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Document Adopted By Governing Body	
Date Document Adopted By Governing Body:	January 2019
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Date:	September 2020
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Date of Next Review:	September 2021

Managing Medicines in School Policy

2020

Managing Children and Young People's Identified Health Needs

Guidance for Schools and Other Education Settings

Sheffield Children and Young People's Service

Sheffield City Council

Issued June 2012

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Sheffield Children and Young People's Service

Managing Children and Young People's Identified Health Needs

Guidance for Schools and Other Education Settings

Introduction

This guidance is designed to help schools and other children and young people's settings develop policies on managing medicines and put in place effective systems to support individual children with medical needs. Positive responses by schools and settings to a child/young person's medical needs will not only benefit the child/young person directly but can also positively influence the attitude of their peers.

This document sets out a clear framework and approved guidelines for schools and other settings to implement ensuring that children and young people requiring medicines and care receive the support they need.

The document is regarded as an essential reference point when schools and settings are dealing with medical/health issues which may not be directly covered in existing policies. Ideally a managing health needs policy should be in place as a stand alone policy to ensure it receives due attention within your school or setting, but it can also be integrated into other current policies such as first aid, health and safety and healthy schools policies. You may already have a policy on the safe storage of medicines or an anaphylaxis policy which can also be combined.

Employees of Sheffield City Council who are not medical healthcare professionals will be supported by their school/setting and the Local Authority in carrying out specified duties, and covered by the Local Authority's insurance arrangements in the circumstances listed in Annex B (Insurers Schedule of Covered Activities), provided that they follow this policy, any care plan in place, act in good faith[1] and act in accordance with their training.

This guidance aims to support schools and settings to:

- Review current policies and procedures in relation to managing children and young people's identified health needs
- Put in place effective management systems to help support individual children and young people with medical needs
- Make sure that medicines are handled responsibly in schools and other children and young people's settings
- Help ensure that all school staff are clear about what action to take in an emergency

[1] This is a legal insurance term to indicate a bond between the insurer and insured. It refers to staff doing something with the best of intentions.

Scope of the guidance

- Addressing the needs of children and young people with long-term medical/health needs including the requirement, development and management of health care plans.

- Meeting the needs of children and young people who require medication in certain circumstances such as during PE lessons or educational visits.

- Meeting the needs of children and young people with short term medical/health needs.

- Parental consent to administer non-prescribed medicines or common remedies, for a period not exceeding eight days (including weekends).

- Supporting children and young people who self-administer their own medication.

All children and young people with medical/health needs have the same rights of admission to a school or other setting as other children who do not have medical needs. For example, this will include children or young people with asthma, epilepsy, diabetes, anaphylaxis or incontinence.

This guidance aims to cover all Sheffield children and young people settings including nurseries, early year's settings, schools and colleges in both the statutory and non statutory sector. The policy covers holiday provision, day and overnight trips and the extended school day.

The following guidance and model policy draw directly on advice contained within DfES publication '*Managing Medicines in Schools and Early Years Settings*': DfES/Department of Health 2005 Ref 1448-2005 DCL-EN.

Equality Act 2010 - Access to education and associated services

From the 1st October 2010 the Equality Act 2010 replaced most of the Disability Discrimination Act 1995. However the Disability Equality Duty in the Disability Discrimination Act continues to apply.

The Equalities Act 2010 still provides protection for children with medical needs from being discriminated against. The Act defines a person as having a disability if s/he has a physical, sensory or mental impairment which has a substantial and long-term adverse effect on her/his abilities to carry out normal day-to-day activities.

Under the Equalities Act 2010, responsible bodies for schools (including nursery schools) must not discriminate either directly or indirectly against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips, clubs and activities. Schools should be making reasonable adjustments for disabled children, including those with medical needs at different levels of school life; and for the individual disabled child who has a disability, in their practices and procedures and in their policies.

Schools are also under a duty to plan strategically to increase access, over time, for disabled children who have a disability, including those with medical needs.

Early years settings not constituted as schools, including childminders and other private, voluntary and statutory provision are also covered by the Equality Act 2010 and should be making reasonable adjustments for disabled children, including those with medical needs to access their facilities and services.

The National Curriculum Inclusion Statement 2000 emphasises the importance of providing effective learning opportunities for all pupils, in terms of:

- Setting suitable learning challenges
- Responding to pupils' diverse needs
- Overcoming potential barriers to learning

If schools/settings encounter difficulties in making adjustments to accommodate children with medical needs, advice may be sought from the Sheffield City Council Hospital and Home Education Service, Tel: (0114) 239 7711.

Duty of Care

The setting manager is responsible for ensuring that the duty of care is discharged within their setting.

If head teachers/staff follow the statutory requirements (including those contained in the Children Act 1989, Human Rights Act 1998 and Equality Act 2010) and do all they can to protect and encourage the child/young person's welfare, then they are acting within the laws of their profession. In addition, to the statutory responsibilities there is also a common law duty to the children and breach of this duty may lead to an action of negligence under the Law of Torts. However, parties will not have breached their duty of care if they have acted in accordance with and applied their professional judgment, training and experience.

Where a school/setting delegates provision of such activities to an external 3rd party provider, the duty of care transfers from the head teacher/setting manager to the provider or contractor running the activity. This must be built in to contracts with external providers so that the medical/health needs of the children/young people attending the sessions continue to be met and providers fully understand their responsibilities.

Roles have been developed for support staff that build the administration of medicines and other health needs into their core job description and contracts of employment. In addition to this there is a voluntary model with allowances available to schools to apply and engage appropriately trained staff in these duties. Schools/settings should ensure that they have sufficient members of staff who are appropriately trained to manage medicines and health needs as part of their duties.

Support for children and young people with medical/health needs

Parents/carers have the prime responsibility for their child's health and should provide schools and settings with detailed information about their child's medical condition. This responsibility should be communicated to parents/carers via school/setting parent/carer meetings and/or prospectus/school website information.

Alongside this it is crucial that all staff working in children and young people's settings understand how the setting will manage the administration of both

prescribed and non-prescribed medicines and also understand the setting's responsibilities with respect to duty of care.

Administering prescription medicines

In many cases a child/young person's medication will have been prescribed for them by a GP, Prescribing Nurse, Dentist or a Pharmacist. In these instances the school/setting should identify a competent member of staff to administer these medicines if the child/young person is not self-administering. The guidelines in this policy in relation to the safe storage of medicines, staff training and emergency procedures should be followed.

Administering non-prescription medicines/common remedies

If a child/young person arrives at the setting with medicine or a common remedy such as paracetomol or anti-histamines that haven't been prescribed for them by a GP, Prescribing Nurse, Dentist or Pharmacist, parent/carer consent should be sought before the medicine is administered (Form 3). **In all cases written Parent/Carer consent should be sought in the first instance. It is only in situations where parental consent is unobtainable that staff should act in "loco parentis."**

- **Loco parentis**

  Under the Children Act 1989, anyone caring for children including teachers, other school staff and day care staff in charge of children, have a common law duty of care to act like any reasonably prudent parent traditionally referred to as 'in loco parentis'. Legally, while not bound by parental responsibility, teachers/school staff must behave as any reasonable parent would do in promoting the welfare, health and safety of children in their care.

  In exceptional circumstances where parental consent is unobtainable, the member of staff acting in loco parentis should use their judgement to determine if the non-prescription medication should be given if a health care plan is not in place and this action should be recorded.

  This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips and after-school/hours sessions/clubs that are running in schools/settings before or after the end of the school day.

Children/young people and parents/carers should not be routinely told that they require a prescription for over the counter medicines/common remedies as this could impact on their attendance. If a child/young person's symptoms persist they should be advised to seek medical attention. If a child/young person is deemed too unwell to be in school/attend the setting they should be advised to stay at home or be sent home if they are too unwell to attend.

Non-medical creams and lotions, such as sun cream and moisturisers, should not require a prescription or medical note; however, schools/settings should encourage parents/carers to provide these in labelled original packaging with written consent. A best practice sun protection policy is available for schools / settings to adopt from Cancer Research UK at www.sunsmart.org.uk. Additional advice & risk assessments with regard to exposure to sun are available on the Health Safety & Risk Document Centre of SchoolPoint.

Staff authorised to apply creams/lotions on behalf of those pupils not capable of undertaking this task themselves should be suitably competent to do so, be provided with protective equipment (e.g. gloves) and ensure cross contamination/infection is prevented.

Managing situations and assessing the risks where young people manage/administer their own medication

In other situations young people, who are competent (defined as Gillick competent see below), may choose to manage their own medication, this is particularly common amongst secondary school aged children and in post 16 educational settings.

A young person is described as 'Gillick competent' and can self consent if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved.

Short term conditions

Occasionally children and young people who are in your care may wish to manage their own medication. In these cases the child/young person's parent/carer should be encouraged to complete Form 7 providing permission for them to carry their own medication (where this is not already stated in a health care plan).

If a child is not deemed Gillick competent and do not have the capacity to consent to manage their own medication, someone with parental responsibility can consent for them. This should be recorded and fed back to parents/carers. If parent/carer consent is unobtainable the individual acting in loco parentis should record this and encourage the young person to manage their medication in accordance with the dosage information on the original packaging. The young person should be advised to seek medical advice from a GP if their symptoms persist and the school/setting must speak to the parent/carer as soon as is practically possible and obtain written consent if the situation is to continue.

Long term conditions

It is good practice to support and encourage children and young people who are able to take responsibility to manage their own medicines. This might be managing their inhaler if they suffer with asthma or injecting insulin if they are diabetic. If such medicines are taken under supervision this should be recorded, such as on Form 5 or 6. There is no set age when a child or young person can take responsibility for their own medication, this needs to be a joint decision between the school/setting, parents/carers and the child/young person.

