



# Management of children with medical needs in schools 2016-2019

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This document can be found on the [SEN Virtual Office](#)

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## 1. Preface

This is the second revision of the Management of Children with Medical Needs in Schools Guidelines and is in line with a planned update of the document last revised in 2011 and the Government's new statutory guidance for governing bodies and proprietors of academies in England, 'Supporting pupils at school with medical conditions' (September 2014). It also takes into account the requirements of the 'Code of Practice for children with special educational needs and disabilities (2014)'.

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## 2. Introduction

LAs, schools and governing bodies are responsible for the health and safety of pupils in their care. Health authorities also have legal responsibilities for the health of residents in their area. The legal framework for schools dealing with the health and safety of all their pupils is based in health and safety legislation. The law imposes duties on employers.

The statutory guidance, 'Supporting pupils at school with medical conditions 2014' requires '**governing bodies to ensure that all schools develop a policy for supporting pupils with medical conditions** that is reviewed regularly and is readily accessible to parents and school staff.'

The guidelines within this document are in line with the statutory guidance and provide additional advice for schools on the management of children with medical needs. This is important in order to ensure such children are able to access the curriculum when in school, and are not excluded unnecessarily.

All schools will, at some time, have pupils on roll with significant medical needs; governing bodies should ensure that the focus is on the needs of each individual child and how their medical condition impacts on their school life.'

Schools may need to know about routine management of a child with a chronic condition or the emergency management of a child with a medical problem. There will be occasions where school staff may be asked to administer medication either in an emergency situation or to facilitate a child's attendance. **They cannot be directed to do so. The administration of medicines by school staff is voluntary and is not a contractual duty.**

For pupils who have serious medical conditions such as diabetes, epilepsy, severe allergies or severe asthma, or who need regular prescribed medication, for example Ritalin, an individual health care plan (see the end of the relevant section and Appendix 2) should be drawn up. This should be done in collaboration with the child (if appropriate), the parents, school nurse/community Nurse/ paediatrician, and the school staff.

- 2.1 Each school should have a policy regarding the management of children with medical needs based on the DfE's statutory guidance 'Supporting pupils at school with medical conditions' September 2014 for the benefit of their children and to ensure the safety of school staff.

This should be developed in collaboration with the school health service and should be communicated to parents.

### **Supporting pupils with medical conditions (2014)**

On 1st September 2014 a new duty came into force for governing bodies to make arrangements to support pupils at school with medical conditions. The statutory guidance in this document is intended to help governing bodies meet their legal responsibilities and sets out the arrangements they will be expected to make, based on good practice. The aim is to ensure that all children with medical conditions, in terms of physical and mental health, are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential.'

The key points from the guidance are:

- Pupils at school with medical conditions should be properly supported so that they have full access to education including school trips and physical education.
- Governing bodies must ensure that arrangements are in place in schools to support pupils at school with medical conditions.
- Governing bodies should ensure that school leaders consult health and social care professionals, pupils and parents to ensure that the needs of children with medical conditions are effectively supported

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### 3. Legal framework

Section 100 of the **Children and Families Act 2014** places a duty on governing bodies of maintained schools, proprietors of academies and management of committees of PRUs to make arrangements for supporting pupils at their school with medical conditions.

Some children with medical conditions may be considered disabled under the definition set out in the **Equality Act 2010**; where this is the case governing bodies **must** comply with their duties under that Act.

Some children may also have special educational needs (SEN) and may have a statement or Education, Health and Care (EHC) plan which brings together health and social care needs, as well as their special educational provision. A child's medical needs should be considered alongside their other needs, as required by the **Special educational needs and disability (SEND) code of practice 2014**.

Section 2 of the **Health and Safety at Work Act 1974**, and the associated regulations provides that it is the duty of the employer (the local authority, governing body or academy trust) to take reasonable steps to ensure that staff and pupils are not exposed to risks to their health and safety.

Under the **Misuse of Drugs Act 1971** and associated regulations, the supply, administration, possession and storage of certain drugs are controlled. Schools may have a child who has been prescribed a controlled drug.

The **Medicines Act 1968** specifies the way that medicines are prescribed, supplied and administered within the UK and places restrictions on dealings with medicinal products, including their administration.

#### **Regulation 5 of the School Premises (England) Regulations 2012 (as amended)**

Provide that maintained schools must have accommodation appropriate and readily available for use for medical examination and treatment and for the caring of sick or injured pupils. It **must** contain a washing facility and be reasonably near to a toilet.

