance**.
7. Preserve dignity should continence have been lost or if intimate medication is required (cover with a light blanket or piece of clothing or use blankets to shield the pupil from sight).
8. Stay with them until fully recovered – NEVER give them anything to eat or drink until they are fully recovered.
9. Manage personal cleaning and biohazards according to procedures.
10. Complete an incident record and copy to everyone necessary as agreed in the care plan – write down as much as can be remembered about triggers.

In a wheelchair follow steps 1 and 6-10 above but substitute steps 2-5 above for steps 2-5 below instead**:**

2. Put the brakes on to stop the chair from moving.
3. Let them stay in the chair during the seizure (unless they have a care plan which says to move them). Moving them could possibly lead to injuries for both you and them.
4. If they have a seatbelt or harness on, leave it fastened. If they don't have a seatbelt or harness, support them gently, so they don't fall out of the chair.
5. Cushion their head and support it gently. A head rest, cushion or rolled up coat or blanket can be helpful.

In water to rescue the person so that steps 1-10 above can be followed:

1. From behind, tilt the person's head so it is out of the water.
2. If possible, move the person to shallow water.

3. Shout for a lifeguard or other adult to help you get the person out of the water.

Once the person is out of the water and steps 1-10 above are being followed, keep them warm.

In addition to the normal reasons one might be required, **call for an ambulance** if the pupil may have swallowed or breathed in water, even if they appear to be fully recovered. There is a potential risk of drowning hours, even days later due ongoing breathing difficulties after the incident due to fluid in the lungs, inflammation, or from developing pneumonia as a result.

5 Managing school AAIs and Inhalers

The Human Medicines (Amendment) Regulations 2017 (AAIs) and Human Medicines (Amendment) (No.2) Regulations 2014 (salbutamol) allow, but do not require, schools to keep an adrenaline auto-injector (AAI) or salbutamol inhaler for use in an anaphylaxis or asthma emergency, even if the school does not currently have pupils diagnosed with either anaphylaxis or asthma and governors have decided that keeping a supply will currently benefit pupils significantly.

This decision is under continual review based on the needs of our pupils as they change.

This school has purchased and will manage at least 2 AAIs and 2 inhalers in case of an anaphylaxis or asthma emergency occurring both on and off site at the same time where a child's own AAI or spare is not available or safe to use. It could potentially save their life. In exceptional circumstances, a 'spare' AAI can be used in the event of an emergency to save the life of someone who develops anaphylaxis unexpectedly or for the first time. **This decision does not in any way release parents or carers from their absolute duty to ensure that their child attends school with a fully functional AAI containing sufficient medicine for their needs.**

5.1 Obtaining AAIs and inhalers

This school will buy AAIs and inhalers from a pharmaceutical supplier in writing confirming the following:

- the name of the school.
- the purpose for which the product is required; and
- the total quantity required.

We will use the template letter in Appendix 1 to the Department of Health and Social Care (DHSC) guidance Using emergency adrenaline auto-injectors in schools to get the right supplies.

5.2 The emergency AAI kit

Each emergency AAI kit will contain:

- 1 or more AAI(s).
- Instructions on how to use the device(s).
- Instructions on storage of the AAI device(s).
- Manufacturer's information.
- A checklist of AAIs, identified by their batch number and expiry date with monthly checks recorded.
- A note of the arrangements for replacing used AAIs.
- A list of pupils to whom the AAI can be administered (AAI Register).
- An administration of AAI record card/sheet.

5.3 Storage and care of School AAIs & Inhalers and Pupils' Emergency Medicines

It is the responsibility of parents or carers to provide enough of the right medicine, in working condition, with a spare to remain in school during term-time only, and to check regularly that neither has expired.

It is the responsibility of class teachers to arrange for or remind pupils who keep a spare lot of emergency medicine at school, to take it home with them every holiday and bring it back at the start of the next half term. This also serves to provide parents and carers the opportunity to carefully examine it for defects or expiry and test and clean it if necessary.

It is the responsibility of Sarah Spires and Claire Nicholson to maintain the school emergency AAI and asthma kit(s) ensuring that:

- on a monthly basis the AAIs are present and in-date and that the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available;
- replacement AAIs and inhalers are obtained when expiry dates approach and we have signed up to receive any manufacturer AAI expiry alerts available;
- replacement spacers are available following a single use;
- the AAIs are being stored at room temperature (in line with manufacturer's guidelines) and protected from direct sunlight and extremes of temperature;
- the plastic inhaler housing (which holds the canister) has been cleaned, dried, and returned to storage following use, or that replacements are available if necessary.