Where children and young people have been prescribed controlled drugs, these must be kept in safe custody. Access arrangements for self-medication could be put in place, if it was agreed that this was appropriate.

The management of both prescription and non-prescription medication for children and young people with a long term condition (lasting for over 8 days including weekends) must be included in a written health care plan.

Home to school travel and transport

Home to school transport can be considered as a setting in its own right. Sheffield City Council has a duty to ensure that pupils are safe during journeys. All drivers and escorts in Sheffield receive the appropriate basic first aid training plus epilepsy and allergy awareness. Additionally trained escorts may be needed to support some pupils with complex health needs according to their health care plans.

Drivers and escorts should know what to do in the case of a medical emergency and operate to agreed safe systems of work. With the exception of the Epi-pen they will not generally administer medicines, but where the Local Authority agrees that a driver or escort will administer medicines they must receive training and support and fully understand what procedures and protocols to follow and work to. They should be clear about roles, responsibilities and liabilities.

Where pupils have complex health needs, specific health care plans (or specific essential information from the plan) should be carried on vehicles. Advice should be sought from the pupil's school, and input will be needed from parents/carers and the responsible health professionals. The care plans should specify the steps to be taken to support the normal care of the pupil, as well as the appropriate responses to emergency situations.

Some pupils are at risk of severe allergic reactions. Risks can be minimised by not permitting eating on vehicles, and Sheffield has a policy of not allowing eating or drinking on vehicles.

Developing policies

Employers, including Local Authorities and school governing bodies, must have a health and safety policy by law. Schools and settings should review existing health and safety policies in order to ensure that they incorporate the management of medicines and the support of children with medical needs.

The registered person in early year's settings, which can legally be a management group rather than an individual, is responsible for the health and safety of children in their care. The legal framework for registered early year's settings is derived from both health and safety legislation and the National Standards for regulation of day care.

Settings outside the LA must take out Employers and Public Liability Insurance to provide cover to staff acting within the scope of their employment and provide against the possibility of litigation by those in their care. Employers should make sure that their insurance arrangements provide full cover in respect of these actions.

Head teachers and governors of schools should also want to ensure that policy and procedures are compatible and consistent with any registered day care (e.g. out of school club) operated by them or an external provider on the school premises.

Policies should aim to enable regular attendance whilst minimising exposure to potential risk to both children/young people and the staff who care for them. Formal systems and documented procedures in respect of administering medicines and

care, developed in partnership with parents/carers, health professionals and staff should back up the policy.

A policy needs to be clear to all staff, parents/carers and children. It could be included in the prospectus, or in other information for parents/carers.

The following model policy is offered for incorporation, or as a basis for incorporating the management of medicines, into the Health and Safety policy of schools and settings in Sheffield. A check list is provided in Annex D, to assist in decision-making, alongside the Local Authority's Insurer's schedule of approved activities (Annex B). Please note that some procedures show as not approved in Annex B may be approved by the Local Authority Insurers on an individual named child basis, as part of an individual health care plan.

Managing Children and Young People's Identified Health Needs Policy

Date Policy Approved:
Date Policy due to be reviewed:

School/setting name:

Ecclesall Primary School is committed to reducing the barriers to participating in school/nursery life and learning for all its children and young people. This policy sets out the steps which Ecclesall Primary School will take to ensure full access to learning for all its children and young people who have medical/health needs and are able to attend. Medicines should only be brought in to school or the setting when essential; that is where it would be detrimental to a child/young person's health if the medicine were not administered during the school/setting day and where approval to do so has been sought and given. The school will inform parents/carers of this policy.

1. Managing medicines which need to be taken during the day.

1.2 Parents/carers must provide full *written* information about their child's medical needs to the school/setting where their child attends.

1.3 Short-term prescription requirements should only be brought to the school/setting if it is detrimental to the child or young person's health not to have the medicine during the day. If the period of administering medicine is prolonged for any reason (more than 8 days including weekends) an individual health care plan is required.

1.4 The school/setting will not accept medicines that have been taken out of the container as originally dispensed, which aren't labelled with the child's details or make changes to prescribed dosages on parental or child instructions.

Medicines should always be provided in the original container as dispensed by a pharmacist and should include the prescriber's instructions for administration. In all cases this should include:

- Name of child
- Name of medicine
- Dose
- Method of administration
- Time/frequency of administration
- Any side effects that the school/setting needs to know about
- Expiry date

1.5 In some cases the school/setting may administer a non-prescribed medicine/common remedy if parent/carer consent is gained or in exceptional circumstances where parental consent is unobtainable and a member of staff is acting in loco parentis, for a period not exceeding eight days (including weekends)

1.6 The school/setting will not regularly administer medicines that have not been prescribed by a Doctor, Dentist, Nurse Prescriber or Pharmacist Prescriber, unless it is done as part of an individual health care plan. Should a

school/setting receive regular/repeated parental consent to administer non-prescribed medicines this will be referred to the school nurse for advice.

1.7 Some medicines prescribed for children (e.g. methylphenidate, known as Ritalin) are controlled by the Misuse of Drugs Act. Members of staff are authorised to administer a controlled drug, in accordance with the prescriber's instructions. A child may legally have a prescribed controlled drug in their possession, however to minimise risks to all pupils this school/setting will keep all controlled drugs on behalf of pupils. The school/setting will keep controlled drugs in safe custody in a locked non-portable container, to which only named staff will have access. A record of access to the container will be kept. Misuse of a controlled drug is an offence, (i.e. the use of medicines for purposes other than their prescribed intended purpose) and will be dealt with under the school's behaviour or code of conduct policy.

1.8 Young people who are competent to manage their own medication/care will be supported to do so, where parent consent is given or young people are judged to be Gillick competent.

1.9 The school/setting will refer to the current DfE guidance document when dealing with any other particular issues relating to managing medicines.

2. Procedures for managing medicines on trips and outings and during sporting activities

2.1 The school/setting will consider what reasonable adjustments might be made to enable children with medical needs to participate fully and safely on visits. This may extend to reviewing and revising the visits policy and procedures so that planning arrangements incorporate the necessary steps to include children/young people with medical needs. It might also incorporate risk assessments for such children and information from their individual health care plan.

2.2 If staff are concerned about how they can best provide for a child's safety or the safety of other children on a visit, they should seek parental views and advice from a health professional or the child's GP.

2.3 The school/setting will support children/young people wherever possible in participating in physical activities and extra-curricular sport. There should be sufficient flexibility for all children and young people to follow in ways appropriate to their own abilities. Any restriction on a child's ability to participate in PE should be recorded on their health care plan. All adults should be aware of issues of privacy and dignity for children and young people with particular needs.

2.4 Some children/young people may need to take precautionary measures before or during exercise, and may need access, for example, to asthma inhalers. Staff supervising sporting activities should be aware of relevant medical/health conditions, and will consider the need for any specific risk assessment to be undertaken.

2.5 The school/setting must fully cooperate with Sheffield City Council in fulfilling its responsibilities regarding home to school transport. This may include giving

advice and/or suitable training regarding a child/young person's medical needs, emergency procedures and sharing of health care plans.

3. The roles and responsibilities of staff managing administration of medicines

3.1 Close co-operation, and use of a standard process between schools, settings, parents/carers, health professionals and other agencies will provide a suitably supportive environment for children/young people with medical needs.

3.2 It is important that responsibility for child safety is clearly defined within each school/setting and that each person responsible for a child with medical needs is aware of and competent to undertake what is expected of them.

3.3 The school/setting will always take full account of authorised volunteers, temporary, supply and peripatetic staff when informing staff of arrangements in place for the administration of medicines and care.

3.4 The school/setting will always designate a minimum of two people it considers suitable and competent to be responsible for the administering of medicine to a child to ensure back up arrangements are in place for when the principal member of staff with responsibility is absent or unavailable. All such staff will undertake a competence assessment (example provided in annex E) prior to undertaking the administration of medicines.

Administration of Rectal Diazepam requires 2 adults and where possible at least one of the same gender as the child to be present because it is invasive.

3.5 Parent/carer consent will be sought before medication/care is given to a child/young person and medicine/care required for a short-term condition (under 8 days including weekends) should be logged on Form 3.

Occasionally the school may be required to administer a non-prescribed medicine or common remedy such as paracetomol or anti-histamines to a child or young person. The consent form (Form 3) is required each time a non-prescribed medicine/common remedy is given, except for exceptional circumstances where a member of staff acts in loco parentis and this is recorded (Form 5). Parents/carers will be informed that all non-prescribed medication should be retained in the original packaging including the information leaflet supplied.

Staff should consider any potential reactions between medications (especially where a child is taking) a prescribed and a non-prescribed medication at the same time as there could be potential side effects. Where staff administering medicines are unsure they should consult a health care professional or pharmacist for advice.

Where the head teacher or staff member agrees to administer medicine to a child for which parental consent has been recorded, it must be in accordance with this policy and agreement to do so should be recorded on Form 4. The school/setting will inform parents/carers of this policy.

Where medicine/care is administered to a child it should be recorded on a form such as Form 5 or 6. If a child suffers from frequent or acute pain the parents/carers should be encouraged to refer the matter to the child's GP.

A health care plan is only required for the administration of medicines/care if the child/young person's condition is considered long term (over 8 days including the weekend). Parent/carer consent will be sought before the medicine is given to the child/young person and any prescribed medicine to be given and parental consent should be additionally logged on Form 3.

3.6 National Guidance states: '**A child under 16 should never be given aspirin-containing medicine unless prescribed by a doctor'.** The school/setting will inform parents/carers of this policy.

3.7 Any controlled drugs which have been prescribed for a child/young person will be kept in safe and secure custody by a nominated person within the school/setting.

