BUXTON INFANT SCHOOL

Headteacher: Jude Boyd

MEDICINE POLICY

BUXTON INFANT SCHOOL

This policy was reviewed by the Governing Body on 21st September 2017

It will be reviewed September 2019

Signed: **Date:**

Medicine Policy

Contents

1. Introduction

This document provides guidance for those who provide, commission and who use children's services in Derbyshire. It reflects the most recent national guidance and replaces earlier Derbyshire guidance published separately for schools. It does not replace the main national guidance documents to which services will need to refer.

2. Indemnity

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

3. Access to Education and Services - The Equalities Act 2010

The Equality Act 2010 provides a single, consolidated source of anti-discrimination law, covering all the types of discrimination that are unlawful. It simplifies the law by removing anomalies and inconsistencies that had developed over time under previous legislation. It also introduces a single combined duty to eliminate discrimination and advance equality of opportunity and replaces the former race, disability and gender equality duties. As far as schools and general children's services are concerned, the effect of the new law for the most part is the same as it has been in the past namely to prohibit unlawful discrimination against children/pupils because of their sex, race, disability, religion or belief and sexual orientation other than in relation to the content of the curriculum, collective worship and admissions to single-sex schools and schools of a religious character.

Under the new act, it is unlawful to offer/provide a lesser standard of service to a child with a disability and there is a new reasonable adjustment duty requiring schools and services to provide auxiliary aids and services to disabled pupils. An important principle underlying how schools respond to the specific duties is proportionality. This means that, for example, more is expected from a large secondary school than from a small primary. A second important principle is flexibility. This means that each individual school is permitted, and indeed expected, to interpret the legislation in ways which are appropriate to its own context, neighbourhood, history and circumstances.

4. Purpose of The Policy

The purpose of this policy is to enable a child to achieve regular attendance at school. The policy is for children who are: -

- suffering from chronic illness or allergy; or
- recovering from a short-term illness and are undergoing or completing a course of treatment using prescribed medicines and are fit to attend.

5. Assessing Needs and Managing Risks

Medicines, whilst not hazardous if used and administrated in the correct manner, present a risk if not used and administered correctly. The main risks associated with the school storing, managing and administrating medicines are:

- Medicines given to wrong child;
- Medicines not given to child at appropriate time;
- Medicines not given at all;

- Wrong dose of medicine given to children;
- Medicines not available when required (particularly rescue medication);
- Medicines being lost;
- Medicines stored incorrectly;
- Medicines not in correct containers and not labelled correctly;
- Young people giving medicines to other young people;
- Needle stick injuries.

See Risk Assessment for 'Storage and Administration of Medicines', available in the School Office.

6. Children with Medical Needs

Children with short term medical needs

Many children will need to take medicines during the day at some time during their time in school. This will usually be for a short period only, perhaps to finish a course of antibiotics or to apply a lotion. To allow children to do this will minimise the time that they need to be absent. However, such medicines should only be taken to school or a service where it would be detrimental to a child's health if it were not administered during the school day/ duration of the service.

Children with long term medical needs

It is important that schools and services have sufficient information about the medical condition of any child with long-term medical needs. If a child's medical needs are inadequately supported this may have a significant impact on a child's experiences and the way they function in or out of school or a service. The impact may be direct in that the condition could affect cognitive or physical abilities, behaviour or emotional state. Some medicines may also affect learning leading to poor concentration or difficulties in remembering. The impact could also be indirect, perhaps disrupting access to education through unwanted effects of treatments or through the psychological effects that serious or chronic illness or disability may have on a child and their family.

- The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that must be considered.
- Some specified medical conditions such as HIV, multiple sclerosis and cancer are all considered as disabilities, regardless of their effect.
- Also, where someone is being helped to get on with day-to-day activities by taking medication, or because they are having some other treatment, they are still to be treated as having a disability.

Schools and services need to know about any such needs before a child is admitted or when s/he first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. For such children, it is often helpful to have a written individual treatment plan drawn up by relevant health professionals in consultation with the parents. This can include:

- details of a child's condition;
- special requirement e.g. dietary needs, pre-activity precautions;
- what constitutes an emergency:
    - what action to take;
    - what not to do;
    - who to contact – including when parents expect to be contacted.
- the role the staff can play.

The overriding duty is to ensure good communication that will ensure a child receives the right medicine at the right time with the minimum risk of error.

Further details on individual treatment plans can be found in Section 13
Further details on children with complex health needs can be found in Section 14

7. The Respective Responsibilities of Schools & Parents
Head teachers of schools have a shared responsibility with parents to ensure good communication and information sharing to ensure a child receives the right medicine at the right time and, furthermore, that when a child is "handed over", parents/carers and staff know what medicines have been given and when the next doses are due. They also have separate responsibilities.

The Responsibilities of Headteachers/Managers
It is the responsibility of the Head teacher/manager to ensure that schools and services have a clear medicines policy which is understood and accepted by staff, parents and children. The policy should be readily accessible and ideally be included as part of the school prospectus or service information/brochure. The policy should set out clearly what is expected of parents and children, including how working together will ensure that children with medical needs are not disadvantaged.

- Head teachers and managers are advised not to allow children to bring medication into school/services except as covered by this document and the relevant codes of practice.
- They should advise parents that schools/services do not keep any medication for distribution to children, e.g. paracetamol. They will, of course, have a first aid kit.
- They should have particular regard to the section dealing with consent below.
- This does not imply a duty on Head teachers/managers or staff to administer medication. The Local Authority wishes to point out to school staff, governors, parents and staff in other services that participation in the administration of medication is on a voluntary basis unless staff have accepted job descriptions that include duties in relation to the administration of medicines.
- Individual decisions on involvement must be respected.
- Punitive action must not be taken against those who choose not to consent.

Notifiable Diseases
Head teachers and managers should also be aware of and make available the document "Guidance on infection control in schools and nurseries" available from the Health Protection Agency website. www.hpa.org.uk/infections/topice-az/schools/default.htm. If they are unsure of any issue relating to notifiable diseases they should seek advice from the Health Protection Team (0844 225 4524).

The Responsibilities of Parents
The responsibility for ensuring that children with medication needs receive the correct "treatment" rests ultimately with their parents/guardians. Before administering medicine to a child, there needs to be written evidence of consent.

8. Working in Partnership

- Working in partnership is about a shared duty of care and is the key to ensuring that all of a child's health care needs are met.
- Many children have no particular needs but may fall ill or have an accident whilst at school or receiving services.
- Most children, at some point during their childhood, will have a temporary need.
- Some will have on-going needs requiring regular medication or procedures that must be followed and for which staff and carers must be trained.

- A small number may occasionally have urgent, including life-threatening, needs which must be met without delay.
- Good planning and communication is fundamental to effective partnership working:
- this begins with a clear statement about a child's health needs and how they are to be met;
- it also includes essential information about any allergies or health conditions such as diabetes and any other information which staff/carers need to know about;
- it must ensure clarity about who needs to do what and when and provide a written record to confirm it has been carried out.

These are the building blocks that ensure the "five rights" are upheld - the right child, the right drug, the right dose, the right route, the right time.

Extra help for children with additional health care needs

Children who have additional needs arising from a medical condition, disability or illness will be under the care of their GP and perhaps also a Paediatrician and/or other health professional. They will have an individual treatment plan which is regularly reviewed and which needs to be implemented across all services and settings – home, school, short break care and in the community.

- Parents and workers alike need to understand what the plan entails and what is required to comply with it.
- This needs to be written down so that it can be shared with all who have the care of a child and to minimise the risk of error.
- Parents will need to supply staff/carers with sufficient medication for the duration of the school day, service or short break.
    - This should be in its original container with the original pharmacy label – this is the only way that staff/carers can evidence that they are acting in accordance with a medical practitioner's instructions.
- Staff need to keep records to show that they have complied with these requirements and returned any unused medication.

See also Sections 13 The individual treatment plan & 14 Children with complex health needs

9. Core Principles of Safe and Appropriate Handling of Medicines

The following principles have been adapted:

1. Staff know which medicines each child has and the school/service keeps a complete account of medicines. Medicine records are essential and all staff should know which children need someone to administer medicines. Those who help children with their medicines should:

 know what the medicines are and how they should be taken and what conditions the medicines are intended to treat;

 be able to identify the medicines prescribed for each person and how much they have left;

 schools are dependent upon the cooperation of parents to enable them to meet this requirement.

2. Staff who help people with their medicines are competent. Head teachers and managers need to ensure that new members of staff understand that there are policies and procedures to be followed when administering medicines to children.

 Where specific training is needed to administer a medicine, or carry out a procedure, only staff who have been given appropriate training and have demonstrated their competence, should be permitted to do this.