The school emergency AAI and asthma kit/s will be clearly labelled and kept separately from pupils' own spare AAIs or inhalers to avoid any confusion the school office. This is a safe and suitably central location in school, known to all staff, and to which all staff have access at all times, but in which the medicine is out of easy reach and sight of children. They will not be locked away.

Storage will always be in line with manufacturer's guidelines, usually below 30°C and protected from direct sunlight and extremes of temperature. Spacers will not be stored in plastic bags to avoid them developing a static charge that causes the asthma medicine stick to the spacer rather than being delivered into the lungs.

An inhaler should be tested before use e.g., held away from the face while spraying one or more puffs as necessary. As it can become blocked again when not used over a period of time, testing will be carried out before each use and monthly as part of the working order checks.

To avoid possible risk of cross-infection and because it goes directly in the mouth and can only be cleaned with gentle detergents, the plastic spacer cannot be reused by a different person and could be given to the child who used it to take home/keep labelled with their name in school for future personal use. The inhaler itself however can usually be reused, provided it is cleaned after use. The canister of salbutamol should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, the cap replaced, and the inhaler returned to the designated storage place. If there is any risk of contamination with blood i.e., if the inhaler has been used without a spacer, it should not be re-used but disposed of.

5.4 Disposal

This school is registered online at www.gov.uk/waste-carrier-or-broker-registration as a waste carrier so that we can legally dispose of spent, expired, or faulty AAIs or return them to be recycled by the manufacturer and will follow the manufacturer's or our pharmaceutical suppliers' guidelines on disposal.

6 Staff training on and use of emergency medicines

The individual responsible for overseeing the protocol for use of the school emergency medicines, monitoring its implementation, identifying training needs, and for maintaining the registers is Claire Nicholson.

All staff are trained:

- To recognise the range of signs and symptoms of an allergic reaction, asthma attack, hypo or hyper-glycaemic event, seizure or absence.
- To understand the rapidity with which they can progress to a life-threatening reaction, and that symptoms can appear very mild at first.
- To appreciate the need to administer emergency medicines as soon as possible once recognised.
- To understand how to distinguish symptoms of an asthma attack from choking, anaphylaxis or other conditions with similar symptoms.

- In how to respond appropriately to an emergency, what checks or tests to carry out before administering an emergency medicine.
- On the policy for supporting pupils at school with their medical conditions, our procedures, and their role in both.
- How to check if a child is on the anaphylaxis or asthma register and whether parental consent is held to administer school supplies of emergency medicines.
- How to access and use the pupils' own, the pupil's spare, or the school spare emergency medicines.
- Who the designated members of staff are and how to access their help.

Pupils are involved in age and developmentally appropriate ways in our emergency procedures e.g., fetching help or equipment, to increase community awareness of severe medical conditions, build peer-to-peer resilience, promote leadership skills, and reduce stigma or bullying.

Designated staff have a specific responsibility for helping to administer the school emergency medicines, i.e., they have volunteered to help a child use the school emergency AAI or inhaler, are trained to do so, and are identified in these procedures as people to whom all staff can turn to for support in an emergency.

Designated staff are trained in everything that all staff are trained in listed above and:

- responding appropriately to a request for help from another member of staff.
- recognising when emergency action is necessary.
- practical instruction in how to use the different AAI devices pupils use and salbutamol through a spacer.
- making appropriate records of allergic reaction; and
- ensuring parents are informed.

Not every designated member of staff is trained in every type of emergency medicine administration.

We arrange specialist training for designated staff and use online resources and introductory e-learning modules for all staff available at http://www.sparepensinschools.uk, (although this is not a substitute for face-to-face training), specific training or advice offered by the school or community anaphylaxis nurse e.g., the joint NHS Trust & Cumbria Public Health 5-19 Service Teacher anaphylaxis with audio - YouTube, or another suitably qualified professional to inform our practice when managing pupils who have anaphylaxis.

We ask children with inhalers to demonstrate to their teachers how they use it, with parental support, if necessary, to understand their technique, to compare it with their asthma care plan and training staff have received.

