**Breadsall Hill Top Primary School**

'Achieving Together'

Administration of Medicines in Schools

# ADMINISTRATION OF MEDICINES IN SCHOOLS

**Review frequency: Annual – August 2025**
Medical First Aid Lead - Mr. R Madeley

**Approval –**

**Recommended associated documents:**
First Aid Policy
Intimate care Policy
Drug Awareness section from the PHSE Jigsaw
Transform Trust –Supporting Pupils with Medical Conditions

**Review date: August 2026**

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## 1. INTRODUCTION

**Breadsall Hill Top Primary school takes the safeguarding of its pupils very seriously and as such has amended this policy below to reflect that.**

The administration of medicine is the responsibility of parents/careers. School staff have a professional and legal duty to safeguard the health and safety of pupils. They will wish to do all they can to enable children to gain the maximum benefit from their education and to participate as fully as possible in school life. Children have a right to be educated and should not be excluded purely as a result of requiring medication.

**This does not imply a duty on head teachers or staff to administer medication. Breadsall Hill Top Primary School wishes to point out to school staff, governors and parents that participation in the administration of medicines in schools is on purely voluntary basis. Individual decisions on involvement must be respected. Punitive action must not be taken against those who choose not to volunteer.**

All staff are advised to consult their Trade Union Branch or Regional Officer or representative for further advice should they feel it necessary.

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

## 2. INFORMATION TO PARENTS/GUARDIANS

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

i) Suffering from chronic illness or allergy or

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

Head teachers are advised not to allow children to bring medication into school except as covered by the guidelines in this document and the relevant codes of practice.

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

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

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

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

Where occasionally this cannot be arranged, parents/guardians are encouraged to note that if the pupil needs a dose of medicine at lunchtime, the parent/guardian should come to school to administer the medicine. If this is not possible, the recommended procedure for administration of medicines should be adopted.

Parents/guardians should have access to these guidelines for reference.

Young people may consult the doctor and receive medication without the parents'/guardians' permission/knowledge when the doctor considers they have sufficient age and understanding. There is no fixed age for this (often it is over 16); in this case the school may have to deal directly with the pupil.

**Parents/guardians should be informed that they will need to ask the pharmacist for duplicate labeled bottles in order to send medicines to school. This should be in the school's prospectus. It should be noted that duplicate containers may not be supplied free of charge - charges will be at the discretion of individual pharmacists**.

Parents/guardians should be made aware that the school does not keep any medication for distribution to pupils e.g. paracetamol.

## 3. PROCEDURE FOR ADMINISTRATION OF MEDICINES IN SCHOOLS

See Appendix 3 & 4

The following procedures are recommended as examples of best practice:

### 3.1 *WRITTEN INSTRUCTIONS*

All medicines that are to be **administered in school** must be accompanied by written instructions from the parent and/or the GP. Schools may wish to allow non- prescription medicines into school, e.g. paracetamol, if accompanied by a parental consent form. **NB one day's dose only.**

Forms: Parental Consent (Appendix 1) and School Medicine Record (Appendix 2), will need to be completed by parents/guardians.
Each time there is a variation in the pattern of dosage, a new form should be completed.
A copy of the forms will be kept in the school office, to provide an overview at all times. The forms with the medication can be destroyed when the course is complete.

### 3.2 *LABELLING OF MEDICINES*

Medication should be stored in original containers and must always indicate the child's name, dosage, expiry date. It is the parent's/guardian's responsibility to ensure that the medication is correctly labeled and in date, this will be checked by BHTP staff and will not be accepted into school if it is out of date or incorrectly labelled.

It is the parents/carers responsibility to provide the school with the medication required. The medication should be as dispensed, in the original container and must be clearly labeled with:

- Name of child
- Name of medication
- Strength of medication
- How much to give i.e. dose
- When it should be given
- Length of treatment/stop date, where appropriate
- Any other instructions
- Expiry date (where there is no expiry date the medication should have been dispensed with the last 6 months)
  NB: The label "to be taken as directed" does not provide sufficient information precise information must be supplied.