3. Medicines are given safely and correctly, and staff preserve the dignity and privacy of individuals when they give medicines to them. Safe administration of medicines means that they are given in a way that avoids causing harm to a child.

- They should only be given to the person for whom they were prescribed.
- Children should receive the right medicine at the right time and in the right way.
- Every effort should be made to preserve the dignity and privacy of individuals in relation to medicine-taking.
- It also means keeping personal medical information confidential, for example, a person's medicines administration record (MAR) should not be kept where everyone can see it.

4. Medicines are stored safely. Medicines need to be stored so that the products:

- are not damaged by heat or dampness;
- cannot be mixed up with other people's medicines;
- cannot be stolen;
- do not pose a risk to anyone else;

5. The school/service has access to advice from a pharmacist

- Every school/service should ensure that it has the contact numbers for their local pharmacy readily available together with a named person to contact.

10 Receipt, Storage and Disposal of Medicines

Prescription medicines

Medicines should only be taken to school or services when essential - that is where it would be detrimental to a child's health if the medicine were not administered during the school or setting 'day'.

- Schools and services should only accept medicines that have been prescribed by a doctor, dentist, or qualified non-medical prescriber (nurse, pharmacist, podiatrist, optometrist and physiotherapist).
- Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions and patient information leaflet (PIL) for administration.
- They should also be accompanied by a fully completed parental consent form See template 2.

Schools and services should never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.

- Any changes to dosages must be authorised by a medical practitioner or responsible prescriber.

Non-prescription medicines

Non-prescription medicines are those which can readily be bought "over the counter", schools and services are advised that they should have very clear rules in place regarding non-prescription medicines.

- Non-prescription medicines should be accompanied by a letter of parental consent.
- Only sufficient non-prescription medication for the duration of the school day or service should be allowed - this may need parents to remove some of the medication from the original container and keep it at home so that only one day's dose comes into school in its original container.
- Medication should only be allowed into school in original containers which clearly state what they are and maximum dose and dose frequency.

Receipt of medicines
Staff must have a record of the medicines they have received and what they will be required to administer. They must know and record:

- the child for whom the medicine – including ointments and creams - is intended;
- tablets should be counted (for hygiene reasons staff should wear rubber gloves where possible);
- ointments/creams should be estimated (for example, half a tube);
- liquids should be measured with a ruler (for example, 5 cm).

Written instructions
All medicines that are to be administered by staff must be accompanied by written instructions from the parent and/or the GP/prescriber.

- Schools/services may wish to allow non-prescription medicines in accordance with the guidance earlier in this document e.g. 1 x day's paracetamol – if accompanied by a parental consent form.
- Each time there is a variation (other than a new prescription) in the pattern of dosage, a new form should be completed and it should be accompanied by written confirmation from a medical practitioner to confirm the variation.

The parental consent form should be made readily available to parents. Good records help demonstrate that staff have exercised a duty of care.

Safe storage of medicines
In schools and services medicines must be stored in a cupboard that is well-constructed with a good quality lock that is big enough to safely store all the medicines that are required. Some medicines must be stored in a refrigerator because at room temperature they break down or 'go off'.

Emergency Medicines
These are medicines which need to be readily available in an "emergency situation" and include medicines such as asthma inhalers and adrenaline pens - these should always be readily available to children as and when they need them.

Hygiene and Infection Control
All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.

- Guidance on infection control in schools and other childcare settings (April 2010) is available from the Health protection Agency at;
  http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947358374
- CAYA guidance can be found at:
  http://dnet/Images/Cleaning%20of%20Bodily%20Fluid%20Spillages%202011.12%20V01_tcm10-201466.doc

11 The Administration of Medicines
1. Administration of Medicines - General Considerations

In Buxton Infant School named and trained consenting staff members administer medicine. The school will, in this circumstance, store the medicines and comply with all requirements on the storage of medicines. The names of the consenting staff willing voluntarily to administer medication is kept up to date, provide cover during periods of absence and be readily available at the storage point in cases of emergency.

2. Administration of Medicines by Staff

All staff who participate in administering medication must receive appropriate information and training for specified treatments in accordance with this guidance and the Codes of Practice. In most instances, this will not involve more than would be expected of a parent or adult who gives medicine to a child.

In schools the Head teacher is responsible for knowing which children are taking medication and who is responsible for administering it. In schools, Headteachers must ensure that:

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

In order to give a medicine safely, staff need to be able to:

- identify the medicines correctly. To do so, the medicine pack must have a label attached by the pharmacist or dispensing GP;
- identify the child/young person correctly – a physical description and or a photograph attached to the written instructions can provide additional safeguards;
- know what the medicine is intended to do, for example, to help the person breathe more easily;
- know whether there are any special precautions, for example, give the medicine with food.

There should be a simple easy-to-follow written procedure for giving medicines which staff must be familiar with and follow carefully. Headteachers should also monitor periodically how well staff follow this procedure. Staff should only give medicines that they are competent to administer. They can give or assist children to:

- administer medication in tablet/liquid form;
- apply creams and lotions;
- administer eye drops, ear drops, nasal sprays;
- support individuals with inhalers;
- support individuals with 'when required' medications;
- support individuals with non-prescribed medications from approved list;
- support individuals who self-administer medicines.

Key responsibilities of staff:

Staff must always check:

- the child's name;
- the prescribed dose;
- the expiry date;
- the written instructions provided by the prescriber on the label or container;
- the individual treatment plan where one exists;
- whether or not it is a controlled drug;
- any requirements for refrigerated storage;
- Prior to administration, the medicine administration record (MAR) to ensure that a dosage is due and has not already been given by another person.

If in doubt about any procedure staff should not administer the medicines but check with the parents or a health professional before taking further action. If staff have any other concerns related to administering medicine to a particular child, the issue should be discussed with the parent, if appropriate, or with a health professional attached to the school.

- Schools and services must keep written records each time medicines are given. See templates 4.

Staff must never give:

- a non-prescribed medicine to a child unless there is specific written permission from the parents on the appropriate form, and it is the medicine supplied by the parent;
- medicine to a child that does not belong to him or her - schools and services should not keep stocks of non-prescription medicines to give to children;
- medicine that belongs to another child;
- a child under 16 Aspirin or medicines containing Ibuprofen unless prescribed by a doctor.

The Head teacher must keep a record of all relevant and approved training received by staff.

Each person who administers medication must:

- receive a copy of these guidelines and Code of Practice;
- read the written instructions/parental consent form for each child prior to supervising or administering medicines, and check the details on the parental consent form against those on the label of the medication;
- confirm the dosage/frequency on each occasion and consult the medicine record for to ensure there will be no double dosing.
- be aware of symptoms which may require emergency action, e.g. those listed on an individual treatment plan where one exists;
- know the emergency action plan and ways of summoning help/assistance from the emergency services;
- check that the medication belongs to the named pupil and is within the expiry date;
- record all administration of medicines as soon as they are given to each individual;
- understand and take appropriate hygiene precautions to minimise the risk of cross-contamination;
- ensure that all medicines are returned for safe storage;
- ensure that they have received appropriate training/information. Where this training has not been given, the employee must not undertake administration of medicine and must ensure that the Head teacher is aware of this lack of training/information.

3. Refusal to Take Medicines

Staff can only administer medicines with the agreement of the child. If a child refuses to take a medicine, staff should not force them to do so, but parents should be informed the same day and where refusal may result in an emergency, the school/services emergency procedures should be followed.

12 Record Keeping

Appendix One provides a range of templates which can be used to support safe and effective record keeping.

Records must include:

- an up to date list of current medicines prescribed for each child that has been confirmed in writing;
- what needs to be carried out, for whom and when;
- for children with ongoing or complex needs, a care plan that states whether the child needs support to look after and take some or all medicines or if care workers are responsible for giving them.

Staff must make a record straight after the medicine has been accepted and taken.

 The records must be complete, legible, up to date, written in ink, dated and signed to show who has made the record.
 From the records, anyone should be able to understand exactly what the staff member has done and be able to account for all of the medicines managed for an individual.

13 The Individual Treatment Plan

The purpose of an individual treatment plan

The main purpose of an individual treatment plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short-written agreement with parents or a parental consent form may be all that is necessary.

 Individual treatment plans are generally required for children with specific medical needs requiring specialised or emergency medication.

An individual treatment plan clarifies for staff, parents and the child, the help that can be provided. It is important for staff to be guided by the child's GP or Paediatrician. Staff should agree with the lead health professional and the child's parents how often they should jointly review the individual treatment plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.

Staff should judge each child's needs individually as children vary in their ability to cope with poor health or a particular medical condition.

 The plan should include action to be taken in an emergency.