3.8 If a child/young person refuses to take medicine, staff will not force them to do so. Staff will record the incident and follow agreed procedures set out in this policy, such as recording 'refused to take' on Form 5 or 6 or as stated in the child's health care plan. The head teacher/setting manager and parents/carers will be informed of the refusal on the same day. If refusal results in an emergency, the school/setting's normal emergency procedures will be followed.

3.9 If in doubt about a procedure, staff will not administer the medicine or care procedure, but will check with the parents/carers or a health professional before taking further action.

4. Parent/carer responsibilities in respect of their child's medical needs

4.1 It is the parents/carers' responsibility to provide the head teacher/setting manager with sufficient written information about their child's medical/health needs if treatment or special care is required.

4.2 Parents/carers are expected to work with the head teacher/setting manager to reach an agreement on the school/setting's role in supporting their child's medical needs, in accordance with the schools/setting's policy.

Responsibility for administering non-prescribed medicines or common remedies to a child or young person in a school or other setting lies with the child/young person's parent/carer. It is the child/young person's parent/carer who is responsible for providing permission for the issuing of non-prescribed medicines in the first instance. It requires only one parent/carer to agree to or request that medicines are administered to a child. It is likely that this will be the parent/carer with whom the school or setting has day-to-day contact. Parent/carers will be advised that the school will not administer non prescribed medications for a period exceeding 8 days (including weekends) without a written care plan.

4.3 The head teacher/setting manager should have written parental agreement before passing on information about their child's health to other staff including transport staff. Sharing information is important if staff and parents/carers are

to ensure the best care for a child. Where a care plan is appropriate, parent/carers should have input into such a plan and must be prepared for all to share.

4.4 In some cases parents/carers may have difficulty understanding or supporting their child's medical condition themselves and in these cases they should be encouraged to contact a health professional or key health worker from the setting to advocate for them, either the school nurse or the health visitor, as appropriate.

4.5 It is the parents/carers' responsibility to keep their children at home when they are acutely unwell.

4.6 Prior written agreement should be obtained from parents/carers for any medicines to be given to a child/young person, except where a member of staff acts in loco parentis and gives non-prescribed medication in exceptional circumstances. (See specimen forms in Annex C.)

5. Supporting children with long-term or complex medical needs

5.1 Where there are long-term medical needs for a child, including administration of medicine for a period of 8 days (including weekends) or more, a health care plan must be completed, such as using Form 2, involving both parents/carers and relevant health professionals.

A health care plan clarifies for staff, parents/carers and the child the help that can be provided. It is important for staff to be guided by a health professional the school nurse or the child's GP or paediatrician.

5.2 Developing children and young people's health care plans

The school/setting will work in partnership with parents/carers, the School Nurse and/or specialist teams as appropriate, including Sheffield Children's Hospital NHS Foundation Trust, to develop in-school/setting care plans to ensure high quality, evidence-based care within a school/setting for pupils with long-term conditions and complex health needs. Specifically the School Nurse or Health Care Professional will support the development of healthcare assessments and plans, facilitate training in the delivery of individual healthcare plans and monitor the delivery of healthcare plans within school.

The school/setting will agree with parents/carers how often they should jointly review the health care 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, e.g. if there was a change in the child's health needs.

5.3 The school/setting will assess each child/young person's needs individually as children and young people vary in their ability to cope with health needs or a particular medical condition. Plans will also take into account a child/young person's age and ability to take personal responsibility.

5.4 Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the needs of the individual child.

Brief health care plans may be all that is required for the notification of mild or less complex conditions, or where medical care would only be required in an emergency. For example, repeat courses of antibiotics which take medication over 8 days, well-controlled mild asthma, and peanut allergy. Asthma health care plans could be supported by annual personal plans (e.g. My Asthma Plan by Asthma UK) routinely provided as best practice care through GP care.

5.5 In addition to input from the school, parents/carers and the school health service, the child's GP or other health care professionals depending on the level of support the child needs, those who may need to contribute to a health care pro forma include the:

- Head teacher or head of setting
- Child/young person (if appropriate)
- Early years practitioner/class teacher - primary schools
  Form tutor/head of year - secondary schools
- Care assistant or support staff
- Staff who are trained to administer medicines or undertake identified health needs
- Staff who are trained in emergency or first aid procedures

5.6 When dealing with the needs of children with the following common conditions schools/settings should refer to Section A which provides further guidance on managing the needs of children with these long term conditions:

- Asthma
- Epilepsy
- Diabetes
- Anaphylaxis
- Continence

6. Staff support and training in dealing with medical/health needs

6.1 The school/setting will ensure that there are sufficient members of support staff who manage medicines. This will involve participation in appropriate training.

6.2 Any member of staff who has responsibility for administering prescribed medicines to a child will receive appropriate training, instruction and guidance. They will also be made aware of possible side effects of the medicines, and what to do if they occur. The type of training necessary will depend on the individual cases. All such training should be relevant to the individual child's needs and documented (Form 8).

6.3 For staff where the conditions of their employment do not include giving or supervising a pupil taking medicines, agreement to do so must be voluntary. However within schools head teachers have a legal duty of care to their pupils that includes meeting their health needs to enable them to participate in education. It is therefore the head teacher's responsibility to ensure systems are put in place within their school to ensure that the health needs of their pupils are met. The same approach should apply to whoever has the legal duty of care within a given setting.

6.4 In line with the contractual duty on head teachers/setting managers, the school/setting will ensure that staff receive appropriate support, information and training where necessary. The head teacher or member of staff in charge of a setting will agree when and how such training takes place, in partnership with the health professional and parents/carers involved. The head teacher of the school / setting manager will make sure that all staff and parents/carers are aware of the Sheffield guidance and procedures for dealing with medical and health care needs.

6.5 Staff who have a child/young person with medical/health needs in their class or group will be informed about the nature of the condition, and when and where the child may need extra attention.

6.6 The child/young person's parents/carers, health professionals, and school/setting staff must work in full partnership to provide the information specified above.

6.7 All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs.

6.8 Back up arrangements must be in place in advance and any relevant training provided for when the member of staff with principle responsibility is absent or unavailable.

7. Off-site education or work experience for children and young people

7.1 The school/setting has responsibility for an overall risk assessment of any off-site activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

7.2 The school will refer to the DfE guidance Work Related Learning and the Law DfES/0475/2004, the Health and Safety Executive and the Learning and Skills Council for programmes that they are funding e.g. Increased Flexibility Programme.

7.3 The school is also responsible for pupils with medical needs who, as part of Key Stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or further education college. The school will comply with LA policy on the conduct of risk assessments before a young person is educated off-site or has work experience.

7.4 The school is responsible for ensuring that a work place provider has a health and safety policy which covers each individual student's needs.

7.5 Parents/carers and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

8. Record keeping

8.1 Parents/carers must tell the school/setting about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However staff should make sure that this information is the same as that provided by the prescriber. Any change in prescription should be supported by either new directions on the packaging of medication or by a supporting letter from a medical professional. Schools/settings should not accept medicines if the label and/or packaging instructions have been altered or tampered with.

8.2 The school/setting will use Form 3 to record parental permission for the short-term administration of medication (not more than 8 days including weekends). Consent forms must be delivered personally by the consenting parent/carer. Staff must check that any details provided by parents, or in particular cases a health professional, are consistent with the instructions on the container.

8.3 The school/setting will use Form 3 to record parental consent for the administration of long-term medication (more than 8 days including weekends) in conjunction with Form 2, a health care plan. Consent forms must be delivered personally by the consenting parent/carer. Staff must check that any details provided by parents, or in particular cases a health professional, are consistent with the instructions on the container.

8.4 It is the parent/carer's responsibility to monitor when further supplies of medication are needed in the school/setting. It is not the school's /setting's responsibility. This will be highlighted in the school/setting prospectus.

The school/setting will use Form 4 to confirm with the parents/carers that a member of staff will administer medicine to their child.

8.5 (For Early Years Settings) This setting will keep written records of all medicines administered to children, and make sure that parents/carers sign the record book to acknowledge the entry. (All Early Years settings must do this as a legal requirement). Other settings covered by Local Authority insurance must do this as a requirement of insurance cover. These records safeguard staff and provide proof that they have followed agreed procedures.

8.6 Although there is no similar legal requirement for schools to keep records of medicines given to pupils, and the staff involved, it is good practice to do so. Records safeguard staff and provide proof that they have followed agreed procedures. For this purpose it is the Council and this school's/setting's policy and our insurer's expectation that Sheffield schools/settings will keep a log of medicines administered. Some schools keep a logbook for this. However, Forms 5 and 6 also provide suitable example record sheets.

9. Safe storage of medicines

9.1 The school/setting will only store supervise and administer medicine that has been prescribed for an individual child unless written consent to administer a non-prescribed medicine has been given by the parent/carer or by the individual acting in loco parentis.

9.2 Medicines will be stored securely and strictly in accordance with product instructions - paying particular note to temperature and in the original container in which dispensed.

9.3 Staff will check that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine, the method and frequency of administration, the time of administration, and the expiry date. School/setting staff must not alter or add to the label. Medicines that do not comply with these requirements will be returned to the parent/carer.

9.4 Where a child needs two or more prescribed medicines, each will require a written consent and be provided in a separate container.

9.5 Non-healthcare staff will never transfer medicines from their original containers.

9.6 Children/young people will be informed where their own medicines are stored and how to access them.

9.7 All emergency medicines, such as asthma inhalers and adrenaline pens, will be readily available to children/young people and will not be locked away.

9.8 Schools will allow children/young people to carry their own inhalers. If the child is too young or immature to take personal responsibility for their inhaler, staff will make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.

9.9 Other non-emergency medicines will be kept in a secure place not accessible to children/young people, unless Form 7 has been completed by the parent/carer providing permission for the child / young person to carry their own medication.