Liquid medicines should be accompanied by a 5ml medicine spoon or oral syringe.

### 3.3 *STORAGE AND ACCESS*

Appropriate amounts only must be kept in secure storage but accessible in the event of a seizure
Access to the prescribed medication must only be available to the named volunteers who have been appropriately trained. Arrangements must be agreed with the parents/guardians to cater for trips off school premises. An individual care plan will be completed in these instances.

Medication, when not in use, should generally be stored in a safe and secure place. This will normally be a locked cupboard/fridge or a locked non-portable container in a cool place. The medication must be accessible to the appropriate members of staff at all times. **However, there are some important exceptions:**

- All emergency medication must be stored safely but must also be readily accessible at all times.

- Asthma "reliever" inhalers must be readily available at all times, including prior to and during exercise. Wherever possible children should be responsible for their own inhalers, but when this is not possible the inhaler should be kept in an easily accessible place e.g. in the classes clear first aid boxes. The need for a child to have ready access to their inhaler should override any concerns about misuse by others.
- In the case of the child misplacing their own inhaler, the school holds spare Salbutamol inhalers and spaces. All children with Asthma have received a letter asking for permission from their parents/guardians to allow them to use the school inhalers. The school inhalers should only be used if they have; forgotten their own, misplaced their own or their own has expired and in need of the "reliever" inhaler.

- Some medications may need to be refrigerated. An appropriate refrigerator, with restricted access, should be identified and the medication should be placed in it original packaging. The lockable fridge is situated in the Blue Zone Disabled Toilet for storage of medications: these may include prescribed antibiotics or vaccines.

Records should be kept of the named staff who are authorized to have access to medication.
This information is found on the parental consent of administration of medicines in school form which is filled out when medication is brought in to school.

Only the Senior First Aiders have Keys to Medication storage cupboards. The Authorized staff are:

- Mr. R Madeley – Medical First Aid Lead
- Miss M Hitchen – Senior First Aider

The Lead First Aider should check the medication cupboard at least once very term, to ensure that medication has not reached its expiry date. Medication which is no longer required should be disposed of in accordance with school procedure.

### 3.4 *Administration of Controlled Drugs*

Storage of Controlled Medicines, there is a procedure, which covers the issue and security of keys to medication storage cupboards. Records should be kept of the named staff who are authorised to have access to medication. These drugs should be stored in a lockable metal cupboard. Only the Senior First Aiders have Keys to the lockable metal cupboard.
The named Medical First Aid Lead and Senior First Aiders are Mr R Madeley and Miss M Hitchen.
A second member of staff should witness the child taking the medication, and both staff should sign the parental consent of administration of medicines in school form.

Any new medication sent into school must be checked in by two members of staff, at least one of these should be one of the Senior First Aiders which hold the keys to the metal cupboard and the other person should be a member of the senior leadership team. The school senior leadership team consists of;

- Mrs R NcNeil- Head teacher
- Mr M Walker – Deputy Headtecher
- Miss A Williams – Assistant Headteacher
- Raine Hart – Pupil and Family Support Manager

### 3.5 *ADMINISTRATION OF MEDICINES*

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

***The Pupil Self-Administers their own Medicine of which the School is Aware***

Many pupils at school will have the capability to keep and administer their own medicine themselves. In all instances where prescribed and non-prescribed medicines are brought into school, the school must be notified on the parental consent form. All parents must report to the school office with the medication.

***The Pupil-Self Administers the Medication but someone Supervises the Pupil*** Where the staff are willing to be involved voluntarily, the head teacher is responsible for ensuring that as a minimum safeguard self- administration of medicines that are safely stored is **supervised** by an adult. This involves ensuring:

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

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

iii) A record is kept in the appropriate form "Appendix 2" noting that session was supervised but clearly indicating that medication was self-administered by pupil.

***A Named and Trained Volunteer at the School Administers the Medicine***

The school will, in this circumstance, be storing the medicines and all the points on the storage of medicines must be adhered to.