Developing an individual treatment plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child. The lead health professional will determine who needs to contribute to an individual treatment plan – they may include:

 the child's GP and Paediatrician;
 other health care professionals;
 the Head teacher or manager;
 the parent or carer;
 the child (if appropriate);
 early years' practitioner/class teacher (primary schools)/form tutor/head of year (secondary schools);
 staff who are trained to administer medicines;
 staff who are trained in emergency procedures;
 social worker;
 any worker engaged via an individual budget.

Early years settings should be aware that parents may provide them with a copy of their Family Service Plan, a feature of the Early Support Family Pack promoted through the government's Early Support Programme. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual treatment plan devised by a health professional, or indeed the record of a child's medicines.

Co-ordinating information

Co-ordinating and sharing information about the special needs and requirements of an individual child's medical needs can represent a significant challenge, both within services and settings and across them where a child uses other services.

 The Head teacher/manager should decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies.

 The child's lead professional, together with the parents, should take responsibility for the co-ordination and communication of information and instructions across the wider plan for the child.

Additional information and training

An individual treatment plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health professionals. When staff agree to assist a child with medical needs, the school or service should arrange appropriate training in collaboration with the school health services. Local health services will also be able to advise on further training needs. In every area, there will be access to training, in accordance with the provisions of the National Service Framework for Children, Young People and Maternity Services, by health professionals for all conditions and to all schools and services.

Together with the parents, the Head teacher/ managers and the lead professional share responsibility for ensuring that staff who may need to deal with an emergency will need to know about a child's medical needs. The head should make sure that supply staff know about any medical needs.

Confidentiality

Medical information should always be regarded as confidential by services and staff and personal data properly safeguarded.

 Records relating to the administration of medicines are health records and should be stored confidentially.

 Instructions should be shared on a "need to know" basis in order that a child's well-being is safeguarded and any individual treatment plan is implemented.

 Parents and older children should be engaged in "need to know" decisions which should be recorded.

Staff cannot be held to account if they fail to carry out key tasks, or do so incorrectly, because relevant information has not been shared with them. Similarly, services can only be provided where there is agreement to share relevant information.

14 Children with Complex Health Needs

As technology develops, growing numbers of children with complex health needs will receive their education in mainstream schools. This group of children and young people may require additional support in order to:

 maintain optimal health during the day;

 access the curriculum to the maximum extent.

Some examples of care of health needs for which children might require additional support in schools and services are:

 restricted mobility e.g. a child with physical impairments who uses a wheelchair;

 difficulty in breathing e.g. a child with a tracheostomy who requires regular airway suctioning during the day;

 problems with eating and drinking e.g. a child who requires a gastrostomy feed at lunch time.

 continence problems e.g. a child who requires assistance with bladder emptying and needs catheterisation at each break time or to follow a toileting plan to aid continence of bladder and bowels

 Susceptibility to infection e.g. a child who is receiving steroid therapy.

In supporting children with complex needs in schools, early years, social care and community settings there are a growing number of clinical procedures which staff may be

trained to undertake. In the main such training is undertaken by Children's Community Nurses, Specialist Nurses or School Community Nurses.

- A detailed Individual Health Plan should be completed as above

Some children with complex physical needs will require a range of specialist equipment to enable them to sit, stand and walk. This equipment should be assessed for by a trained health professional; (Children's Occupational Therapist, Local Authority Moving and Handling Adviser, Physiotherapist or Community Nurse) and the appropriate Local Authority Moving and Handling Advisor or School Link Worker in accordance with the Derbyshire Inter Agency Group (DIAG) guidance document. The equipment should be adjusted to suit an individual child. On the rare occasion when one piece of equipment is used for more than one child, the health professional should supply written instructions, (or manufacturer's instructions), on altering the equipment.

Children may also require a Moving and Handling Plan, completed by school staff or a moving and handling advisor and a Therapeutic Variance Form attached to a Moving and Handling Plan, (completed by the therapist). In order to promote physical well-being and optimise a child's learning and integration opportunities, specialised equipment should be an integral part of a child's day rather than seen as 'therapy'.

Some children with complex communication needs may require assessment for a communication aid or other relevant specialist equipment. The Speech and Language Therapy Service should be involved in assessment procedures for communications aids. Advice is available from the Speech and Language Therapist when a child is a communication aid user.

Off-Site and Community Activities

Schools and services should actively promote the participation of children with medical needs in educational visits, outings, and community activities which may need to be safely managed. Schools and services should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. The national standards for under 8's day care and childminding mean that the registered person must take positive steps to promote safety on outings. This will include reviewing and revising existing information, policies and procedures so that planning arrangements will include the necessary steps to include children with medical needs.

- It might also include risk assessments for such children.

Sometimes additional safety measures may need to be put in place. An additional supervisor, a parent or another consenting staff member might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration.

- Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures.
- A copy of any individual treatment plans should be taken on visits in the event of the information being needed in an emergency.

Sporting and Leisure Activities

Most children with medical conditions can participate in physical activities and extra-curricular sport and leisure. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being.

- Any restrictions on a child's ability to participate in PE should be recorded in their individual treatment plan.
- All staff should be aware of issues of privacy and dignity for children with particular needs.

Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma

inhalers. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

- More details about specific health conditions can be found in the Codes of Practice.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the most appropriate person identified by the child's individual treatment plan.

- Children may not be able to participate in off-site activities where their parents do not share relevant information or decline to give their appropriate consents
- Concerned staff should contact the Health & Safety section for advice

Emergency Procedures

Where children have conditions, which may require rapid intervention, parents must notify the Head teacher/manager of the condition, symptoms and appropriate action following onset, advice may need to be sought on an appropriate response. They should also share any individual treatment plan. All schools and services should have a risk management plan for such situations that covers all possible circumstances when the child is attending the school or service, including off-site activities. Planning should take into account access to a telephone in an emergency in order to summon medical assistance or an ambulance. The Headteacher/ manager must make all staff aware of any child whose medical condition may require emergency aid and staff should know:

- which children have individual treatment plans;
- possible emergency conditions that might arise, how to recognise the onset of the condition and take appropriate action i.e. summon the trained person, call for ambulance if necessary etc. and the emergency instructions contained within them;
- who is responsible for carrying out emergency procedures in the event of need;
- how to call the emergency services;
- what information from the individual treatment plan needs to be disclosed.

Other children should also know what to do in the event of an emergency, such as telling a member of staff.

When a child needs to go to hospital

Staff should not normally take children to hospital in their own car - it is safer to call an ambulance. However, in remote areas a school or service might wish to make arrangements with a local health professional for emergency cover. The national standards require early years' services to ensure that contingency arrangements are in place to cover such emergencies.

- A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives.
- Health professionals are responsible for any decisions on medical treatment when parents are not available.
- Training and practical advice on the recognition of the symptoms can usually be offered by a range of staff including Children in Care nurses, school nurses or community children's nurses who are employed by NHS Trusts.

Where an activity is planned where there is a known risk, however unlikely, that a child might need emergency health care, the risk assessment/individual treatment plan should address what should happen; exceptionally this may include a staff member using his or her own vehicle.

All such arrangements must be agreed and recorded in the child's individual treatment plan and be referred to Risk and Insurance for approval before they are carried out.

These guidelines do not cover First Aid or the role of trained First Aiders or appointed persons. Guidance is available in the County's Code of Practice for Health and Safety

(First Aid) Regulations 1981 or the Children & Younger Adults' Department Health and Safety Handbook.

Unusual Occurrences, Serious Illness or Injury

All parents should be informed of the school's/service's policy concerning children who become unwell whilst in the care of the school. This should be contained within the school's prospectus or service brochure. This will include home/mobile/work telephone numbers and other instructions e.g. relatives who can be contacted. If parents and relatives are not available when a pupil becomes seriously unwell or injured, the Head teacher/manager should, if necessary call an ambulance to transport the child to hospital.

- If the pupil is on medication, whether self-administered, under supervision or administered by staff, details must be provided to the emergency service, e.g. details of the written parental consent form in (Template 2 or 8and 11), the medicine itself and a copy of the last entry on the medication record form, see template 4/5 or 13-15

These guidelines do not cover First Aid or the role of trained First Aiders or appointed persons. Guidance is available in the County's Code of Practice for Health and Safety (First Aid) Regulations 1981 or the Education Department Health and Safety Handbook.

15 Staff Training

In addition to the basic training for their roles as children's services workers across all settings, all staff must be appropriately trained in the handling and use of medication, and have their competence assessed. The school's/service policy on the administration of medicines should state how frequently this should happen and when it will be reviewed and updated. All staff training should be documented for each staff member.

The minimum training requirements are:

- the supply, storage and disposal of medicines;
- safe administration of medicines;
- quality assurance and record-keeping;
- accountability, responsibility and confidentiality.