9.10 Some medicines need to be refrigerated. They *can* be kept in a refrigerator containing food but *must* be in an airtight container and clearly labelled. There will be restricted access to a refrigerator holding medicines

10. Disposal of medicines

10.1 Staff must not dispose of medicines. Parents/carers are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. Return of such medicines to parents/carers will be documented.

10.2 Parents/carers should also collect medicines held at the end of each term. If parents/carers do not collect all medicines, they will be taken to a local pharmacy for safe disposal. This process will be documented.

10.3 Sharps boxes will always be used for the disposal of needles. Collection and disposal of the boxes will be arranged with Sheffield City Council.

11. Hygiene and infection control

11.1 All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures.

11.2 Staff will have access to protective disposable gloves to avoid infection or risks of cross contamination when administering medicines/lotions, in addition

staff will take care when dealing with spillages of blood or other body fluids, and disposing of dressings or equipment. (Guidance on the disposal of clinical and sanitary waste is available in Code of Practice COP31 on SchoolPoint)

11.3 Ofsted guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.

11.4 The Education (School Premises) Regulations 1999 require every school to have a room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. It **must** contain a washbasin and be reasonably near a water closet. It **must not** be teaching accommodation. If this room is used for other purposes as well as for medical accommodation, the body responsible **must** consider whether dual use is satisfactory or has unreasonable implications for its main purpose. The responsibility for providing these facilities in all maintained schools rests with the Local Authority.

12. Access to the school/setting's emergency procedures

12.1 As part of general risk management processes the school/setting *must* have arrangements in place for dealing with emergency situations. Where medical needs are known the care plan will document all emergency information. [This could be part of the school's first aid policy and provision. See DfE Guidance on First Aid for Schools: a good practice guide, 1998]

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

12.3 All staff should know how to call the emergency services. Guidance on calling an ambulance is provided in Form 1. This information must be displayed in a prominent location within the school/setting.

12.4 All staff should also know who is responsible for carrying out emergency procedures in the event of need.

12.5 A member of staff will always accompany a child taken to hospital by ambulance, and will stay until the parent arrives.

12.6 Health professionals are responsible for any decisions on medical treatment when parents/carers are not available.

12.7 Staff should never take children to hospital in their own car; it is safer to call an ambulance.

12.8 In remote areas a school might wish to make arrangements with a local health professional for emergency cover.

12.9 The national standards require early year's settings to ensure that contingency arrangements are in place to cover such emergencies.

12.10 Individual health care plans will include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency. Those with responsibility at different times of day (e.g. lunchtime supervisor) will need to be very clear of their role.

13. Risk assessment and management procedures

13.1 This policy will operate within the context of the school/setting's Health and Safety Policy.

13.2 The school/setting will ensure that risks to the health of others are properly controlled.

13.3 The school/setting will provide, where necessary, individual risk assessments for pupils or groups with medical needs.

13.4 The school/setting will be aware of the health and safety issues relating to dangerous substances and infection.

14. Home to school travel and transport

14.1 The school will ensure that there is timely effective liaison with drivers and escorts providing home to school transport.

14.2 Prior to transport commencing, transport staff must be fully briefed about the health needs of pupils being transported. A care plan will be carried with the children and young people. Briefings to drivers and escorts will be given by a health professional, or by another appropriately informed member of staff within the school/setting.

14.3 There should be regular reviews of the needs of the child undertaken between the school/setting and drivers/escorts, so that everyone has up-to-date information, support and training.

14.4 Where pupils have complex health needs, individual health care plans (or specific essential information from the plan) should be carried on vehicles. The care plans should specify the steps to be taken to support the normal care of the children and young people, as well as the appropriate responses to emergency situations.

14.5 Training will be given to all relevant travel and transport staff, as per standard agreed health care protocols provided by health care professionals and Sheffield City Council standard practice. Drivers or escorts who have any concerns should raise these in the first instance with their line manager.

14.6 Where incidents occur these should be reported to Children Young People and Families (CYPF) Travel and Transport Service. The school/setting and NHS will share critical information with drivers/escorts and CYPF Travel and Transport Services and vice versa to ensure minimisation of risk during the journey, and develop incident management strategies as necessary.

Annex A: Information on long term conditions

Asthma

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time, for example when the pollen count is high, or during cold weather. Asthma is a variable disease which comes and goes. Each child's asthma presents itself in a unique way, with different trigger factors and different symptoms.

However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens.

Information about individual children/young peoples' asthma should be supported by health care plans, asthma school cards and regular training and support for staff. Health care plans for children/young people with mild and well-controlled asthma can be brief and may be supplemented or replaced by annual individualised self-management care plan produced by the child's GP / Practice Nurse. An example would be a completed copy of 'My Asthma Care Plan' available from Asthma UK. Children with significant or severe asthma should have a more thorough individual health care plan in place.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school/nursery day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms, and are also taken during an asthma attack. They are sometimes taken before exercise**.** Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits. Some

children with exercise induced asthma may choose to take their reliever inhaler before PE or playtime.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. **An ambulance should be called if:**

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to complete sentences
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents/carers of children and young people with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child should have a regular asthma review at their GP surgery, usually with a practice nurse who has specialised training. Some pharmacists who have received specialised asthma training may also be able to conduct a review. Parents/carers should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children should expect to have control of their asthma. National guidelines define control as:

- No daytime symptoms
- No night time awakening due to asthma
- No need for rescue medication
- No attacks
- No limitations on activity including exercise

Reluctance to participate in physical activities should be discussed with parents/carers, staff and the child/young person. However children with asthma should not be forced to take part if they feel unwell. Children/young people should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children/young people with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents/carers or attendance officers as appropriate

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and managing identified health needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK: http://www.asthma.org.uk/how_we_help/schools_early_years/index.html). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year as appropriate. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack. Asthma UK provides useful training materials for school/setting staff which can be used to provide detailed information to staff (see 'A school healthcare professional's resource' at www.medicalconditionsatschool.org.uk).

School staff are in an ideal position to be able to provide valuable information to parents/carers of children with asthma, and to GP surgeries. Good working relationships and communication between GP surgeries and schools should be encouraged, in order to support the control of children's asthma.

Records show that in September, many more children go to hospital with increased asthma symptoms than at any other time of year. This increase in asthma symptoms may be due to the fact that some children experience fewer symptoms during the summer holidays, and sometimes forget to take their asthma medication regularly. Schools/settings could send a reminder out to parents/carers to remind them of the importance of ensuring that their child takes their "preventer" asthma medication during the summer holidays and throughout the year to help their child control their asthma.

Epilepsy

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child experiences a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual "feelings" reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear ‘blank’ or ‘staring’, sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.
Triggers such as anxiety, stress, tiredness or being unwell may increase a child’s chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child’s movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child’s head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child’s first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child’s health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child’s health care plan

Such information should be an integral part of the school or setting’s emergency procedures but also relate specifically to the child’s individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution

midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam (see Forms 9 and 10). Instructions for use must come from the prescribing doctor. For more information on administration of rectal diazepam see Form 9.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. Arrangements must be in place for two adults, where possible at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8's day care require the registered person to ensure the privacy of children when intimate care is being provided.

Diabetes

What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly and they are resistant to insulin (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They usually have to have multiple daily injections of insulin given via an insulin pen or an insulin pump. They should monitor their blood glucose levels and have regular meals and snacks according to their own personal dietary plan. Children with Type 2 diabetes may be treated with diet and exercise, tablets or insulin.

Each child may experience different symptoms of low or high blood glucose levels and this should be discussed when drawing up the health care plan.
Needing to go to the toilet more frequently, being thirsty, tiredness and weight loss may indicate poor glucose control [high blood glucose levels] and staff should report such symptoms to the parents/carers. Poor control will significantly increase the risk of long term complications of diabetes including damage to the eyes, kidneys and nerve endings. Frequent episodes of low glucose levels should also be reported as changes to the insulin doses may need to be made.

Medicine and Control

The diabetes of the majority of children is controlled by multiple daily injections of insulin. This will include an injection immediately before or after lunch in school or a dose delivered by the insulin pump. The dose of insulin for the food eaten will be calculated and then extra units of insulin will be added if the blood glucose result is above the target range. The amount will differ from child to child and will need to be discussed as part of the health care plan. Most children will manage their own injections or pump but will require supervision and a suitable private place to do this. Younger children will need help to inject or to be injected.
Older children will be taught how to adjust their insulin doses according to the amount of carbohydrate in their meals and snacks to enable them to have more flexibility around food. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give.

Children with diabetes need to keep their blood glucose levels within a target range and will check their blood glucose levels before lunch, before and after exercise or more regularly if they are experiencing symptoms of high or low blood glucose. Younger children who cannot express the symptoms of high or low blood glucose may need to be tested at morning and afternoon breaks as well.
Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

When staff agree to do blood glucose testing and or insulin injections they should be given training by the appropriate health professional, usually the Paediatric Diabetes Specialist Nurses.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to

make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. Staff who are managing lunchtimes should also be aware of any children who need to eat their meals at a certain time, or who need their plate/lunch box checking to ensure they have had an appropriate amount of carbohydrate.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

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

If a child has a hypoglycaemic episode [hypo] the child should not be left alone or sent to another part of the school alone. A fast acting sugar should be administered immediately such as dextrose/glucose sweets/tablets, Lucozade or sugary drink, if the child is unable to take these then a sugary gel should be given [glucose]. If the child were not about to eat a snack or lunch then a slower acting starchy snack should be given such as a plain biscuit, glass of milk or piece of fruit.
The blood glucose level should be re-checked 10 minutes later to ensure the treatment has been effective, if not then the treatment should be repeated again.

An ambulance should be called if the child has had 3 lots of treatment and the blood glucose level is not responding [risen above 4 mmols] or if the child becomes unconscious or is having a fit.