Where the head teacher or staff are willing voluntarily to administer medication, the names of the volunteer staff must be kept up to date, provide for cover during periods of absence and be readily available at the storage point in cases of emergency.

To avoid the risk of double dosing in schools, the headteacher must clarify who is responsible for administering medications. As an extra precaution, staff who administers medication must routinely consult the record form before any medication is given.

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

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

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

Each and every person who administers medication must:

Receive a copy of these guidelines and code of practice;

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

Confirm the dosage/frequency on each occasion, and consult the medicine record form (Appendix 2) to ensure there will be no double-dosing;

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

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

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

Record on the medication record form "Appendix 2" all administration of medicines as soon as they are given to each individual;
Understand and take appropriate hygiene precautions to minimize the risk of cross- contamination;
Ensure that all medicines are returned for safe storage;

Ensure that they have received appropriate training/information. Where this training has not been given, the employee must not undertake administration of medicine and must ensure the head teacher is aware of this lack of training/information.
If a child refuses to take a medication they should not be forced to do so. Refusal should be documented and agreed procedures followed. Parents should be informed as soon as possible on the same day. If a refusal could result, or results in an emergency then the school's emergency procedures must be followed.

**4. INDIVIDUAL TREATMENT PLAN**

For all pupils who may require individual specialized treatment, a clear treatment plan will be available. Treatment plans should be prepared by the doctor responsible for the management and prescription of treatment and should be shared with parents/guardians and child's GP. When appropriate the School Health Service should provide a support role in ensuring an individual treatment plan is understood and carried out in school.
In some circumstances school nurses may have a specific responsibility for an individual child's medical management in school. Appropriate information and training is available from the School Health Service to support school staff.

**5. EDUCATIONAL VISITS**

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

**6. OUT OF SCHOOL ACTIVITIES/ EXTENDED SCHOOL DAY/ RESITENTAIL VISITS**

If medication is required during a school trip it should be carried by the child if this is normal practice e.g. asthma inhalers. If not, then the medication should be carried by a member of staff who would be responsible for administering the medication, or the parent/career if present. If a child requires a travel sickness remedy, parents/carers should provide written consent and a suitable medication in its original container.
If trips outside of the UK are being considered, parents may need to seek advice from the child's clinician or pharmacist on the timings of medication, especially those such as medication for epilepsy.
Information on the carriage of medication including specific advice about the carriage of controlled drugs can be obtained from the Home Office and the Embassy of the country to be visited. In addition, you may need to contact your airline for advice on the carriage of medication in hand luggage particularly if liquid medication is involved.

**It is essential to inform all members of staff who may have responsibility for the child during the day about the need for medication and what to do should a medical emergency arise.** The accessibility of medication, particularly for the use in an emergency, may need to be reviewed if the staff running the activity are different from the normal school staff responsible for the supervision or administration of medication e.g. in breakfast/after school clubs or during sports events.

**7. PAIN RELIEF AND ANTIHISTAMINE**

Sometimes pupils may ask for pain relief (analgesics) at school e.g. paracetamol. Generally, school staff should not give non-prescribed medication to pupils. This is because they may not know whether the pupil has taken a previous dose or whether the medication may interact with other medication being taken. If, however, a school does decide to allow the administration of pain relievers, it must be made by the Head teachers discretion and the following procedures must be followed. In the event of the Head teacher being absent a decision will be made by one of the Senior Leadership Team (SLT).

Parents/carers must fill out the appropriate form (Appendix 3) which states:

- Names of the analgesic
- States the dose to be given
- Gives the circumstances in which it may be given
- Includes checking when the previous dose has been taken/given
- Includes obtaining parental permission
- Adheres to the manufacturer's instructions and warnings which accompany the product to be used
- Includes a procedure for informing parents/carers when medication has been given.

***Consideration should be given to the choice of analgesia. A child under 16 should never be given aspirin unless prescribed***.