Three levels of training need to be delivered:

 induction training - identify what previous training and experience a new member of staff has had of giving medicines to people in order to ascertain whether they are competent to give medicines when they get to know the children & young people in their care and their needs.

 basic training in safe handling of medicines - basic training is intended to ensure that staff are competent to undertake the following:

- administer medication in tablet/liquid form;
- apply creams and lotions;
- administer eye drops, ear drops, nasal sprays;
- support individuals with inhalers;
- support individuals with 'when required' medications;
- support individuals with non-prescribed medications from approved list;
- support individuals who self-administer medicines.

Staff will also understand:

- the need for clear instructions and accurate record keeping;
- how to receive medicines and record instructions;
- the requirements for safe storage of medicines;
- how to record medicines administered;
- the arrangements for safe disposal/return of unused medicines;
- identify medicines and associated procedures for which specific training is required;
- understand when to seek advice.

 specialised training to give medicines - this only happens where:
    - it is part of a child/young persons' care plan;
    - a risk assessment has been carried out;
    - clear roles and responsibilities are agreed by the agencies and the people involved in providing care;
    - appropriate consents have been obtained from the young person or person with parental responsibility;
    - appropriate training has been provided and a worker's/carer's competence to carry out the procedure established – this will need to be refreshed at intervals determined by the training provider;
    - their agreement to do so has been recorded.

CODES OF PRACTICE

TO BE READ IN CONJUNCTION WITH:
Schools, other educational settings and Early Years: Managing Medicines in Schools and Early Years Settings
This code of practice will be subject to regular review as new guidance is drafted in response to the changing requirements of services

1 Allergy/Anaphylaxis
2 Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in school and other settings
3 Asthma
4 The asthma attack – What to do
5 Children with Diabetes needing insulin
6 Continence management & the use of Clean Intermittent Catheterisation (CIBC)
7 Epilepsy - Treatment of Prolonged Seizures
8 Action to be taken if a medicine administration error is identified
9 First Aid

The Handling of Medicines in Social Care: Royal Pharmaceutical Society
http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf
Managing Medicines in Schools and Early Years Settings:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108489aging-medicines-in-schools

1 Allergy / Anaphylaxis

This code of practice only applies when the acute allergic condition is known and notified to the school or service.

What is anaphylaxis?

Anaphylaxis is an extreme and severe allergic reaction. The whole body is affected, often within minutes of exposure to the allergen but sometimes after hours.

What can cause anaphylaxis?

Common causes include foods such as peanuts, tree nuts (e.g. almonds, walnuts, cashews, Brazils), sesame, fish, shellfish, dairy products and eggs. Non-food causes include wasp or bee stings, natural latex (rubber), penicillin or any other drug or injection. In some people, exercise can trigger a severe reaction - either on its own or in combination with other factors such as food or drugs (e.g. aspirin).

What are the symptoms?

- Generalised flushing of the skin
- Nettle rash (hives) anywhere on the body
- Sense of impending doom
- Swelling of throat and mouth
- Difficulty in swallowing or speaking
- Alterations in heart rate
- Severe asthma
- Abdominal pain, nausea and vomiting
- Sudden feeling of weakness (drop in blood pressure)
- Collapse and unconsciousness

An individual would not necessarily experience all of these symptoms

Why does anaphylaxis occur?
Any allergic reaction, including the most extreme form, anaphylactic shock, occurs because the body's immune system reacts inappropriately in response to the presence of a substance that it wrongly perceives as a threat. An anaphylactic reaction is caused by the sudden release of chemical substances, including histamine, from cells in the blood and tissues where they are stored. The release is triggered by the reaction between the allergic antibody (IgE) and the substance (allergen) causing the anaphylactic reaction. This mechanism is so sensitive that minute quantities of the allergen can cause a reaction. The released chemicals act on blood vessels to cause the swelling in the mouth and anywhere on the skin. There is a fall in blood pressure and, in asthmatics, the effect is mainly on the lungs.
Many reactions are mild and do not require specific treatment, but anaphylaxis is a very severe and life threatening allergic reaction affecting one or more of the body's systems and its organs – i.e. breathing difficulties or airway compromise/shock. It may happen very quickly or develop gradually.

Types of treatment
The treatment may involve both of the treatments below or just one of them, dependent on the type and severity of the reaction. At all times the individual treatment plan must be consulted.

- An oral antihistamine (Chlorphenamine)
- An Adrenaline injection (epinephrine) administered by EpiPen or Anapen which acts quickly to constrict blood vessels, relax smooth muscles in the lungs to improve breathing, stimulate the heartbeat and help to stop swelling around the face and lips.

Immediate emergency medical aid should be called in all cases where an adrenaline injection is administered, informing the doctor/ambulance service of the acute allergic reaction.

Additional Requirements
In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

- The parent must agree to be responsible for ensuring that the school/service is kept supplied with injections which are 'in date'.
- The Head teacher/Manager must ensure appropriate training and yearly updates are given to staff.

In schools the School Health Service following consultation with the prescribing Paediatrician is responsible for arranging the appropriate information and training for a minimum of two responsible persons who have consented to administer adrenaline. It may be necessary for the Head teacher to arrange for the teachers and other staff to be briefed about a child's condition and about the arrangements contained in the written instructions.

- If there are no consenting staff members to administer the medication, then an ambulance must be called should a child suffer a reaction.

Individual treatment plan
The instructions may include detailed arrangements for meals and that steps are taken to ensure that the child does not eat or handle any items of food other than items prepared/approved by the parents/guardians as far as is reasonably practicable. Consideration should be given to play materials, Science and Food Technology – all healthy snack initiatives/ healthy eating options.

- The School Health Service following consultation with the prescribing paediatrician is responsible for arranging the appropriate information and training

for sufficient staff to be identified to administer adrenaline in schools and education settings.

- An Individual Treatment Form must be completed by the Consultant Paediatrician or the General Practitioner.
- An individual treatment plan should be completed by the lead health professional in consultation the parents, school/service and, where appropriate nurse, including contact details for parents/carers, specific symptoms and medication for the child.

It will indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor. This should be used in accordance with the training provided for that individual child. In the event of the child showing any of the signs documented in their individual treatment plan, staff and carers are instructed to follow the agreed emergency procedure for that child documented in the plan.
If Adrenaline is administered then the emergency services/hospital must be given the used device for disposal and told the time of administration.

Storage and access
As the medication is required immediately, the adrenaline injection should be available to the responsible persons at all times, including off-site, trips/visits etc. It would be inappropriate to have the medication in a locked storage cabinet with limited access as any delay in administering the adrenaline is unwarranted.

- The location and access to a second syringe which may be provided as a reserve should be clearly known to the responsible persons.
- Appropriate arrangements must be agreed with parents for provision and safe handling of medication during educational visits away from the school/service.

Administration of medicines
The syringe carries a small concealed needle which needs triggering against an area of fatty tissue, e.g. side of the thigh. If a second injection is administered it must be in a different site on the thigh.

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

Although the administration of injections is considered to be a matter for medical staff, the advice is that this process can be carried out with confidence after appropriate training. Training can be provided by the School Health Service, the Children in Care Health Service or the Children's Community Nurse Training Team.

2. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in school and other settings
Introduction
Attention deficit disorder, with or without hyperactivity, are common problems in schools and other settings characterised by persistent and pervasive difficulties of concentration and attention control (ADD), frequently associated with hyperactivity (ADHD).
These children are easily distracted, have poor attention skills and lack the ability to concentrate for periods of time. They may also be impulsive and volatile resulting in actions they often find difficult to inhibit before it is too late. They are frequently therefore seen as "naughty", "defiant" and "disruptive".
Specific advice on management in schools is available via the Children & Younger Adults Department Educational Psychology Service pamphlet "Management of ADHD in schools".
ADD/ADHD may be associated with a wide range of other conditions including generalised learning difficulties, specific learning problems e.g. dyslexia and dyspraxia and in association with autism. It may also be secondary to emotional difficulties, neglect and other psychological problems.

Types of treatment
1. Behavioural strategies as outlined in 'Management of ADHD in schools'.
2. Individual Education Plan (IEP) developed with advice of Special Educational Needs Care Officer (SENCO), Local Inclusion Officer (IO) and Educational Psychologist.
3. A written care plan or specific behaviour management strategy under the supervision of an experienced clinician such as a psychologist or child Psychiatrist
4. Short acting medication e.g. Methylphenidate, ("Ritalin", "Equasym"), and Dexamphetamine. These are controlled drugs.
5. Long activating medication e.g. 'Concerta XL' and 'Equasym XL' and Atomoxetine ("Strattera"). These are controlled drugs

Additional Requirements
In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Individual treatment Plan
Any changes in child's behaviour, concentration and attention should be documented carefully to allow monitoring of the treatment.