Some children may experience hyperglycaemia [high blood glucose levels] particularly when unwell in any way. If the child has vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone on the breath this can be a sign of ketosis which is extremely dangerous to a child with diabetes and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan.

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical

attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it

- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

Continence

The Disability Discrimination Act (DDA) requires all education providers to re-examine all policies, consider the implications of the Act for practice and revise their current arrangements. In the light of historical practices that no longer comply with new legislation, changes will particularly be required wherever blanket rules about continence have been a feature of a setting/school's admissions policy. Schools and settings will also need to set in motion action that ensures they provide an accessible toileting facility if this has not previously been available. The Department of Health has issued clear guidance about the facilities that should be available in each school (Good Practice in Continence Services, 2000).

Agreeing a procedure for personal care in your setting/school

Settings/schools should have clear written guidelines for staff to follow when changing a child, to ensure that staff follow correct documented procedures and are not worried about false accusations of abuse. Parents should be informed of the procedures the school will follow should their child need changing during school time.

Your written guidelines will specify:
• Who will change the nappy?
• Where nappy changing will take place
• What resources will be used (cleansing agents used or cream to be applied?)
• How the nappy will be disposed of
• What infection control measures are in place?
• What the staff member will do if the child is unduly distressed by the experience or if the staff member notices marks or injuries

Schools may also need to consider the possibility of special circumstances arising, should a child with complex continence needs be admitted. In such circumstances the child's medical practitioners will need to be closely involved in forward planning.

Resources

Depending on the accessibility and convenience of a setting/school's facilities, it could take ten minutes or more to change an individual child.

This is not dissimilar to the amount of time that might be allocated to work with a child on an individual learning target, and of course, the time spent changing the child can be a positive, learning time.

However, if several children wearing nappies enter foundation stage provision of a setting/school there could be clear resource implications. Within a school, the foundation stage teacher or coordinator should speak to the SENCO to ensure that additional resources from the school's delegated SEN budget are allocated to the foundation stage group to ensure that the children's individual needs are met. With the enhanced staffing levels of provision within the private, voluntary or independent sector, allocating staff to change the children should not be such an issue, although there may be circumstances within an individual setting that merit an application for additional funding being made through the Early Years Support Link Teacher.

Keys to success

It is not helpful to assume that the child has failed to achieve full continence because the parent hasn't bothered to try. There are very few parents for whom this would be true. In the unlikely event this is the only reason why the child has not become continent then continence achievement should be uncomplicated if a positive and structured approach is used.

Remember that delayed continence may be linked with delays in other aspects of the child's development, and will benefit from a planned programme worked out in partnership with the child's parents.

There are other professionals who can help with advice and support. The School Nurse or Family Health Visitors have expertise in this area and can support parents to implement toilet training programmes in the home. Health care professionals can also carry out a full health assessment in order to rule out any medical cause of continence problems. The Specialist Community Child Health Services has produced a helpful publication 'Toileting Issues for Schools and Nurseries' which you may send for (See Further Information and Guidance) to get additional information on continence issues.

Parents are more likely to be open about their concerns about their child's learning and development and seek help, if they are confident that they and their child are not going to be judged for the child's delayed learning.

Partnership working

In some circumstances it may be appropriate for the setting/school to set up a home-setting/school agreement that defines the responsibilities that each partner has, and the expectations each has for the other. This might include:

• *The parent*

- agreeing to ensure that the child is changed at the latest possible time before being brought to the setting/school
- providing the setting/school with spare nappies and a change of clothing
- understanding and agreeing the procedures that will be followed when their child is changed at school –including the use of any cleanser or the application of any cream
- agreeing to inform the setting/school should the child have any marks/rash
- Agreeing to a 'minimum change' policy i.e. the setting/school would not undertake to change the child more frequently than if s/he was at home.
- agreeing to review arrangements should this be necessary

• *The school*

- agreeing to change the child during a single session should the child soil themselves or become uncomfortably wet
- agreeing how often the child would be changed should the child be staying for the full day
- agreeing to report should the child be distressed, or if marks/rashes are seen
- Agreeing to review arrangements should this be necessary.

This kind of agreement should help to avoid misunderstandings that might otherwise arise, and help parents feel confident that the setting/school is taking a holistic view of the child's needs.

For further information and guidance see Appendix A

Appendix A

Promotion/Management of Continence

Introduction

Continence problems have wide ranging physical, emotional, social and psychological consequences and are common in children of all age groups. The effects on self-esteem and confidence must not be underestimated. They can be a source of bullying and social isolation and family stress and require a great deal of sensitivity and understanding.

The acquisition of continence, both bladder and bowel, is a developmental milestone often taken for granted. However not only does each child mature at differing rates but there are many factors which affect the ability of a child to become and remain continent. For some children the goal of attaining continence can be unrealistic and unachievable

Parents are sometimes made to feel guilty if their child is not continent at school entry age and may be denied entry. The acquisition of continence should not be prerequisite policy for school entry as this is contravenes the DDA and is therefore discriminatory. Education providers have an obligation to meet the individual needs of children with continence problems, ensuring they are not discriminated against and have the same rights and access as other children to pre-school and school activities. This includes after school clubs/ school trips and residential. It is vital therefore that school staff respect the need of the child and family for confidentiality, support and understanding with all aspects of the child's management.

Causes of continence problems

Achieving and maintaining continence is reliant on many factors; not only on developmental ability but also on a child's anatomy and pathology, communication skills and behaviour. The majority of children with continence problems have no specific illnesses or abnormalities but have, for instance developed severe constipation which often results in both faecal and urinary incontinence. However some children are born with (congenital) or develop significant abnormalities which impair their ability to pass stool or urine. There are therefore many causes of continence problems the most common groups are highlighted below.

Constipation and soiling

Constipation occurs in 29% of ½ year olds in the UK and 27.5% of 9 ½ year olds and approximately 1% of 12year olds (ERIC).
There are a variety of causes of constipation including; poor fluid intake, poor diet, illness, withholding or toilet avoidance, toilet phobias, changes in daily routine, poor toileting routines and anxiety/emotional upset. If not recognised or treated effectively it can become a chronic problem and its effects are often misunderstood and not managed sensitively in school. As constipation builds up, children often experience abdominal pain, lose the sensation to have their bowels opened and have accidents or soiling/overflow diarrhoea. The child has no awareness or ability to prevent this from happening. Behaviour, concentration, learning and school attendance can be affected. The anxiety and embarrassment can also sometimes result in school refusal.

Treatment of constipation is dependent on compliance with laxative therapy combined with good toileting routines and good fluid intake. There are often periods of regression during treatment or difficulty finding most effective dosages of

medication which can lead to intermittent soiling. For some children these problems can continue for years before completely under control.

Urinary problems
Dysfunctional voiding is a term given to a range of bladder problems which can develop at any age and can result in daytime wetting, urinary tract infections, an inability to hold on and the need to visit the toilet very frequently. Day wetting occurs in 1 in 75 children over the age of 5yrs and can be very stressful and cause great anxiety in school. It can be caused by poor toileting habits (e.g. holding or infrequent voiding), inadequate fluid intake, anxiety/ stress, urinary tract infections or a consequence of constipation.

Treatment: In all bladder problems there is a need for a good fluid intake and bladder retraining programmes. Medication may also be required. Voiding difficulties take time to resolve and require a lot of motivation, support and understanding. Some children may have bladder and bowel dysfunction and may therefore have both wetting and soiling accidents.

Nocturnal enuresis
30% of 4 ½ year olds wet the bed at night this falls to 9.5% by the age of 9 ½ yrs. It is important for school staff to recognise that some children with nocturnal enuresis may experience interrupted sleep which can affect concentration and learning at school. It also needs to be considered when planning school trips and residential, as it can be a source of great anxiety for children and parents. Some children with nocturnal enuresis may also have daytime symptoms including urgency frequency and wetting.

Congenital abnormalities;
Children can be born with a range of different abnormalities which can affect the kidneys, bladder, urinary tract or bowel, or a combination of these. Common examples of these include spina-bifida, sacral agenesis, imperforate anus, Hirshprungs disease. Many of these children require surgery and sometimes alternative ways of managing continence. These alternative methods may include intermittent catheterisation, permanent indwelling catheters or stomas. For some of these children the ultimate goal of continence may not be attainable or may take years to achieve and require different medical interventions.

Conditions affecting learning and development may delay or prohibit acquisition of continence. Examples included cerebral palsy, global developmental delay, Down's syndrome, Autism and ADHD. Intensive toileting programmes and support and patience are often necessary to promote continence for these children.
Children with severe learning disabilities may not be able to achieve continence and may require continence pads/products to be changed on a regular basis during the school day.

Other problems
Children who have initially acquired continence can develop conditions which subsequently cause continence difficulties. Examples of this include food intolerances, Crohns disease and irritable bowel syndrome. Some children are so severely affected that they require surgery and stoma (colostomy) formation in order to manage symptoms effectively.

Management of continence

The management of continence problems, whatever the cause, can be considered in three groups.

- children who are unable to achieve continence and require continence pads/nappies either a) permanently due to their underlying condition or b)temporarily whilst they are undergoing/ awaiting treatment/surgery.
- Children who have continence difficulties requiring assistance with wetting and/or soiling accidents, fluid intake, bladder and bowel training/ toileting programmes
- Children who have alternative methods of managing their continence such as intermittent or permanent catheter, stomas/bowel irrigation systems

Younger children/children with learning/physical difficulties may require personal care to be done for them. The long term aim however is to encourage children where possible to be independent. All groups of children however, will require varying degrees of assistance and support throughout school and may need additional support during transition periods between classes and schools. For children with more complex problems it is recommended that multidisciplinary planning meetings should be arranged when transitioning or major changes in management occur.