Sometimes pupils may ask for antihistamine at school e.g. piriton. Generally, school staff should not give non-prescribed medication to pupils. This is because they may not know whether the pupil has taken a previous dose or whether the medication may interact with other medication being taken. If, however, a school does decide to allow the administration of pain relievers, it must be made by the Head teachers discretion and the following procedures must be followed. In the event of the Head teacher being absent a decision will be made by one of the Senior Leadership Team (SLT).

Parents/carers must fill out the appropriate form (Appendix 3) which states:

- Names of the antihistamine
- States the dose to be given
- Gives the circumstances in which it may be given
- Includes checking when the previous dose has been taken/given
- Includes obtaining parental permission
- Adheres to the manufacturer's instructions and warnings which accompany the product to be used
- Includes a procedure for informing parents/carers when medication has been given.

A parental consent from, reviewed annually, must always be completed, and this form should confirm that the child has been given the stated medication without any adverse effect in the past.
The parent/carer should always be informed on the same day, when such medication has been given.
As with any medication, records must be kept of when pain relief has been administered and checks made.
If a child suffers from pain regularly the parents/carers should be encouraged to seek medical advice.

## 8. SPECIAL SCHOOLS, ENHANCEDRESOURCE SCHOOLS AND PUPIL REFERRAL UNITS

The principles contained in these guidelines and code of practice apply equally in
special and enhanced resource schools and pupil referral units. Any specialised or complex procedures will be addressed in individual treatment plans for pupils.

## 9. RESIDENTIAL SCHOOLS

The Social Services Medicine Code produced in conjunction with Southern Derbyshire Health Authority may be suitably adapted to meet the needs of Special Residential Schools. If School Health Nurses are based in Special Residential Schools, they will provide medical support. Schools may have an existing medicines policy which should be reviewed in light of this guidance.

## 10. EMPLOYEE MEDICINES

An employee may need to bring their medicine into school. All staff have a responsibility to ensure that their medicines are kept securely and that pupils will not have access to them, e.g. locked desk drawer or staff room. Adequate safeguards must be taken by employees, who are responsible for their own personal supplies, to ensure that such medicines are not issued to any other employee, individual or pupil.

## 11. EMERGENCY AID

Where children have conditions, which may require rapid intervention, parents must notify the senior first aiders

and head teacher of the condition, symptoms and appropriate action following onset. The headteacher may wish to discuss this with the School Health Service.
The senior first aiders and head teacher must make all staff aware of any pupil whose medical condition may require emergency aid.
It is essential that all staff (including supply staff, lunchtime supervisory staff etc.) are able to recognise the onset of the condition and take appropriate action, i.e. summon the trained person, call for ambulance if necessary etc.
Training and practical advice on the recognition of the symptoms can usually be offered by the school doctor/nurse.
All schools should devise an emergency action plan for such situations after liaising with the School Health Service. Planning should take into account access to a telephone in an emergency in order to summon medical assistance or an ambulance.
This has implications for school journeys, educational visits and other out-of-school activities.

## 12. UNUSUAL OCCURRENCES, SERIOUS ILLNESS OR INJURY

All parents/guardians should be informed of the school's policy concerning pupils who become unwell while at school, or on authorised educational visits, trips, etc. This should be contained within the school's Information to Parents booklet (prospectus).
It is vital to have not onlythe pupils' home telephone numbers, but parents'/guardians' daytime numbers and other emergency numbers such as those of relatives, in order to make contact.
If parents and relatives are not available, when a pupil becomes seriously unwell or injured, senior first aiders in agreement with the head teachers should, if necessary, call an ambulance to transport the pupil to hospital.

**Note:** If the pupil is on medication, whether self-administered, under supervision or administered by staff, details must be provided to the emergency service, e.g. details of the written parental consent, form "Appendix 1", the medicine itself and a copy of the last entry on the medication record form "Appendix 2".