Administration of Medicines
Methylphenidate treatment is short acting so timing of administration may be critical and may need to be adjusted to get maximum benefit with minimum side effects.
Variation of dosage must be notified in writing. Older children who are competent may self-administer but must be supervised to ensure medicine has been taken.

Overdose and Misuse
High doses of methylphenidate may cause side effects such as irritability, drowsiness, emotional liability and tics (twitches). Any symptoms suggesting side effects should be documented carefully and reported to parents so the dose of medication may be adjusted accordingly.
There is no evidence of drug dependency developing with Methylphenidate treatment.
Accidental overdose of treatment is unlikely to cause serious side effects. Any effects are likely to resolve quickly within hours of stopping treatment.
See code of Practice 8 "Action to be taken if a medicine administration error/near miss incident is identified"

3. Asthma
Introduction
Children with asthma have inflamed sensitive airways that can become acutely narrowed when in contact with certain triggers producing the characteristic symptoms of Cough, Breathlessness & Wheeze. Common triggers in children include viral infections, exercise, certain allergies (e.g. grasses & pollens, animal furs/feathers, house dust mite) cigarette smoke, emotion and stress.

Types of treatment
The most effective way to take asthma medications is to inhale them. This may be via:
- pressurised aerosol
- dry powder device – e.g. Diskhaler, Turbohaler, Accuhaler

The inhaled medicine has to be taken properly otherwise the medicine may spray out into the surrounding air, never getting down into the lungs and therefore have no effect.
The use of a "Spacer" (holding chamber) with the pressurised aerosol overcomes some of the problems children have using inhalers alone and is the most efficient way of getting the treatment into the lungs.

There are two types of treatment for asthma: -

- “Relievers”

  These are bronchodilators that reduce the airway narrowing that produces the wheeze & breathlessness. They result in immediate relief. They are BLUE (Ventolin/Bricanyl) inhalers.

- “Preventers”

  These treatments are needed to be taken regularly to reduce the inflammation & sensitivity of the airway. They are not helpful in acute attacks as they have no immediate effects. They are generally BROWN/ORANGE or PURPLE inhalers and contain inhaled corticosteroids.

Only “Reliever” inhalers need to be available in school and other settings.
“Preventer” treatments can all be prescribed in regimes that do not require these to be taken during school hours.
Children may be prescribed oral steroid tablets (prednisolone, betamethasone) if their asthma is poorly controlled. Generally, if they require oral steroids they are probably not fit for school. However, they only need to be taken once daily & should not be required to be given in school hours.

Additional Requirements
In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Written instructions
Written instructions should be provided with details of the “reliever” inhaler type & dosage provided for school/services. Availability of a Spacer should be recorded & encouraged. Instructions can also include details of how to help a child breathe. In an acute attack asthmatics tend to take quick shallow breaths and may panic. Some children are taught to adopt a particular posture which relaxes their chest and encourages them to breathe more slowly and deeply during an attack. If they have learnt such a technique encourage them to use it. The emphasis should always be on the rapid provision of “reliever” medication.

Labelling
There are several types of inhalers. It is the parent’s/guardian’s responsibility, in consultation with the child’s GP and dispensing chemist, to ensure that the inhalers rather than the boxes are clearly labelled with the child’s name and to identify the medicine as a “reliever” or “preventer” (as stated previously the availability of “preventer” inhalers in school/other settings should not be necessary). Pharmacists would not normally add this to the label and so this may appear on the label in the parents/guardians handwriting. This must then be checked against the parental consent form. Alternatively, parents/guardians can ask pharmacists to add this information to the label, this is the preferred option.
If a Spacer is provided then this also needs to be labelled with the child’s name, again the pharmacist should be asked to add this information.

Storage and access
Asthmatic children must have immediate access to their “reliever” inhaler at all times. Where possible children of junior school age and above should carry their own inhalers. It is not necessary to lock the inhalers away for safety reasons.
Younger children should be encouraged to be responsible and carry their own inhalers also. However, when this is not practically possible then parents may request after consultation with the Head teacher/person in charge for inhalers to be kept with the supervising teacher/worker for safe-keeping and ease of access.

Where Spacers are required arrangements need to be made for appropriate storage and access to these devices as it is not practical for them to be carried around by the child. Inhalers should be taken to swimming lessons, sports, cross country, team games etc. and on educational visits and used accordingly. Some children benefit from taking a dose of their “reliever” prior to taking part in exercise and this should be supported and encouraged.

Administration of medicines
Self-administration is the usual practice. Staff need to be alert to the possible over use of “reliever” inhalers and the Head teacher/person in charge should inform parents/guardians as appropriate.
In circumstances where staff assist a child to use an inhaler, an individual treatment plan provided by the parents in consultation with the GP/asthma nurse should be followed. A record should be made in the Medicine Record Form or equivalent.

Overdose/misuse
No significant danger to health results from occasional overdose/misuse of inhalers. They will do no harm to non-asthmatic children.

4. The Asthma Attack – What to Do
Ideally there should be a school plan of action for asthma attacks. If you do not have a plan of action follow the advice below.
If an asthmatic child becomes breathless and wheezy or coughs continually:
1 Let the child take their usual “reliever” treatment (BLUE INHALER) immediately – using the Spacer if available for that child
If the child has forgotten their inhaler and you do not have prior permission to use another inhaler:
- Call the parents/guardians;
- Failing that call the family doctor;
- Check the attack is not severe – see below.

2 Keep calm and reassure the child it’s treatable.
3 Help the child to breathe:
- Sit child upright – lean forward slightly (do not make them lie down);
- Encourage slow deep breaths;
- Offer a drink of water.

4 The reliever should work in 5 – 10 minutes.
5 If the symptoms disappear, the child can go back to what they were doing.
6 If the symptoms have improved, but not completely disappeared, call the parents and give another dose of the inhaler while waiting for them.
7 If the normal medication has had no effect, see severe asthma attack below.

What Is a Severe Attack?
Any of these signs mean severe:
- normal relief medication does not work at all;
- the child is breathless enough to have difficulty in talking normally;
- the child is distressed or becoming exhausted;
- the pulse rate is 120 per minute or more;
- rapid breathing of 30 breaths a minute or more.

How to Deal with A Severe Attack
Either follow your school protocol or:
- Call an ambulance (or the family doctor if they are likely to be able to come immediately);

- Get someone to inform the parents while you stay helping the child;
- Keep trying the usual reliever inhaler, preferably with a supplied Spacer, every few minutes and don't worry about the possibility of overdosing as reliever medication is extremely safe.

5. Children with Diabetes Needing Insulin

Introduction

These children need to monitor their blood sugars by blood testing. They are at risk of high and low blood sugars which may make them unwell.

Children with diabetes will be under the care of a hospital based diabetes team, including a Consultant Paediatrician, paediatric diabetes specialist nurses and dieticians.

The diabetic specialist nurse will be available to support the school staff. They will draw up written care plans agreed by parents, school or care staff and medical team for use as appropriate (see below).

New presentation of diabetes

Diabetes is becoming increasingly common in children. Typical symptoms include excessive thirst, needing to pass urine more frequently, weight loss.

If any of these symptoms are noticed by the teaching staff, the concerns should be raised with the parents so they can seek medical advice.

Routine Care

Insulin

Many children will require 2 injections a day (one before breakfast and one before tea) and therefore are unlikely to need to inject Insulin at school or day care settings.

An increasing number of children will be on 4 injections a day and will need to inject themselves with fast acting Insulin before their lunch.

A small number are now receiving insulin via an 'insulin pump' and receive a continuous infusion of Insulin. They will be trained to administer insulin via the pump before meals.

Those that require insulin before their lunch time meal, will have a pen injector device to administer Insulin.

Each child should have an individual Care Plan detailing:

- safe storage of the Insulin and pen injector;
- location of a private and safe room in which to do the injection;
- arrangements to ensure the child is able to eat immediately after giving the injection (e.g. pass for early school meal /packed lunch).

Blood testing

Children may be required to test their blood sugar prior to meals, prior to exercise and in an emergency situation (see hypoglycaemia and hyperglycaemia).

Each child should have an individual care plan detailing:

- safe storage of glucose meter and supplies;
- the individual performing the blood test. If this is someone other than the child or young person then they must receive training which is reviewed annually;
- safe disposal of all sharps and contaminated equipment.

Food

Children with diabetes should have a healthy balanced diet like all children – low in sugar but high in fibre.

It is however important that they eat at regular intervals – many will be advised to have a snack midmorning and mid-afternoon, in addition to their lunch, to avoid hypoglycaemia.

It is important that children with diabetes are:

- given priority in the queue at meal times;

 allowed to have snacks as directed by the diabetes team. These can usually be taken at break times but in some circumstances, may need to be eaten during class time.