We use How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk), free and accredited online training from the George Coller Memorial Fund, manufacturer's user training materials, and specific training or advice offered by the school or community asthma nurse or another suitably qualified professional to inform our practice when managing pupils who have asthma.

When a pupil needs support with the emergency administration of insulin or buccal midazolam or similar, we engage with community and school nurses to get the right training for designated staff.

7 Record keeping

At the beginning of each school year or when a child joins our school, parents/carers are asked if their child has any medical conditions on their enrolment form.

All parent or carers of pupils with emergency medicines an IHCP or other care plan with advice from their GP or asthma, diabetes or other community nurse where needed, to help us manage their child's exposure to triggers and their symptoms during school activities (see section 4.1 for links to a number of templates we rely might on).

The information will be used to update the school anaphylaxis or asthma register and these procedures to include:

- Known risk factors for AADE.
- Whether a pupil has been prescribed salbutamol, AAI(s), insulin, buccal midazolam etc. (and if so what type, dose, frequency etc.).
- Where a pupil has been prescribed salbutamol or an AAI, whether written parental consent has been given for use of the spare school emergency supplies of salbutamol or AAIs which may be different to the personal reliever inhaler or AAI prescribed for the pupil.
- A photograph of each pupil to allow a visual check to be made (this will require parental consent) which is made available to all school staff and other adults working in the school where necessary to ensure medicines are administered appropriately.

The use of **any** emergency medicine will be recorded including:

- Where and when the reaction, attack, hyper/hypo-glycaemic event, or seizure took place (e.g., PE lesson, playground, classroom).
- How much was given, and by whom.
- When and how the person given it was transferred to hospital for further monitoring.
- When and how parents were contacted to inform them (hospital discharge documentation should be sent to the pupil's GP to inform them of the emergency incident).

The use of a pupil's own reliever inhaler is recorded and notified if necessary and as agreed with parents/carers.

We review all IHCPs and other care plans at least annually, asking parents and carers to update their existing plan or exchange it for a new one, and we remind them to tell us as soon as possible if their child's condition or medical needs changes.

8 Exercise and activity - PE and games

Taking part in sports, games and physical activities is an essential part of school life for all pupils but can be a trigger for pupils with AADE.

To maximise participation by and minimise the risks to these pupils we:

- Take reasonable steps to make the activities we offer accessible so that they can participate alongside their peers e.g., moving an outdoor activity indoors at times of very high pollen counts, kit checks that include personal, spare, and school AAIs, inhalers etc.
- Ensure all staff and other activity leaders are aware which of the pupils they work with have AADE, how to recognise an emergency, what to do, and have access to the pupil's own, pupil's spare, and the emergency AAI/asthma kit e.g., in the school emergency asthma kit they might need to use.
- Require all activity leaders to remember to include emotions and pollen in their dynamic risk assessments and take steps to control triggers where possible including regularly reminding pupils at risk how to reduce their environment or exercise-related triggers or reduce their response to triggers.
- Require all activity leaders to encourage pupils experiencing worsening symptoms to stop, take action to slow or stop the symptoms e.g., eating something, using their reliever inhaler, and to sit out quietly until their symptoms have gone before starting the activity again. Anyone experiencing symptoms must not be left alone until they feel better and are continuing with normal activities.
- Have a simple procedure for ensuring pupils' own emergency medicines are easily available to them during activities when they are not competent to or cannot physically carry them which is clearly communicated with signage if necessary. Procedures vary slightly depending on the pupils and locations, but they all involve the principle of staff gathering clearly labelled personal inhalers, storing them in a hygienic manner which is immediately accessible to pupils throughout activities, carrying or having access to a pupil's own spare inhaler if they have one, and returning them.
- Have clear learning objectives for and plans for the inclusion of pupils with AADE who are too unwell to participate in physical activities e.g., referee, coaching, or other lower risk role.
- Take steps to reassure parents, carers, and pupils that we understand their condition and can help them manage it and be active.

9 Out of Hours

Extra-curricular activities and out-of-school clubs operated by this school are open to all pupils equally and those with AADE are encouraged to participate in everything we offer alongside their peers.

To enable them to participate as safely as possible, we ensure that all teaching, teaching support staff, sports coaches, and other activity leaders who run school activities outside of normal school hours are aware of our procedures, the pupils they need to be applied for, and how to minimise triggers and reactions.