## 13. NOTIFIABLE DISEASES

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

## 14. DISPOSAL OF MEDICINES

Any medication which has reached its expiry date should not be administered.
Medicines which have passed the expiry date should be returned to parents/guardians for disposal. Parents should be advised that the medicines are out of date and should be asked to collect them. Parents should also be advised that out-of-date medicines can be returned to the pharmacy for safe disposal Out-of date medicines should not be sent home with pupils.
Provision for safe disposal of used needles will require appropriate special measures, e.g. a "sharps box", to avoid the possibility of injury to others. This "sharps box" must be kept secure with no access for pupils or unauthorised persons. This should be disposed of in a safe way using a specialist licensed contractor.

## 15. TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

When medication is prescribed for ADHD it is actually as part of a comprehensive treatment programme and ***always*** under supervision of a specialist in childhood behavioral conditions, a lunchtime dose of medication may be required to control the child's symptoms during the afternoon, thus allowing effective learning to take place.

Methylphenidate (e.g. Ritalin, Concerta XL, Equasym) is a stimulant medication that is used in the UK for the treatment of ADHD. Although methylphenidate is legally categorized as a Controlled Drug, in mainstream schools it should be treated in exactly the same way and the same safeguards as may other medication which the school agrees to administer. However, even when a child is self managing their medication, Controlled Drugs should be kept securely in a locked non-portable container. Only Named staff should have access to Controlled Drugs. Schools with residential facilities may have additional storage requirements.

## 16. CODES OF PRACTICE

These codes of practice have been drawn up with advice from the Health Authorities and pediatricians both community and hospital based. Each individual code is set out in a similar format.
It is important when receiving any written parental consent/instruction to examine and identify any variation from the detail contained in the relevant code of practice to avoid any confusion at a later date.

The codes of practice are set out in a standard format and provide:
Detailed guidance and sources of further information, and
At-a-glance "what to do" in an emergency guides where appropriate.
The codes must be readily available and within easy reach of a storage facility used for administering medicines or for providing specific treatments.

**CODE OF Practice**
***FORMAT***

1. Types of Treatment
2. Written Instructions
3. Labeling
4. Storage and Access
5. Administration of Medicines
6. Overdose/Misuse
7. Further Information
8. "What to Do" Guide where appropriate

**CODE OF PRACTICE**
***ASTHMA***

1. Types of Treatment
2. Written Instructions
3. Labeling
4. Storage and Access
5. Administration of Medicines
6. Overdose/Misuse
7. Further Information
8. "What to Do" Guide

**CODE OF PRACTICE**

**CODE OF PRACTICE**
***DIABETES IN SCHOOLS***

1. Types of Treatment
2. Written Instructions
3. Labelling
4. Storage and Access
5. Administration of Medicines

**CODE OF PRACTICE**
***CONTINENCE MANAGEMENT***
***THE USE OF CLEAN INTERMITTENT CATHETERISATION (CIBC)***
Introduction

1. Types of Treatment
2. Written Instructions
3. Labelling
4. Storage and Access
5. Administration Procedure

***ANAPHYLAXIS (Allergy Shock Syndrome)***

1. Types of Treatment
2. Written Instructions
3. Labeling
4. Storage and Access
5. Administration of Medicines
6. Overdose/Misuse

**CODE OF PRACTICE**

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

1. Types of Treatment
2. Written Instructions
3. Labelling
4. Storage and Access
5. Administration of Medicines
6. Overdose/Misuse
7. Further Information

**CODE OF PRACTICE**
***ASTHMA***

## 1. TYPES OF TREATMENT

There are two types of treatment for asthma:

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

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

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

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

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

Young children and those with co-ordination problems may sometimes use a "spacer" device into which the aerosol is released and through which the medication is inhaled.
Some children use dry powder devices. Tablets and syrups are rarely given.

## 2. WRITTEN INSTRUCTIONS

Written instructions should clearly identify between "**relievers"** and "**preventers".** In **most** situations relievers only should need to be provided in school.
Instructions can also include details of how to help a child breathe. In an attack, asthmatics tend to take quick shallow breaths and may panic.
Some children are taught to adopt a particular posture which relaxes their chest and encourages them to breathe more slowly and deeply during an attack. If they have learnt such a technique, encourage them to use it. The emphasis should always be on the rapid provision of reliever medication.