Areas of consideration for schools

It is essential schools consider the following general areas when managing continence problems;

- facilities are appropriate and accessible
- there is easy access to drinking water
- support is available to meet the needs of individual children to deliver toileting programmes and continence management
- staff and children are protected from harm
- health and safety issues are addressed
- staff receive appropriate support and training

Facilities

The Department of Health has issued clear guidance about the facilities that should be available in each school (Good Practice in Continence Services, 2000). Current DFES recommendations are for purpose built foundation stage units to include an area for changing and showering children in order to meet the personal care needs of young children. A suitable place for changing children therefore, should have a high priority in any setting's/school's access plan. The Department of Health recommends that one extended cubicle with a wash basin should be provided in each school for children with disabilities. If it is not possible to provide a purpose built changing area, then changing mats should be provided and appropriate surfaces such as changing tables provided.

National and local surveys have repeatedly identified poor toilet facilities, restricted accessibility, lack of privacy, rationed/unsatisfactory toilet paper, as reasons for children to avoid using the toilet at school. This can lead to the development of bladder and bowel dysfunction and lack of compliance with treatment programmes. Every effort should be made to ensure:

- Toilets are clean and hygienic
- They should contain soap and appropriate hand washing facilities
- Toilet roll should be of good quality, easily accessible and not rationed
- Where necessary, wheelchair access should be provided to toilet facilities

- Reasonable Adaptations to accommodate alternative continence needs should be made. (The DDA requires schools to make reasonable adjustments to meet the needs of each child.*)*

Toilet access
Attention should be given to ensuring privacy. For some children, offering the use of staff toilets may be appropriate in the absence of disabled facilities or lack of privacy in communal toilets. Do not enter' signs may also be used to ensure that privacy and dignity are maintained during the time taken to undertake personal care.

- Toilets should be easily accessible to children throughout the school day
- Toilets should not be locked or require children to obtain keys for access. Delayed access to toilets may cause avoidable accidents and undue anxiety
- Staff should be aware of continence difficulties and allow children to leave the class as necessary without causing embarrassment or drawing undue attention to the child
- Use of toilet passes should be encouraged to aid communication, alleviate anxiety and maximise confidentiality

Toileting programmes
Children should be encouraged to visit the toilet regularly during the school day. Younger children in particular may well need reminding or support in this from school staff.

Access to drinking water
The importance of fluid intake in prevention and management of bladder and bowel problems has been previously alluded to. Clean, fresh water drinking facilities must be available throughout the school day. Children should actively be encouraged to drink at least 2-3 drinks during the school day at break times, lunchtimes and during lessons in order to promote good kidney and bladder function. Evidence has shown that when children use water fountains they fail to drink sufficient amounts and therefore the use of cups or water bottles is preferred. The table below shows the total volumes of oral fluid required per day as recommended in the NICE guidance 111.

	Female	Male
4-8 years	1000 - 1400 ml	1000 - 1400 ml
9-13 years	1200 – 2100 ml	1400 – 2300 ml
14 -18 years	1400 – 2500 ml	2100 – 3200 ml

NICE clinical guideline 111

Child protection
School staff act in loco parentis and have a duty of care to meet the continence needs of the child whilst they are in school. There should be no concerns regarding child protection, whether changing continence pads, assisting a child who has had an accident, helping with toileting routines or undertaking/assisting with alternative continence management. There are no regulations that indicate that a second member of staff must be available to supervise these processes in case of allegations of abuse. (DFES/CDC 2005) Few setting/schools will have the staffing

resources to provide two members of staff to undertake this care and the mandatory CRB checks employed in childcare and educational settings are considered sufficient to promote the safety and wellbeing of the children concerned. Education/school managers are encouraged to remain highly vigilant for any signs or symptom of improper practice, as they do for all activities carried out on site.
If a child has an accident in school it is not acceptable to ask the parent to come into school to change the child. Nor is it acceptable to leave children in soiled clothing as this constitutes abusive behaviour.

It is however important that written consent is obtained from the parent (and child if old enough) for school staff to undertake intimate personal care in school and this agreement should be recorded in the school healthcare plan.
Alternative procedures for managing continence i.e. catheterisation, stoma care should not be undertaken without appropriate training and proven competence (see education and training section).

Health and safety
Most schools will already have hygiene/infection control policies to address accidental wetting or soiling and sickness as part of their health and safety policy. These can be extrapolated to the changing of continence products, intimate care or alternative continence management procedures.

- Staff should wear disposable gloves and aprons whilst providing intimate care. These should be provided by the school
- Soiled materials should be double wrapped and placed in bins or placed in a hygienic disposal unit if the number produced each week exceeds that allowed by Health and Safety Executive's limit. Catheters may be alternatively disposed of in Sani bins.
- There should be appropriate provision of hot water, liquid soap, hot air driers/paper towels for hand washing and for cleansing of the immediate environment where necessary.

Equipment and supplies.
There should be clear identification of the role and responsibility of parents in providing supplies and specialist equipment if needed.
The school should provide secure, accessible storage for each child's equipment/spare clothing. If more than one child requires supplies they should be kept separately and individually labelled.

Resources
All three categories of personal care can be undertaken by school staff. Generally the personal care roles are undertaken by care assistants, however sometimes dinner staff or office staff may also be considered.
Although individual children may require differing support with their continence needs most interventions take approximately 15-20 mins once or twice a day. Statement of educational needs are not usually required for continence support as the total time requirement is usually less than 3 hours per week and schools are usually required to fund this level of support from existing special needs budgets.

If the child has additional complex needs it may be appropriate to seek educational statement/extra resources. If there are several children with problems within one school, and there is a perceived lack of adequate resources to provide effective support, additional funding should be discussed with the education authority.

Education and training and support

There are many healthcare professionals involved in managing children with continence problems. The School Nurse or Family Health Visitors may be involved in managing basic continence problems and may be able to provide support to schools with toilet training programmes. The school nurse or other health care professional can support the development of the health care plan. For complex problems a variety of professionals may be involved from the Sheffield Children's Hospital Trust such as paediatricians, surgeons and specialist nursing staff from the continence team.
The healthcare plan should be negotiated with the parents and child (where appropriate) and address, where necessary, issues such as type of person care required, frequency/timing of personal care, provision of equipment and supplies, possible topical skin applications such as barrier creams, action in the event of complications/illness/emergency relating to continence problem, appropriate contacts.

Alternative intimate procedures
For carers undertaking procedures such as catheterisation or stoma care they should receive training and support from the continence specialist nurses within the continence team at the Children's Trust. Parents should not be expected to go into school to undertake these procedures as this contravenes the DDA and does not foster independence for the child/parent nor promote normality. Parents should not be responsible for training carers to do procedures as this will invalidate liability insurance. Collaboration with parents however, is essential when planning and implementing training programmes.
Healthcare professionals caring for each individual child are responsible for ensuring carers receive knowledge, information and training and support. It is recognised that intimate procedures may cause concern to school staff and so healthcare professionals should provide guidance and information to potential carers, for them to consider whether to volunteer to support the child concerned. Training and achievement of competency should be documented along with parental and carer consent.

Training and competency packages should be completed for each individual carer with each individual child. A carer assessed as competent caring for one child who requires catheterising should not assume competency to catheterise another child without specific training for that child. Documentation should include contact numbers for ongoing support and troubleshooting advice in the event of problems or complications. The healthcare plan may cross reference training documentation for children with more complex continence difficulties. All carers once assessed as competent to catheterise are entered onto a register kept by the risk management officer for education. This ensures liability insurance is validated.

Collaboration and communication
Communication between home and school is important to determine progress, potential difficulties and changes in management as medications etc may change on a frequent basis. Home school books can be a useful way to promote effective communication. Some children may require regular school reviews to consider levels of support and progress.
The distress caused to children and families by continence problems and the potential far reaching effects on educational, social and emotional development cannot be underestimated. Continence problems are often difficult and embarrassing for parents and children to talk about. This can result in parents not disclosing the full extent of a problem, or indeed that their child has a problem, for fear of stigmatisation or exclusion.

Successful management of children with continence difficulties requires approachability, sensitivity and understanding and is dependent on effective multidisciplinary, multi-agency communication and collaboration.

Further information and guidance

Enuresis Resource & Information Centre (ERIC) Telephone 0117 9603060, www.eric.org.uk

Promocon Management of bladder and bowels in schools and the early years setting www.promocon.co.uk

Including Me" Managing Complex Health Needs in Schools and Early Years Settings. Carlin J. (2005) Dfes/Council for Disabled Children. London

Good practice in continence services, 2000. Available free from Department of Health, PO Box 777, London SE1 6XH or www.doh.gov.uk/continenceservices.htm

Paediatric Continence Team Sheffield Children's Hospital - telephone 01142260502

NICE clinical guidance 111 nocturnal enuresis management of bedwetting in children and young people www.nice.org.uk/guidance111

NICE Clinical Guidance 99 Constipation in children and young people www.nice.org.uk/guidance99

NICE Clinical Guidance 54 UTI in children www.nice.org.uk/54

ANNEX:

B. Insurer's schedule of activities covered

Please note that some procedures show as not approved in Annex B may be approved by the Local Authority Insurers on an individual named child basis, as part of an individual health care plan.

C. Forms

Form 1: Contacting Emergency Services
Form 2: Health Care Plan
Form 3: Parental agreement for school/setting to administer medicine
Form 4: Head teacher/setting manager agreement to administer medicine
Form 5: Record of medicine administered to an individual child
Form 6: Record of medicines administered to all children
Form 7: Request for child to carry his/her own medicine
Form 8: Staff training record – administration of medicines
Form 9: Authorisation for the administration of rectal diazepam
Form 10: Authorisation for the administration of buccal midazolam

All forms set out below are examples that schools and settings may wish to use or adapt according to their particular policies on administering medicines.