10 School Environment

This school does all that we reasonably can to ensure the school environment is as favourable to pupils with AADE as it is to their peers and we recognise that stress can be a key factor in determining .

We also have a duty of care for the health, safety, and wellbeing of pupils and must identify the seriousness of the risks to their health from exposure to their known triggers and take reasonable action to eliminate or manage the risks.

Areas of the curriculum we pay particular attention to which may expose pupils to triggers like allergens, humidity, extremes of temperature, fumes, smoke, dust, pollutants, flashing lights, sugary food & drinks etc. include science, design technology, food technology, art, religious studies, drama, PE, and outdoor activities.

We do not own or keep animals that create known triggers and where contact is unavoidable e.g., in the presence of disability service animals or on educational visits off-site, we carefully manage situations that may cause a reaction.

This school has a strict 'no smoking' policy in force throughout the site, both indoors and outdoors, and steps are taken to ensure that staff and other adults leading or supervising off-site visits follow this policy.

This school is kept well ventilated to control humidity and temperature, and to prevent dust accumulation, damp, and mould through open doors and windows in line with our security and our fire risk assessment and through forced ventilation/air conditioning.

We actively look for damp and mould problems through normal premises condition monitoring and take action to prevent and deal with incidents as a high priority.

When we have pupils or staff with severe symptoms triggered by dust, we will ensure classrooms and any other areas necessary are regularly wet dusted to reduce dust and dust mites.

When contractors are on site, regular discussions take place with them to ensure that their work will not increase risks to pupils or staff in an unmanageable way e.g., create fumes, smoke, dust, flashing lights etc.

Where possible, grassed areas are not mowed during school hours, and we avoid keeping pollinating plants inside school buildings.

Rooms where pupils change their clothing are well ventilated and pupils are encouraged to use unscented and non-aerosols deodorants or other permitted products.

We consider the possible effects of flashing lights on photo-sensitive epilepsy in drama, performances, science etc.

All vending machines stock snacks that comply with legislation on healthy eating and the School food standards practical guide - GOV.UK (www.gov.uk) and support for healthy eating is available from staff.

stress

This school is aware that as many as 1 in 50 pupils has a nut allergy, that free-from environments can create a false sense of security and do not prepare pupils for the world outside school, and that a nut-free policy still cannot guarantee that we would be a nut-free site because pupils and staff bring food and other items like deodorant sprays into school. However, sometimes, the risk to an individual pupil from exposure to their allergens is so high and difficult to manage that we may try to take additional school-

wide action to protect them for as long as the risks are unacceptable if we don't. An example of this might be asking parents and carers not pack snacks or lunches containing nuts. Our main focus will always remain on education and awareness raising and our procedures and hygiene arrangements to manage risk.

11 Off-site and Residential Visits

On-site procedures to manage AADE must be suitably adapted to be carried out off-site by the visit leader,

Visit leaders may need to identify significant health and medical needs at the earliest planning stages, seeking advice from Penny Leck, if necessary, to ensure equality of access to the curriculum and to be suitably prepared for their visit, for example:

- to understand which pupils, have AADE.
- the severity of their symptoms.
- relevant triggers to be avoided or reduced.
- their treatment or care plan, especially out-of-hours arrangements which school is normally unfamiliar with, and the role of staff.
- and the pupil's competence in carrying and administering their own emergency and other medicines.
- distance from emergency services at any point in time on the visit.

Parental consent to attend a residential visit may need to include a review of and additions to an IHCP because a medicine or other treatment school does not normally manage is required.

All medicines provided for educational visits must be handed over to school already clearly labelled with the pupil's full name.

12 When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school, or is distracted by their symptoms or health worries, or is always tired because their medical condition is disturbing their sleep at night, Laura Ball will initially talk to the parents/carers to develop a plan to support better management of their symptoms and/or to prevent their child from falling behind. If appropriate, the member of staff taking this initial action will then talk to the school or community nurse and SENDCo about the pupil's further needs.

We recognise that it is possible for pupils with anaphylaxis, asthma, diabetes, and epilepsy to have special education needs (SEN) due to their medical condition which may also be a disability under the Equality Act 2010.

13 Bullying

Whilst bullying can happen to any pupil, this school recognises that those who feel or seem different to others can be particularly vulnerable. Our Anti-bullying procedures which are part of the Whole School Behaviour Policy will be used and enforced in any situation where a pupil is being bullied or intimidated due to their medical condition.