## 3. LABELLING

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

## 4. STORAGE AND ACCESS

Asthmatic children must have immediate access to "reliever" inhalers at all times.
It is not necessary to lock the inhalers away for safety reasons. Where possible, children of junior school age and above should carry their own inhalers.
Younger children should be encouraged to do so. However, some parents, after consultation with the headteacher, may request that inhalers are kept with the supervising teacher for safe-keeping and ease of access.
Inhalers should be taken to swimming lessons, sports, cross-country, team games, etc and on educational visits and used accordingly.

## 5. ADMINISTRATION OF MEDICINES

Self-administration is the usual practice. Staff need to be aware of possible over- use of inhalers and the head teacher should inform parents/guardians as appropriate.
In circumstances where staff assist a pupil to use an inhaler, the individual treatment plan, where one exists, should be followed. A record should be made in the School Medicine Record Form - Appendix 2.

Staff involved in helping a child during an attack should:

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

## 6. OVERDOSE/MISUSE

No significant danger to health results from occasional overdose/misuse of inhalers.
Staff, however, should be vigilant for inhaler abuse as there is evidence nationally that children are selling use of their inhalers to friends in the mistaken belief that it will induce some sort of high.
"INTAL" capsules are not harmful if swallowed.
Other capsules, e.g. "VENTOLIN" will have no side effects UNLESS MORE THAN 10 ARE SWALLOWED.
In all suspected cases, note the School Medicine Record and note the action taken to seek medical advice and advise parents.

## 7. FURTHER INFORMATION

Schools should have a copy of the National Asthma Campaign Pack issued in 1993/94. Further copies can be obtained from:
The National Asthma Campaign
Providence House
Providence Place
London N1 ONT

This organisation is funded by voluntary donations. Further advice and guidance can be obtained from:
The Local School Health Team
Community Child Health
The author of an Individual Treatment Plan, if one exists, for a specific child
The Child's Family Doctor

**THE ASTHMA ATTACK - WHAT TO DO**

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

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

1. **Keep calm.** It's treatable.
2. **Let the pupil sit down** in the position they find most comfortable. Do not make them lie down.
3. **Let the pupil take their usual reliever treatment -** normally a blue inhaler. If the pupil has forgotten their inhaler, and you do not have prior permission to use another inhaler:
    - Call the parents/guardians
    - Failing that, call the family doctor
    - Check the attack is not severe - see below
4. **Wait 5-10 minutes.**
5. **If the symptoms disappear,** the pupil can go back to what they were doing.
6. **If the symptoms have improved,** but not completely disappeared, call the parents and give another dose of inhaler while waiting for them.
7. If the normal medication has had **no effect,** see severe asthma attack below.

**WHAT IS A SEVERE ASTHMA ATTACK?**

Any of these signs mean severe:

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

**HOW TO DEAL WITH A SEVERE ATTACK**

Either follow your school protocol or:

1. **Call an ambulance or the family doctor** if they are likely to come immediately.
2. Get someone to **inform the parents.**
3. **Keep trying with the usual reliever inhaler every 5/10 minutes and** don't worry about the possibility of overdosing.

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

**CODE OF PRACTICE**
***ANAPHYLAXIS***
***(ALLERGY SHOCK SYNDROME)***

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

## 1. TYPES OF TREATMENT

The treatment may involve all three of the treatments below or any combination of them, dependent on the type and severity of the reaction. At all times the individual treatment plan must be consulted.
An **anti-histamine** may be prescribed according to the severity of the reaction.
Use of an **adrenaline inhaler** may be prescribed if respiratory symptoms appear.
An **adrenalin** injection "should be immediately administered" as a life-threatening situation develops quickly.