These forms are downloadable as WORD documents, so that it is possible to personalise for a particular school or setting from Sheffield City Council School Point or at:
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFES-1448-2005.

D. Checklist for administering medication/care

Annex B: Insurer's schedule of activities covered

PLEASE NOTE THAT WHILST THE ACTIVITIES BELOW FALL WITHIN THE SCOPE OF CURRENT INSURANCE COVER THIS ONLY APPLIES WHEN THE PROCEDURE IS ALSO SUPPORTED BY SHEFFIELD CITY COUNCIL'S POLICIES & PROCEDURES.

Please note that some procedures show as not approved in Annex B may be approved by the Local Authority Insurers on an individual named child basis, as part of an individual health care plan.

TRAVELERS

Examples of treatment

PROCEDURE	DESCRIPTION	ACCEPTABLE TO UNDERWRITERS	TREATMENT TREE
Anal plugs	Plug to prevent bowel movements in incontinent adults or children.	No	2
Bathing		Yes – following training and subject to routine visits to service users by senior officer to check for abuse Safe Manual Handling Practice to be followed	5
Bladder wash out		No	1/2
Blood Pressure	Taking of BP by automated machine only	Yes – following training and variation from specified limits in Health Care Plan referred to medical staff	5
Blood samples	Glucometer or fingerprick only	Yes – following written Health Care Plan and adherence to manufacturers' guidelines	2a/5
Body fluid balance monitoring	Measurement and recording of fluids in and urine out via toilet capture device	Yes – following training and referral of abnormalities to medical staff	5
Breathing monitoring	Visual monitoring	Yes – as routine check only	5
	Monitoring by machine	Yes – following written Health Care Plan	5
Buccal medazolam	Administered by mouth	Yes – following written Health Care Plan	5
Catheters	Change bags and cleaning of tube	Yes – following written Health Care Plan	5
	Insertion of tube	No	1/2
Colostomy/Stoma care	Change bags	Yes – following written Health Care Plan	5
	Cleaning	Yes – following written Health Care Plan	5
Contact lens fitting	Insertion of contact lenses	No	2
Defibrillators /First aid only	In emergency	Yes – following written Health Care Plan	5
Denture cleansing		Yes – following appropriate training and using proprietary cleaner only	5
Dressing care (external)	application	Yes – following written Health Care Plan	5
	replacement	Yes – following written Health Care Plan	5
Ear syringe		No	1
Ear / nose drops		Yes	5
Enema suppositories		No	2a
Eye care	For individuals unable to close eyes	Yes – following written Health Care Plan	5
Eye drops		Yes	5
First Aid	In emergency (including use of defibrillators)	Yes – by employees with valid first aid certificate.	Covered as standard by Public Liability Insurance
Gastrostomy tube Peg feeding (Through the abdominal wall)	A tube to be inserted	No - by qualified medical staff only	1/2
	Feeding and cleaning	Yes – following written Health Care Plan	5
	Reinsertion of gastronomy tube Testing	No - by qualified medical staff only	1/2
Gastrostomy tube Peg feeding with medication		Yes – following written Health Care Plan and in consultation with pharmacist, and prescribed by a medical professional	5
Gastrostomy tube Bolus feed via a gastrostomy tube	Using a large syringe or feed bag to provide 'bulk' feed	Yes – following written Health Care Plan	5

Gastrostomy tube -Peg feeding with medication		**Yes– following written Health care plan** and in consultation with pharmacist, and prescribed by a medical professional	5
Gastrostomy tube - Bolus feed via a gastrostomy tube	Using a large syringe or feed bag to provide 'bulk' feed	**Yes– following written Health care plan**	5
Gastrostomy tube - Pump feeds via a gastrostomy	Pumps are usually used to provide a constant feed – say through the night	**Yes– following written Health care plan**	5
Hearing aids	Checking	**Yes– following written Health care plan**	5
	Fitting (but not measuring for a hearing aid)	**Yes– following written Health care plan**	5
	Replacement (but not measuring for a hearing aid)	**Yes– following written Health care plan**	5
Inhalers, and nebulisers	Provide assistance to user – both hand held and mechanical	**Yes– following written Health care plan**	5
Injections	Assembling syringes and administering intravenously or controlled drugs	**No**	2
	Pre packaged doses administered on a regular basis*	**Yes- see medipens below**	**5**
	Carer using judgement to determine frequency and dosage	No	**2b**
	Pre packaged doses administered (intramuscular or subcutaneous only) on a regular basis or in pre planned emergency may only be provided by - First aider to have been deemed competent to administer prescribed medication (Accredited by the appropriate professional body) -refresher training/competency assessment as recommended by the professional body		
Manual evacuation	Of the bowel	**No**	2
Medipens (Epipens & Anapens)	For anaphylactic shock (intramuscular) with a preassembled pre-dose loaded epipen epinephrine or adrenaline/epinephrine.	**Yes– following written Health care plan**	5
Mouth toilet	For individuals unable to swallow	**Yes**	5
Naso-gastric tube- feeding	Tube to be inserted. Carers and staff will be trained on an individual basis for individual child/young person/adult.	**No** by qualified acute sector medical staff only so that the tube can be scanned to check for correct insertion.	1/2
	Feeding and cleaning of tube	**Yes– following written Health care plan**	5
	Reinsertion Testing	**No** by qualified acute sector medical staff only so that the tube can be scanned to check for correct insertion	1/2
Naso-gastric tube- Bolus nasogastric feeds	This is where a syringe is used to provide a bulk feed	**Yes– following written Health care plan**	5

ST PAUL TRAVELERS

Occupational therapy		**No**
Oral medication - prescribed	Antibiotic syrup, tablets etc	**Yes** as prescribed and directed by a medical professional following written Health Care plan (refer to additional notes below)
Oral suction	To remove excess secretions from the upper respiratory tract for individuals who are unable to do so independently	**No**
oxygen -administration of	Provide assistance to user	**Yes– following written Health care plan**
	Fitting oxygen tubes	**No** – if invasive **Yes** – if applying a mask
Pessaries		**No**
Physiotherapy		**No** – other than chest drainage, limb massaging, exercise therapy under the direction of a physiotherapist and documented in a Health Care Plan
Pressure bandages	Application to assist with positioning of digits	**Yes– following written Health care plan**
Rectal midazolam prepackaged dose	Tends to be used for individuals suffering from repeated epileptic fits	**Yes– following written Health care plan and 2 Members of Staff must be present**
	emergency situation	**Yes– following written Health care plan and 2 Members of Staff must be present**
Rectal diazepam in prepackaged dose	Tends to be used for individuals suffering from repeated epileptic fits Routine administration	**Yes– following written Health care plan and 2 Members of Staff must be present**
	emergency situation	**Yes– following written Health care plan and 2 Members of Staff must be present**
Rectal Paraldehyde	Used for individuals suffering from repeated epileptic fits- and can't use other forms of medication Routine and emergency – needs to be applied by catheter – highly skilled application/ and drug storage	**No**
Suction machine	To remove excess secretions from the upper respiratory tract for individuals who are unable to do so independently	**No**
Splints, braces, corsets etc	Application of appliances	**Yes** – as directed by a medical professional
Syringe drivers- Programming of		**No**
Suppositories or pessaries -Inserting with a prepackaged doses		**No other than Rectal diazepam and midazolam. See above**
Swabs	external	**yes**
	Internal(other than oral) invasive	**No**
Toe nail cutting		**Yes** **No** - if the patient has diabetes or

		vascular disease a chiropodist should only do this.	
Topical medication	Pre prescribe medication only -Creams lotions etc	**Yes– following written Health care plan and** as prescribed and directed by a medical professional	5
Tracheotomy care	Clean round edge of tube only.	**Yes– following written Health care plan**	5
	Testing, Replacement, suction	**No**	1
	Emergency:	**N0**	2
Ventilators	Use of	**Yes– following written Health care plan**	5
Vene puncture	A method of collecting blood	**No**	1/2

Local Authority Education – Day Schools only (not residential)

Oral medication - prescribed	Antibiotic syrup, tablets etc	**Yes** as prescribed and directed by a health care professional (i.e. Doctor) • **Adherence to Authorities Medication Policy** • **Parental consent form completed**	5 **Health Care plans required for the administration of oral medication over a period of 8 days or more**
Oral medication as directed and authorized by a parent/Guardian	Paracetemol, antihistamine (i.e. for hay fever etc)	**Yes :** • **Adherence to Authorities Medication Policy** • **Parental consent form completed**	5**Health Care plans required for the administration of oral medication is over a period of 8 days or more**

Residential establishments

Oral medication - prescribed	Antibiotic syrup, tablets etc	**Yes** as prescribed and directed by a health care professional (i.e. Doctor) **Adherence to Authorities Medication Policy**	5 **Health Care Plans must be amended to include reference to the oral medication if administration is required for a period of 8 days or more ***

* We appreciate that a resident will have a Health care plan in place, but at times may need short courses of antibiotics etc. We wouldn't expect a revised Health Care Plan in these circumstances.

The list of Healthcare activities is not all-inclusive and over time and in consultation with our insured's this list will be added to.

Annex C: Forms

FORM 1 Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number

2. Give your location as follows
   [insert school setting address]

3. State that the postcode is

4. Give exact location in the school/setting
   [insert brief description]

5. Give your name

6. Give name of child and a brief description of child's symptoms

7. Give details of any medicines given or prescribed

8. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

Speak clearly and slowly and be ready to repeat information if asked

Put a completed copy of this form by the telephone

FORM 2 Health Care Plan (this should be regularly reviewed)

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	/ /
Child's address	
Medical diagnosis or condition	
Date	/ /
Review date	/ /

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

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 copied to

Signed _____ (Parent/carer) Date: _____

Signed _____ (Member of school /setting staff) Date: _____

FORM 3 parental agreements for school/setting to administer medicine

In accordance with the school/setting policy, medicine will not be routinely administered to children without parental consent. You are also agreeing to other appropriate employees of the Local Authority (such as Home-School transport staff) to administer medicine if authorised to do so by the school/setting.