Primary school children should have their snacks and meals supervised.

Physical activity

Children with diabetes should participate in all the usual activities. Physical activity may cause the blood sugar to fall and may cause a hypo. This can be avoided by having a snack before and possibly during or after an activity, depending on the level of activity.
Each child should have an Individual Care Plan detailing:

 Recommended snack prior to, during and after exercise as appropriate.

Common problems encountered

1. Hypoglycaemia (low blood sugar)

Hypoglycaemia ('hypo') is the commonest problem encountered and occurs when the blood sugar level falls too low (less than 4 mmo/l).
Typical symptoms and signs include: feeling faint, sweating, pallor, trembling or shakiness, lack of concentration, irrational or aggressive behaviour.
Hypo's can result from: a missed meal or delayed meal or snack, physical activity, too much insulin.

Treatment

It is very important that a hypo is treated quickly. If left untreated the blood sugar will fall further and the child could become unconscious.
Each child should have an individualised treatment plan and an emergency pack available in school containing:

 fast acting sugar (e.g. glucose, dextrose or lucozade tablets / sugary drinks), Glucogel (formerly known as hypostop gel) and snack foods.

The child should never be left unattended and the emergency box should be taken to taken to the child.
Management is as follows:

 testing of blood sugar if kit available;
 immediate treatment with fast acting sugar to quickly raise the blood sugar e.g. lucozade drink or glucose tablets;
 if the child is conscious but unable to cooperate with this treatment the Glucogel can be given. This is sugary gel which can be rubbed into the cheek;
 if the child is unconscious then contact emergency services immediately. Do not give Glucogel;
 once the hypo has been treated then the child will require a snack (or a meal if it is meal time).

2. Hyperglycaemia (high blood sugar)

High blood sugars cause thirst and the need to pass urine more frequently. If untreated, the child can become seriously unwell with vomiting and increasing drowsiness.
Management is as follows:

 check blood sugar;
 inform parent or carer immediately;
 if not available and child unwell: call emergency services.

Outings and Trips

Day trips

Children with diabetes should not be excluded from trips/activities which should be discussed with the parent /carer and, if necessary, the Diabetic Specialist Nurse.

It is important to take: blood testing kit, extra snacks and insulin and injection kit.

6 Continence Management and the Use of Clean Intermittent Catheterisation (CIBC)
Introduction
There are many causes of incontinence in children and therefore the management will vary. Every child requires individual assessment.

Learning, emotional and behavioural difficulties
Bladder and bowel control are a function of physical, intellectual and social development, therefore children with learning difficulties or emotional and behavioural difficulties may be incontinent. These children will require:
1. Full assessment by a continence advisor.
2. A toileting regime designed to accommodate the demands of the school day.
3. A positive rewarding approach.

Urinary continence problems with day time wetting
Daytime wetting is very common in children, particularly younger children in reception and infants. This is usually due to an irritable bladder precipitated by changes in routine when children enter school or move from an early years setting. A few will have an intrinsic problem which may require long term treatment.
Most continence problems may be managed by:
1. Increase total daily fluids spread evenly throughout the day, including school (<5 years 1 litre fluid a day, 5-11 years 1 ½ litres fluid a day, >11 years 2 litres fluid a day).
2. Avoiding irritant fluids e.g. blackcurrant juice and carbonated drinks.
3. Regular toileting usually in natural breaks in the school day, but for some children easy and immediate access to toilets is essential (“holding on” is counterproductive).
4. Medication e.g. oxybutynin may be required if other measures are insufficient and may need to be administered at school.

Neuropathic bladder and bowel
Bladder and bowel function is disrupted by abnormal development of the nerve supply and can rarely be cured by treatment. However, medication, surgery and specialist techniques can usually achieve a reasonable level of continence. To achieve social control requires very careful assessment by the continence adviser and doctors and a specific care plan implemented by children, parents and care staff. Such a care plan should be designed to achieve continence, encouraging as much independence as possible and respect for the child’s dignity and privacy.
All children will require:
1. Regular medical and nursing supervision
2. Private and accessible toilet facilities
3. Accessible cupboard to store equipment
4. Disposal facility for soiled pads and catheters
5. Assessment of welfare support needs
6. Independence training plan
7. Access to specialist counselling as and when required

Types of treatment
Regular Toileting
Planned usually to coincide with breaks in the day. Children may however require more frequent toileting to achieve specific short term gains in agreement with staff. Bowel continence can usually be managed at home.

Medication
Anticholinergics e.g. Oxybutynin may require administration as regular treatment. Children will require this during the day.

Catheterisation (CIBC)
This is a clean (usually not sterile) procedure and can often be performed by children with appropriate supervision. Most can catheterise on the toilet or in a wheelchair alongside the toilet. Whilst independence is being developed children will need supervision to ensure appropriate techniques and regular bladder emptying.

Additional Requirements
In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Storage and access
All equipment should be stored in a cupboard easily accessible to child and carer during catheterisation.
Toilet facilities must be easily accessible to the children with the advice of continence adviser and Occupational Therapist and be of sufficient size to allow procedures to take place easily but with sufficient privacy to preserve dignity and independence.
Facilities should be clean, secure, private and, if not for sole use, be accessible as required. Large schools need to consider the need for more than one facility to allow the child access to all facilities on site and access to all areas of the curriculum. Clearly this is essential for split site schools.

Administration of procedure
Training
 At least 2 suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave.
 Training should be provided by the appropriate specialist nurse through the School Health Service.
 It is the role of the school or service to supervise and support rather than carry out procedures wherever possible to aid the independence of the child.
 The child will require ongoing supervision. Skills may appear to have been lost during extended holidays but increased levels of supervision early in the term to aid settling in should restore efficiency.
 Staff training should be updated by the appropriate specialist nurse at regular intervals.
 Staff will require additional training in lifting and handling for children with additional mobility problems.

7 Epilepsy - Treatment of Prolonged Seizures
Introduction
Epilepsy is a tendency to have recurrent and unprovoked seizures. Most generalized convulsive seizures last for 2-3 minutes after which the child normally sleeps for a few hours. Status epilepticus develops when a seizure does not stop or one seizure happens after another without recovery in between. It is a rare occurrence, but it is a medical emergency due to abnormal breathing, stress on the heart and lack of oxygen leading to brain injury. Staff and carers are asked to give emergency medication to prevent this happening and to stop the seizure as soon as possible.

Types of Treatment
 Regular anti-epileptic medication to help prevent seizures – it is usually taken twice, very occasionally three times, a day: Sodium Valproate, Carbamazepine.

 Emergency Treatment (Rescue medication): rectal Diazepam and Buccal Midazolam.

Additional Requirements
In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Individual Treatment Plan
For each child who is likely to have prolonged seizures there must be an individual treatment plan signed by the most appropriate clinician i.e. epilepsy specialist nurse, paediatrician. This plan must state:

- what type of seizure to treat with emergency medication;
- what medication to give;
- the dose;
- at what point a paramedic ambulance should be called for;
- any other special instructions.

The individual treatment plan must be linked to individual treatment plan or individual safety plan.

Administration of Medicines
All staff/carers administering the emergency medication should have received training and have been assessed as competent to do so. This training is available through the Derbyshire Children's Community Nursing Training Team.

- Staff and carers will sign a form to confirm they have been trained in the use of Buccal Midazolam or rectal Diazepam.
- After the initial full training this training should be updated annually.
- It is the school's/agency's responsibility to contact the trainer to provide refresher teaching.

8 Action to Be Taken If a Medicine Administration Error/ Near Miss Incident Is Identified
The aim of all medication-related guidance is to minimise the risk of an administration error occurring. An error in medication administration is defined as any deviation from the prescribed dose.
Errors fall into three different categories (plus the temporary category of unresolved at the time):
(a) Major Error - is an incident which results in major harm or death, admission to hospital for 24 hours or more or in the service user being rendered unconscious.

- Major errors must be reported immediately to the Head Teacher to contact the Health and Safety Section.
- The Head teacher should report the incident to the HSE in line with CAYA

Accident Reporting Guidance if it results in a fatality or the pupil/service user going straight to hospital for treatment from the scene of the incident. This can be found at;

- The Head teacher should obtain any witness statements immediately or as soon as possible after the event.
- A written report detailing the facts must be completed within 24 hours and sent to Health and Safety Section together with this form. A copy must also be filed at the workplace.
- The Manager and a Health and Safety Officer will then compile a detailed accident investigation report
- Services subject to inspection will also need to notify the regulatory body

(b) Unresolved Error - is an incident the outcome of which for the service user is unknown at the time,
(c) Minor Error - is an incident which results in no significant harm to the service user

(d) Near Miss Incident - A near miss in medication administration is defined as an incident which might have resulted in an error if it had not been noted and rectified before the error occurred. There have been no consequences for the service user.
In all circumstances where there has been a failure to comply with written instructions, whether resulting in an over or under administration:

- advice as to what action should be taken should immediately be sought from the person who has prescribed the medication;
- if this person is not available, advice from another medical practitioner or pharmacist should be sought;
- where none of these are available, the local hospital accident and emergency department should be contacted;
- a full record of the incident and action taken is to be recorded,
- the following should be informed:
- Child's parents/carers
- Health & Safety section at County Hall:

Jerry Sanderson 01629 536499

Finally:

- the incident should be discussed with the staff team to ensure that any lessons are learned and any changes to practice/procedure introduced to ensure there is no recurrence.