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

## 2. WRITTEN INSTRUCTIONS (INDIVIDUAL TREATMENT PLANS)

An Individual Treatment Plan must be drawn up by the Consultant Paediatrician or the General Practitioner.
The parent/guardian must agree in writing to be responsible for ensuring that the school is kept supplied with injections which are "in date".
The parent/guardian is responsible for providing the school with names and telephone numbers of persons who can be contacted in a matter of emergency.
The head teacher, through the employer, must ensure appropriate training is given to staff. The School Health Service, following consultation with the prescribing pediatrician, is responsible for arranging the appropriate information and training for a minimum of two responsible people who have volunteered to administer adrenalin. It may be necessary for the headteacher to arrange for the teachers and other staff in the school to be briefed about a pupil's condition and about the arrangements contained in the written instructions. If there are no volunteers to administer the medication, then an ambulance must be called should a child suffer a reaction.

The instructions may include detailed arrangements for meals and that steps are taken to ensure that the pupil does not eat any food other than items prepared/approved by the parents/guardians as far as is reasonably practicable.
Appropriate arrangements must be agreed with parents/guardians for provision and safe handling of medication during educational visits away from the school.
For each child the symptoms which indicate the onset of an acute allergic reaction may be different. It is the parents'/guardians' responsibility to ensure, in conjunction with the GP, that the list of symptoms which indicate onset are notified to the school within the written instructions.

In the event of the child showing any of the physical symptoms, staff are instructed to follow the agreed emergency procedure.
The instruction must clearly indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor/guardians.
If adrenalin is administered, then the emergency services/hospital must be informed of the dose administered

## 3. LABELLING

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

## 4. STORAGE AND ACCESS

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

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

## 5. ADMINISTRATION OF MEDICINES

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

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

## 6. OVERDOSE/MISUSE

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

Any injection held in reserve must not be administered to another child - even if symptoms similar to an acute reaction are presented. An acute reaction not previously known must only be dealt with as a medical emergency and no medication administered.

**CODE OF PRACTICE**

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

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

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

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

There are 4 types of rescue medication – Rectal Diazepam and Rectal Paraldehyde (rarely used) Buccal Midazolam (10mg/1ml) and Buccolam pre-filled syringes (10mgs/2mls).

**1. TYPES OF TREATMENT**

Administration of prescribed rescue medication

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

**2. WRITTEN INSTRUCTIONS**

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

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

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

**3. LABELLING**

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

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

**4. STORAGE AND ACCESS**

Appropriate amounts only must be kept in secure storage.

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

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

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

**4. ADMINISTRATION**

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

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

- **include** aspects of storage of the drug and completion of records;
- be updated annually;
- **eradicate** all "as and when" decisions, and each case must include clear protocols for the timing of events in sequence.

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

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

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

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

**6. OVERDOSE/MISUSE**

[Details to be provided by medical adviser (consultant paediatrician), to include any specific health and safety (COSHH) requirements, child protection issues and hygiene arrangements.]

**7. FURTHER INFORMATION**

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

*[Form devised in conjunction with Consultant Paediatricians, to be completed by Paediatricians and forwarded to schools],*

***INSTRUCTIONS FOR THE ADMINISTRATION OF RECTAL VALIUM***

Name of Child: _____

Date of Birth: _____

School Attended: _____

In the event of a fit, the above named child should be given rectal valium according to the following instructions:

Name of Consultant Paediatrician: _____

Signature of Consultant: _____

Date

**CODE OF PRACTICE**
***DIABETES IN SCHOOLS***
**Type 1 Diabetes Management in School**
Type 1 Diabetes Mellitus occurs with a lack of insulin to utilise glucose effectively. Children with Type 1 Diabetes Mellitus manage this condition with subcutaneous insulin and are at risk of high and low blood sugars which may make them unwell.

## 1. TYPES OF TREATMENT

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

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

### *Twice Daily Insulin Regimen*

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

### *Multiple Injections of Insulin (MDI) or Basal Bolus Regimen*

MDI is designed to copy normal insulin production. An injection of fast acting insulin is given via a pen device before each meal (bolus) and one injection usually later in the evening is given as basal insulin. The fast acting insulin should be given within 10 minutes of eating.
The child/ Young person will require carbohydrate free snacks when applicable with school policy as discussed with their individual care plans.