Name of school/setting	
Name of child	
Date of birth	/ /
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Date dispensed (if prescribed)	/ /
Expiry date	/ /
Agreed review date to be initiated by	[name of member of staff]
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school/setting needs to know about?	
Self administration	Yes/*No* (Where 'No', Form 4 should be completed by the school/setting)
Procedures to take in an emergency	
Name and tel. number of child's GP	

Parent / carer contact details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the school/setting and other authorised members of staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately of any changes (such as to dose or frequency, or stopping the medication) in writing. I understand that a non-medical professional will oversee my child's medication. I understand that it is my responsibility to dispose of any unused medicines and ensure medicines provided are within date.

Parent/carer signature: _____ Date: _____

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

FORM 4 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 day 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 medicine or until instructed by parent/carers].

Date _____

Signed _____

(The Head teacher/Head of setting/named member of staff)

FORM 5 Record of medicine administered (or refused) to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent/carer	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent/carer _____

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 6 Record of medicines administered to all children

Name of school/setting

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Signature	Print name

FORM 7
Request for child/young person to carry his/her own medicine

This form must be completed by parent/carers/guardian

If staff have any concerns, discuss this request with healthcare professionals.

Name of school/setting	
Child's name	
Group/class/form	
Address	
Name of medicine	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime phone no.	
Relationship to child	

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

I understand that s/he must comply with the conditions contained in the school policy.

Signed _____

Date _____

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

FORM 8 Staff training record – administration of medicines

Name of school/setting	
Name	
Type 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 detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [please state how often].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

FORM 9 Authorisation for the administration of rectal diazepam

Name of school/setting	
Child's name	
Date of birth	/ /
Home address	
G.P.	
Hospital consultant	

Should be given rectal diazepam mg.
If s/he has a *prolonged epileptic seizure lasting over minutes
OR
*serial seizures lasting over minutes.
An Ambulance should be called for *
OR
If the seizure has not resolved *after minutes.
(*please enter as appropriate)

Health Care Specialist's signature _____

Parent/carer's signature _____

Date _____

The following staff have been trained:

Trainers name and post

NB: Authorisation for the administration of rectal diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- When the diazepam is to be given e.g. after 5 minutes; and
- How much medicine should be given?

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar.

FORM 10 Authorisation for the administration of buccal midazolam

Name of school/setting	
Child's name	
Date of birth	/ /
Home address	
G.P.	
Hospital consultant	

Should be given buccal midazolam mg.
If s/he has a *prolonged epileptic seizure lasting over minutes
OR
*serial seizures lasting over minutes.
An Ambulance should be called for *
OR
If the seizure has not resolved *after minutes.
(*please enter as appropriate)

Health Care Specialist's signature_____

Parent/carer's signature_____

Date _____

The following staff have been trained:

Trainers name and post

NB: Authorisation for the administration of buccal midazolam

As the indications of when to administer the midazolam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- When the midazolam is to be given e.g. after 5 minutes; and
- How much medicine should be given?

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar.

ANNEX D: Checklist for administering medication/care

To support school/setting staff in the safe administration of medication/care, the following checklist summarises the key points contained within the policy.

Before administering medicine/care, a school/setting must ensure:

- Medication/care requested is covered by the Insurer's schedule of activities (Annex B or agreed to be insured on an individual named child basis).
- Staff responsible for administering medication/care has received any appropriate training.
- Non-prescribed medication does not contain aspirin.
- Non- prescribed medication – is the medication in the original package and information sheet included?
- Non- prescribed medication – has the parent/carer written the child's name and date of birth on the medication.
  NB – care must be taken as some medications may have different branded names but the medication may be the same e.g. paracetomol – also known and contained in 'calpol, para-med'.
- Parental/carer consent has been recorded.
- An individual health care plan is in place for medication/care that is long-term (over 8 days including weekends).
- You have communicated and shared all critical information to any contracted providers to assist them in managing continuity of care.

Annex E

CHILDREN & YOUNG PEOPLE

MEDICATION ADMINISTRATION

COMPETENCY ASSESSMENT

General Guidance

This document offers practical advice and provides operational guidance to staff that administer medicines to children and young people and should be read in conjunction with the school policy and guidance on managing children and young peoples identified health needs.

Competence – To safeguard both those receiving medication and those administering it staff should achieve a recognised level of competence, this can be assessed through the competence assessment tool attached as appendix A1. This tool provides competence based evidence of the standard achieved by staff administering medication to children and young people.

Preparation - This should be undertaken in advance of any administration of medication, this will ensure that staff undertaking the task are not interrupted once the procedure begins (to prevent errors) and will limit the potential for young people to have to hang around waiting for their medication.

KEY STEPS:

- ☑ Sort out the medication and any documentation to be completed in advance of the designated time to administer the medication.
- ☑ Gather together any equipment you may need, e.g. medicine pots, spoons, water, protective gloves etc
- ☑ Ensure that the location that you are using is free from distractions and allows those receiving medication an adequate degree of privacy.
- ☑ Check the medication label (for date, dosage etc) and any care plans or consent forms, (where applicable), to ensure the dosage has not changed and that you have the correct time/date and medication for the appropriate young person.
- ☑ Double check the label on the medication and greet the young person by name to confirm the young person is the correct person to receive the medication.
- ☑ If non prescribed medication is to be given ensure that this will not adversely react with any prescribed medications.
- ☑ Once administered ensure no significant side effects are evident
- ☑ Complete any appropriate documentation and wash your hands, if wearing gloves dispose of them appropriately.

Remember If in any doubt contact a medical practitioner or prescribing pharmacist for advice. Where practical the young person should be encouraged to take the medication themselves under supervision.

Housekeeping - Ensure the medicine cabinet is kept clean and tidy, that it is kept locked when not in use and access to it is by authorised staff only. Keep medicine cups, pots, spoons etc clean. Check that medicines held are still in date, where a medicine is near its expiry date the parents/carers should be informed. Documentation relating to administration of medicines should be

kept up to date and periodically a senior member of staff should undertake a check of medicines to ensure errors have not occurred.

APPENDIX A1

MEDICATION COMPETENCY ASSESSMENT

Name of Person Assessed	
Name of Assessor	
Date of Assessment	

THEORY ASSESSMENT

Question No	Question	Answer	Assessment
1	How should medicines be stored?		
2	What checks should be made before administering medicines?		
3	What would you do if a child refused their medication?		
4	What would you do if a child dropped their tablet on the floor?		
5	Why is it important no to touch medicines or creams whilst administering them?		
6	Why is it important that you record that medication has been given?		
7	What would you do if a child reacted to their medication/ cream?		
8	What would you do if a child was going out for the day?		
9	What would you do if you noticed the medicine/cream was running low or out of date?		
10	What would you do if a child complained of toothache and had not been prescribed pain relief?		

Signed Assessor	Signed Assessed Person

PRACTICAL ASSESSMENT

Assessment	Yes	No	Assessor Comments
Are Medicines administered in a clean, tidy and well lit area free from distractions?			
Are medicines kept securely with restricted access?			
Are medicines/creams and any equipment required prepared in advance?			
Are labels/dosages/care plans etc checked before administration?			
Is identity of young person checked to medicine/cream prior to administration?			
Is a drink of water offered where appropriate?			
Are protective gloves worn where appropriate to avoid cross contamination?			
Before administering is one final check made - Right Person, Right Medication, Right Day/Time, Right Dose			
Where the young person is able too, are they offered a self medication option?			
Are expiry dates routinely checked?			
Are hands washed before and after giving a medication/application of a cream?			
Are medications (including spoilt or refused) properly recorded and reported where necessary?			
Where non prescribed medicines/creams are given are appropriate checks made first?			
Are routine stock checks made to ensure errors, low stocks etc are detected?			
Is the storage facility for medication clean, tidy and suitable for the medications stored?			

Signed Assessor	
Signed Assessed Person	
Date	

Date of next Practical Assessment _____

Competency Assessment Documents to be retained in HR File

NOTES FOR ASSESSORS

Guidance Notes –

- You need to be familiar with and understand the LA Guidance Managing Children & Young People's Identified Health Needs
- You need to be familiar with and understand the schools policy and procedures on Administering medication
- You need to be familiar with and understand the school Health & Safety Policy
- You need to be a senior member of school management
- You should assess each member of staff who will undertake administration of medicines or application of creams/lotions (prescribed and non prescribed)
- The assessment should be documented and signed off using the template supplied at Annex A1.
- Completed assessments should be retained on staff HR files.

Theory Assessment - This should be undertaken by the member of staff before allowing them to administer medicines, staff must demonstrate an acceptable level of competence. In the assessment column of the grid you should mark the answer provided to the question as acceptable (a tick) or not acceptable (a cross) the member of staff should get all 10 questions correct.

Staff should be given time away from their desk to review guidance provided by the LA and relevant school polices before undertaking the competence assessment. Staff who does not correctly answer all ten questions should be given a further opportunity to take the assessment within two weeks, they should not be told which questions they incorrectly answered. If they do not pass the assessment on the second attempt, school management need to review their suitability for the task.

Practical Assessment - This should be undertaken by observing the member of staff undertaking the administration task once they have successfully passed the theory assessment. The assessor must complete the assessment truthfully based on their observations, selecting the Yes or No option as appropriate. Where a member of staff receives a no the assessor must advise them of this and explain how they should approach the task/offer additional training as appropriate. A date for the next practical assessment

should be recorded, it is suggested that the practical observation is undertaken annually.

The assessor should periodically check medicines held to ensure no errors in administration have occurred and out of date medicines or creams are not retained.