9 First Aid

First aid can save lives and prevent minor injuries becoming major ones. It does not include giving tablets or medicines to treat illness. Although the regulations are intended to cover employees, the same level of treatment should be provided for all other persons – pupils/service users, parents, visitors, staff, contractors, members of the public etc.
Staff should consult their organisations Health & Safety at Work procedures.

APPENDIX 1 - USEFUL PRO-FORMAS

Based on DFES Guidance for schools and early years settings
Form 1 - Individual treatment plan
Form 2 - Parental Consent for Schools/Setting to Administer Medicine
Form 3 - Head teacher/Head of Setting Agreement to Administer Medicine
Form 4 - Record of medicine administered to an individual child
Form 5 - Staff training record – Administration of Medicines
Form 6 - Checklist – individual safety plan for children with disabilities and/or health/medication needs
Form 7 - Clinical procedure plan
Form 7a - Administration of emergency/recovery medication individual treatment plan
Form 8 - Clinical Procedures training record – individual
Form 9 - Health & medicines information sheet
Form 10 - Medication error/near miss incident report

Form 1 – Individual treatment plan

Name of School/Setting

Childs name

Date of birth Day / Month / Year

Group/Class/Form

Childs Address

Medical diagnosis or condition

Date

Review Date

Family Contact Information – First Contact

Name

Phone Number (work)

(home)

(mobile)

Family Contact Information – Second Contact

Name

Phone Number (work)

(home)

(mobile)

Clinic/Hospital Contact

Name

Phone Number

General Practitioner (G.P.)

Name

Phone Number

Describe medical needs and give details of child's symptoms

Daily care requirements (e.g. before sport/at lunchtime)

Describe what constitutes an emergency for the child, and the action to take if this occurs

Follow up care

Who is responsible in an emergency (state if different for off-site activities)

Form copies to

Form 2 - Parental Consent for Schools/Setting to Administer Medicine

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.
Note: Medicines must be in the original container as dispensed by the pharmacy

Name of School/Setting	
Date	Day / Month / Year
Childs name	
Date of birth	Day / Month / Year
Group/Class/Form	
Medical condition or illness	

Medicine

Name/type of medicine/strength *(as described on the container)*	
Date dispensed	Day / Month / Year
Expiry date	Day / Month / Year
Agreed review date to be initiated by (name of member of staff)	
Dosage and method	
Timing – when to be given	
Special precautions	
Any other instructions	
Number of tablets/quantity to be given to School/Setting	
Are there any side effects that the School/Setting needs to know about?	
Self-administration	Yes / No (*delete as appropriate*)
Procedures to take in an emergency	

Contact Details – First Contact

Name	
Daytime telephone number	
Relationship to child	
Address	

I understand that I must deliver the medicine personally to (agreed member of staff)

Contact Details – Second Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I accept that this is a service that the School/Setting is not obliged to undertake.
I understand that I must notify the School/Setting of any changes in writing

Date _____ Signature(s) _____

Parent's signature _____

Print name _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one.

For School/Setting Use

Reviewed by	Date	Signature	Print Name

To be reviewed annually or if dose changes

Form 3 - Head teacher/Head of Setting Agreement to Administer Medicine

Name of School/Setting

It is agreed that (name of child) _____ will receive (quantity and name of medicine) _____ every date at (time medicine to be administered e.g. lunchtime or afternoon break) _____.

(Name of child) _____ will be given/supervised whilst he/she takes their medication by (Name of member of staff) _____
_____
_____

This arrangement will continue until (either end date of course of medication or until instructed by parents) _____.

Date _____

Signed _____
(The Head teacher/Head of Setting/named member of staff

Form 4 - Record of medicine administered to an individual child

Name of School/Setting	
Childs name	
Date of birth	Day / Month / Year
Group/Class/Form	
Date medicine provided by parent	
Quantity received	
Name and strength of medicine	
Expiry date	Day / Month / Year
Quantity returned	
Dose and frequency of medicine	
Staff signature	
Signature of parent	

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			
Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			
Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Form 5 - Staff Training Record – Administration of Medicines

Name of School/Setting	
Name	
Types of training received	
Date of training completed	
Training provided by	
Profession and title	

I confirm that (name of member of staff) _____ has received the training details above, is competent and has agreed to carry out any necessary treatment. *

* *Use continuation sheet where more than one member of staff has been trained*

I recommend that the training is updated (please state how often) _____

Trainers signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Continuation sheet for staff team members who have received the training are competent and who have agreed to carry out the necessary treatment

I confirm that the following staff members _____ have received the training details above, are competent and have agreed to carry out any necessary treatment. *

Name	Post:	Signed to confirm receipt of training	Date

I recommend that the training is updated (please state how often) _____

Trainers signature _____

Date _____

Suggested review date _____

FORM 6	CHECKLIST – INDIVIDUAL SAFETY PLAN FOR CHILDREN WITH DISABILITIES AND/OR HEALTH/MEDICATION NEEDS		
CHILD'S NAME		**DOB**	

Please tick yes or no box to indicate whether or not a plan or a risk assessment is required. If you tick yes please state what document you have and where it can be found.

	Plan or Risk assessment required		LOCATION OF PLAN OR RISK ASSESSMENT Where existing/new document will be kept
	Y	**N**	
Allergies			
Health Issues			
Medication			
Feeding Plan			
Moving & Handling			
Behaviour			
Child Protection Plan			
Home Visiting			
Travelling			
Personal evacuation plan			
Other			

Completed by:		**Date:**	
To be reviewed in line with usual processes			

FORM 7 CLINICAL PROCEDURE PLAN			
CHILD'S NAME		**DOB**	

Type of procedure	

Is this a procedure covered by a Code of Practice?	**Yes**		**No**	

If ***yes***, please cross reference with the relevant code of practice.

If ***no,*** there should be a meeting with a manager, health & safety officer, clinicians, legal advisor, parent and others as necessary to consider alternative ways of meeting the needs and seeking to ensure that the health care needs do not become a barrier to service provision. The meeting should identify the following:

Instructions to staff/carers	
Under what conditions or circumstance do they apply?	

Possible difficulties that can be anticipated	**Agreed Response**

Risk to the child if plan is not followed	

The service will not be provided until the minimum training requirements have been fulfilled

Training needs identified	**To be provided by**

Plan agreed by:	Name	Signature
Parent/carer		
Worker		
Manager		

FORM 7a	**ADMINISTRATION OF EMERGENCY/RECOVERY MEDICATION INDIVIDUAL TREATMENT PLAN**		
CHILD'S NAME		**DOB**	

Name of Medication			
Its purpose			
When to be given List types of seizures including description of seizure and actions to be taken for each type **NB** **always cross-reference with the child's current care plan**			
Dose to be given			
Method of administration			
Child's usual response to the medication			
Further action			
Can a second dose be given and when?	**Yes**		Comments
	No		
At what point a paramedic ambulance should be called for			

Name of clinician completing this form	
Title	
Signature	
Date	
Contact details	

Name of parent	
Signature	
Date	
Contact details	

Or:

Signature of older child	
Date	

FORM 8: CLINICAL PROCEDURE TRAINING RECORD - INDIVIDUAL STAFF MEMBER

Worker/Carer Name:		**Post:**	
Setting and Address:			

Procedure:	

To be completed at time the procedure is demonstrated/competencies checked

1.	**MEDICAL PROFESSIONAL**	
I confirm that I have instructed the following in the above protocol/procedure in respect of:		
(Child's name):		
Signed, designation & date:		

2.	**WORKER / CARER**	
I confirm that I have received medical instruction and training for the above protocol/procedure from a medical professional and agree to carry it out.		
Signed & date:		

3.	**PARENT**	
I confirm that following training I am happy for the above-named worker/carer to carry out the above protocol procedure for my child.		
Signed & date:		

FORM 9 HEALTH & MEDICINES INFORMATION SHEET		**Date completed**	
CHILD'S NAME		**DOB**	

Disability/ condition									
Summary of health care needs									
Allergies									
Medication *including recovery medication*	Name	Form	Route	Purpose	Maximum dose in 24 hours	Time between doses	Effective for how long?	Equipment	Special instructions/ when medical advice should be sought