### *Continuous Subcutaneous Insulin infusion (Pump Therapy)*

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

### *Insulin Regimens and monitoring*

Most children/young people will require some supervision when monitoring their blood glucose levels in the event of requiring any emergency treatment or advice. Some children/ young people will require supervision of the insulin dose given or depending on age and maturity they may require trained school staff to administer the injection. All insulin regimens require the child/young person to monitor blood glucose and blood ketone levels and for staff to be aware of signs, symptoms and treatment of Hypoglycaemia (low blood sugars) and Hyperglycaemia (high) blood sugar levels as written in the individual care plans.

### *Hypoglycaemia (Low blood sugar levels)*

Hypoglycaemia is when the blood glucose level falls below 4mmol/l
Each child is encouraged to carry their own equipment to deal with a low blood sugar however an emergency box supplied by parents to school is also advised. The emergency box should contain, glucose drinks, glucose tablets, Glucogel and starchy carbohydrate snacks
*Can occur regularly due to:*

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

*Signs and Symptoms of Hypoglycaemia are:*

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

**Mild**

Pupil requires supervision but can take instruction for necessary treatment

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

**Moderate**

Pupil is conscious however requires intervention from a supervising adult

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

**Severe**

Pupil is semi conscious or unconscious and requires emergency intervention

- **Glucagon Injection**

**Follow up treatment**

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

***Hyperglycaemia (High blood sugar levels)***

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

**Danger signs of ketoacidosis to look for:**

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

**Any signs of ketoacidosis dial 999**

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

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

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

**Blood Glucose and Ketone Testing**

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

## 2. WRITTEN INSTRUCTIONS

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

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

## 3. LABELLING

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

## 4. STORAGE AND ACCESS

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

Any medical equipment that needs to be kept locked away or stored away. Will be and the following people will be authorised to hold the key to the medical safe cabinet.

- Mr R Madeley – Senior First Aider
- Miss M Hitchen – Senior First Aider

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

## 5. ADMINISTRATION OF MEDICINES

It is advised that all schools, document any blood glucose/ketone levels and insulin given and by whom.

## 6. ADMINISTRATION OF MEDICATION TRAINNING

It is advised that schools have training this would be given by the child's diabetic nurse.

The staff that would be trained are;

- Mr R Madeley – Medical First Aid Lead
- Miss M Hitchen – Senior First Aider
- Miss J Kendrick – Main First Aider
- Mrs S Curzon – Main First Aider
- The child's class teacher – for awareness
- The child's teaching assistant – for awareness

**CODE OF PRACTICE**
***CONTINENCE MANAGEMENT***
***THE USE OF CLAN INTERMITTENT CATHETERISATON (CIBC)***

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

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

1. Full assessment by a continence adviser.
2. A toileting regime designed to accommodate the demands of the school day.
3. A positive rewarding approach.

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

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

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

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

All children will require: -

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

## 1. TYPES OF TREATMENT

### *REGULAR TOILETING*

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

### *MEDICATION*

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

### *CATHETERISATION (CIBC)*

This is a clean (usually not sterile) procedure and can often be performed by children with appropriate supervision. Most can catheterise on the toilet or in a wheelchair alongside the toilet.

## 2. WRITTEN INSTRUCTIONS

There must be a written care plan on every child drawn up by a continence adviser/ community paediatric nurse in conjunction with the consultant pediatrician or surgeon. The care plan should be reviewed at least annually. The instructions must be approved and signed by the parents/guardians and health professional responsible.

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

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

## 3. LABELLING

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

## 4. STORAGE AND ACCESS

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

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

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

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

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## 5. ADMINISTRATION OF PROCEDURE

At least two suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave.

Training should be provided by a nurse either through the School Health Service or voluntary agencies (e.g. ASBAH).

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

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

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

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