14 Disclaimer

While every effort will be made to ensure appropriate medical attention is sought at the earliest opportunity in the event of a pupil experiencing a medical or health emergency, this school cannot accept responsibility for adverse events when parents/carers have failed to provide the medicines or working devices their child needs to manage their medical condition.

15 Access to and review of procedures

The AADE Procedures will be accessible to all staff and other adults working in the school and the community on our website. A printed copy is available from the school office.

These procedures will be reviewed on a two-yearly cycle.

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How to recognise a mild to moderate allergic reaction

Symptoms include:

- sneezing and an itchy, runny or blocked nose (allergic rhinitis)
- itchy, red, watering eyes (conjunctivitis)
- wheezing, chest tightness, shortness of breath and a cough
- a raised, itchy, red rash (hives)
- swollen lips, tongue, eyes or face
- tummy pain, feeling sick, vomiting or diarrhoea
- dry, red and cracked skin

A child will not necessarily experience all of these symptoms in the same episode.

ACTION:

- Stay with the person, call for help if necessary
- Locate adrenaline auto-injector(s) in case needed
- Give antihistamine according to the child's allergy treatment plan
- Phone parent/emergency contact
- **WATCH FOR SIGNS OF ANAPHYLAXIS**

Signs of anaphylaxis

Airway

Persistent cough

Hoarse voice

Difficulty swallowing

Swollen tongue

Breathing

Difficult or noisy breathing

Wheeze or persistent cough

Consciousness

Persistent dizziness

Becoming pale or floppy

Suddenly sleepy, collapse, unconscious

IF ANY ONE (or more) of these signs are present:

1. Lie child flat with legs raised: (if breathing is difficult, allow child to sit)
2. **Use Adrenaline auto-injector* without delay**
3. Dial 999 to request ambulance and say **ANAPHYLAXIS**

***** IF IN DOUBT, GIVE ADRENALINE *****

After giving Adrenaline:

1. Stay with child until ambulance arrives, do NOT stand them up
2. Commence CPR if there are no signs of life
3. Phone parent/emergency contact
4. If no improvement after 5 minutes, give a further dose of adrenaline using another autoinjector device, if available.

Anaphylaxis may occur without initial mild signs: **ALWAYS use adrenaline auto-injector FIRST in someone with known food allergy who has SUDDEN BREATHING DIFFICULTY** (persistent cough, hoarse voice, wheeze) even if there are no skin symptoms

How to recognise an asthma attack

Signs that someone may be having an asthma attack include:

- Symptoms that are getting worse e.g. coughing, breathlessness, wheezing, or having a tight chest
- The reliever inhaler is not helping relieve symptoms or is needed more than every four hours
- Being too breathless to speak, eat, walk, or sleep
- The person's breathing is getting faster, and they feel like they cannot catch their breath
- Their peak flow score is lower than normal
- They complain of a tummy or chest ache (more commonly a tummy ache in younger children)

Symptoms will not necessarily occur suddenly. They often come on slowly over a few hours or days.

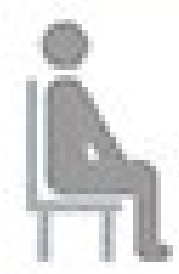
DIALL 999 FOR AN AMBULANCE IMMEDIATELY IF:

- There is no working reliever inhaler available
- The child feels worse despite using a reliever inhaler
- The child does not improve after taking 10 puffs of their reliever inhaler
- The child:
    - Appears drowsy, confused, exhausted, or dizzy
    - Has blue tinged lips, nails, tongue, gums, skin, or ears
    - Has collapsed

Give paramedics the child's medicines.

What to do in the event of an asthma attack

Do <u>not</u> follow this procedure if the child having the suspected asthma attack is on a MART treatment plan. Say where MART personal action plans can be found.



- Keep calm and reassure the child
- Encourage the child to sit up straight
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take **one** puff of salbutamol via the spacer
- If there is no immediate improvement, continue to give **one** puff at a time **every 30-60 seconds**, up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until they feel better and can return to school activities
- If the child does not feel better or you are worried at **ANYTIME** before you have reached 10 puffs, **CALL 999 FOR AN AMBULANCE**. Give attending paramedics the child's medicines.
- If an ambulance does not arrive within **15 minutes** give another 10 puffs in the same way

Inform parents or carers as agreed (no matter how minor) or as soon as possible (if serious).