Equipment used/required	**Provider**	**Training**	**By whom**	**Fitted by**
Diet				
GP			**Tel**	
Address				
Consultant/ Community Nurse/ Other			**Tel**	
Address				
Optician			**Tel**	
Address				
Dentist			**Tel**	
Address				
Form completed by:			**Date:**	

FORM 10 MEDICATION ERROR/NEAR MISS INCIDENT REPORT

1.	**Level of Error**		✓
	(a) Major Error	(Incident resulting in major harm or death)	
	(b) Unresolved Error	(The outcome at present unknown)	
	(c) Minor Error	(No serious harm suffered)	
	(d) Near Miss	(Error was avoided)	

2.	**Service details**	
	Service name	
	Address	
	Telephone	
	Person in Charge	

3.	**Person completing this form – *sign and date at end of form***	
	Name	
	Job Title	

4.	**Person(s) involved in the incident**	
	Name 1	
	Job Title	
	Name 2	
	Job Title	
	Name 3	
	Job Title	

5.	**Details of the medication error or near miss**	
	Name of Child/ Young Person	
	Date and time error occurred	
	Date and time error discovered	
	Details of the error - attach separate report if necessary	

6.	**Health professionals involved with the child/young person**	
	GP	
	Consultant	
	Nurse	
	Pharmacist	

7.	**All others staff/persons involved in the incident**			
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	

8.	**Who was contacted for advice?**					
	GP	Yes	No	NHS Direct	Yes	No
	Consultant	Yes	No	H&S Officer	Yes	No
	Nurse	Yes	No	Parent	Yes	No
	Pharmacist	Yes	No		Yes	
	Time of Contact	Advice received:				
	Time of Contact	Advice received:				

9.	**Advice and Action**			
	By whom - name and contact details		Time	
	Advice given			
	Action Taken			
	By Whom		Time	
	Advice given			
	Action Taken			

10.	**Who has been informed about the incident**			
				If no, give reasons
	Child/young person	Yes	No	
	Parent/Person with PR	Yes	No	
	Other Carer	Yes	No	
	Manager	Yes	No	
	H&S Officer	Yes	No	
	Head of Quality Assurance	Yes	No	If child/young person is in care
		Yes		

11.	**Type of incident**	**Detail**	✓
	Wrong service user		
	Wrong quantity given		
	Wrong strength of medicine administered		
	Wrong form of the medicine		
	Dose omitted		
	Wrong medicine given		
	Medicine out of date		
	Recording error		
	Medicine given at wrong time		
	Medicine refused/staff unable to administer		
	Other		

12.	Cause of incident	Detail	✓
	Unclear labelling caused confusion		
	Unclear instructions caused confusion		
	Wrong service user name		
	Product out of date		
	Interruptions		
	Service user refused		
	Staff/carer unable to administer		
	Other cause		

13.	Immediate action to be taken	✓
	Investigation by manager	
	Investigation by Health and Safety Officer	
	Investigation under complaints procedure	
	Investigation by external body	

14.	Action to prevent a recurrence	✓
	Workplace procedures/systems review	
	Workplace training	
	Wider procedures/systems review	
	Wider training	

15.	Additional Notifications – ***Major Incident Only***	✓
	Health& Safety Officer	
	Health & Safety Executive	
	Senior Departmental Manager	
	OFSTED	
	CQC	

Name		**Position**	
Signed		**Date**	

Useful Contacts

Children's Community Nurse Training Team (North County)
The Den, Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire, S44 5 BL
Tel: 01246 514563
Fax: 01246 512630

Children's Community Nurse Training Team (Countywide)
The Den, Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire, S44 5 BL
Tel: 01246 514511
Fax: 01246 514424

Allergy UK
Allergy Help Line: (01322) 619898
Website: www.allergyfoundation.com

The Anaphylaxis Campaign
Helpline: (01252) 542029
Website: www.anaphylaxis.org.uk and www.allergyinschools.co.uk

SHINE (formerly Association for Spina Bifida and Hydrocephalus)
Tel: (01733) 555988 (9am to 5pm)
Website: www.shinecharity.org.uk

Asthma UK (formerly the National Asthma Campaign)
Asthma UK Adviceline: 0800 121 62 44 (Mon-Fri 9am to 5pm)
Website: www.asthma.org.uk

Council for Disabled Children
Tel: (0207) 843 1900; cdc@ncb.org.uk
Website: http://www.councilfordisabledchildren.org.uk/

Contact a Family for families with disabled children
Helpline: 0808 808 3555; helpline@cafamily.org.uk
Website: www.cafamily.org.uk

Cystic Fibrosis Trust Helpline: 0300 373 1000
Website: www.cftrust.org.uk

Diabetes UK
Supporter Services: 0845 123 2399, Monday to Friday 9am to 5pm.
supporterservices@diabetes.org.uk
Website: www.diabetes.org.uk

Department for Education
Telephone: 0370 000 2288 Typetalk: 18001 0370 000 2288 Fax: 01928 738248
Website: www.education.gov.uk/

Department of Health Phone: 020 7210 4850 (Office opening hours 08:30-17:30 Mon-Fri) Textphone: 020 7210 5025 (for people with impaired hearing) Fax: 020 7210 5952
Online: web contact form

Website: www.dh.gov.uk

Equalities & Human Rights Commission (DRC)
Equality and Human Rights Commission Helpline: 0845 604 6610
Monday - Friday 8am - 6pm
Textphone: 0845 604 6620 Fax: 0845 604 6630
Freepost RRLL-GHUX-CTRX, Arndale House, Arndale Centre, Manchester , M4 3AQ
Email: englandhelpline@equalityhumanrights.com
Website: http://www.equalityhumanrights.com/

Epilepsy Action
Freephone Helpline: 0808 800 5050 (Mon – Thurs 9am to 4.30pm, Fri 9am to 4pm)
Fax: (01133) 910300 (UK)
Email: epilepsy@epilepsy.org.uk
Website: www.epilepsy.org.uk

Health and Safety Executive (HSE)
HSE Infoline: 08701 545500 (Mon-Fri 8am-6pm)
Website: www.hse.gov.uk
Health Education Trust
Tel: (01789) 773915
Website: www.healthedtrust.com

Hyperactive Children's Support Group
Tel: (01243) 551313
Website: www.hacsg.org.uk

MENCAP
Learning Disability Helpline: 0808 808 1111
Mencap Direct: 0300 333 1111
Website: www.mencap.org.uk

National Eczema Society
Helpline: 0800 089 (Mon-Fri 8am to 8pm)
Website: www.eczema.org

NHS Direct
Helpline: 0845 4647
Website: www.nhsdirect.nhs.uk/

Epilepsy Society
Helpline: (01494) 601 400 (Mon-Fri 10am to 4pm)
Website: http://www.epilepsysociety.org.uk/

Psoriasis Association
Tel: 0845 676 0076 (Mon-Thurs 9.15am to 4.45pm Fri 9.15am to 16.15pm)
Fax (01604) 251621
Email: mail@psoriasis-association.org.uk Website: www.psoriasis-association.org.uk/

North Derbyshire
School Health Service School Health Department,
Poplar Court, Chesterfield Royal Hospital
Calow, Chesterfield

Derbyshire S44 5BL
Tel: 01246 516102
Community Childrens Team
The Den, Chesterfield Royal Hospital
Calow, Chesterfield
Derbyshire S44 5BL
Tel: 01246 514563

South Derbyshire Special Needs Care Programme
(School Nursing)
Wilderslow
121 – 123 Osmaston Road
Derby DE1 2GA
Tel: 01332 363371

ERIC 34 Old School House
Britannia Road
Kingswood
Bristol
BS15 8DL

PromoCon Redbank House
4 St Chad's Street
Manchester
M8 8QA
Tel: 0870 7774 714

ASBAH – Association ASBAH House
for Spina Bifida 42 Park Road
and Hydrocephalus Peterborough PE21 2UQ
Tel: 01733 555988

FLARE Derbyshire ADHD support service
01246 969012
flareadhd@aol.com

Asthma UK provide guidelines for school and other settings to help them develop a Schools Asthma Policy. They also provide a sample "School Asthma Card" to be completed by the parent/carer giving required details of asthma medication.
Asthma UK
Summit House
70 Wilson Street
London
EC2A 2DB
or
www.asthma.org.uk

North Derbyshire
Chesterfield Royal Hospital
Office hours: 01246 512113 and ask for Diabetic Liaison Nurse
Out of hours: 01246 277271 and ask for Paediatric registrar
Diabetes UK www.diabetes.org.uk
'Children with diabetes at school: what all staff need to know.'