It **must not** be a teaching accommodation. (Also applies to independent schools and academies under School Standards [England] Regulations 2010.)

**Section 19 of the Education Act 1996** provides a duty on local authorities of maintained schools to arrange suitable education for those who would



not receive such education unless such arrangements are made for them. This education must be full-time, or part-time as is in the child's best interests because of their health needs.

**Section 21 of the Education Act 2002** provides that governing bodies of maintained schools must, in discharging their functions in relation to the conduct of the school, promote the wellbeing of pupils at the school. (For a full list of safeguarding legislation see page 21 of the, 'Supporting pupils at school with medical conditions', statutory guidance 2014)

There is no legal or contractual duty on staff to administer medicine or supervise a child taking it. **This is a voluntary role.**

## 4. Responsibilities

### 4.1 Sandwell MBC

Local authorities are commissioners of school nurses for maintained schools and academies. Under section 10 of the Children Act 2004, they have a duty to promote cooperation between relevant partners such as governing bodies of maintained schools, proprietors of academies, clinical commissioning groups and NHS England, with a view to improving the wellbeing of children with regard to their physical and mental health, and their education, training and recreation.

LAs should provide support, advice and guidance including suitable training for school staff, to ensure that the support within individual healthcare plans can be delivered effectively.

LAs should work with schools to support pupils with medical conditions to attend full time.

LA has a duty to make arrangements for pupils who cannot attend full-time because of their health needs when it is clear that a child will be away for 15 days or more across a school year, whether consecutive or cumulative.

LA maintains appropriate insurance cover for staff in maintained schools who are appropriately trained, as set out in these guidelines. Proprietors of academies should arrange their own insurance cover for staff or ensure that the academy is a member of the DfE's Risk Protection Arrangements (RPA).

### 4.2 The governing body

#### **The governing body must:**

- make arrangements to support pupils with medical conditions in school, including making sure that a policy for supporting pupils with medical conditions in schools is developed and implemented;
- ensure that the policy is appropriately implemented and monitored within the school;
- ensure that staff have the appropriate to support pupils with medical needs; the policy should set out clearly how staff will be

supported and how training needs will be assessed and how and by whom training will be commissioned and provided;

- ensure that sufficient staff have received suitable training and are competent before they take on responsibility to support children with medical conditions;
- liaise with the health services when necessary regarding the policy in general or its application to specific pupils
- ensure that the policy covers arrangements for children who are competent to manage their own health needs and medicine
- ensure that the school's policy is clear about the procedures for managing medicines.
- ensure there are written records kept of all medicines administered to children
- ensure that the school's policy sets out what should happen in an emergency situation.
- ensure that their arrangements are clear and unambiguous about the need to actively support pupils with medical conditions to participate in school trips, visits and sporting activities and not to prevent them from doing so.
- ensure that the appropriate level of insurance is in place that appropriately reflects the level of risk.

### **4.3 The head teacher**

The head teacher should:

- ensure the school's policy for management of medical needs is developed and effectively implemented with partners.
- ensure that staff are appropriately insured and are aware that they are insured and (in maintained schools) sign the indemnity form with each employee administering medications in school (Appendix 10)
- ensure that the awareness training so that all staff are aware of the school's policy for school policy includes arrangements for whole

school supporting pupils with medical conditions and their role in implementing that policy

- ensure that all staff who support children with medical needs are appropriately qualified, trained, and supported and that there are sufficient numbers of staff trained; this may involve recruiting a member of staff for the purpose
- ensure procedures are followed and Health Care Plans are reviewed as appropriate, including contingency and emergency situations
- ensure that all staff are familiar with the policy
- ensure that accurate records are kept regarding children with medical needs
- ensure there is liaison with the school health nurse or community children's nurses about the specific medical needs of children in the school including the need for Health Care Plans and training for staff
- be responsible for making decisions about administering medication in school, guided by the school's policy
- share information with parents to ensure the best care for a pupil
- seek parents' agreement before passing on information about their child's health to other school/health service staff in line with data protection requirements
- ensure that parents' cultural and religious views are respected
- make sure that all parents are aware of the school's policy and procedures for dealing with medical needs.

#### **4.4 Teachers and other school staff**

School staff responsible for the welfare of pupils should:

- take part in training regarding a child's medical needs if they have volunteered to support the child or administer medication. No member of staff can be required to administer medicines they have the right to refuse. (This includes supervising pupils who self-administer medication if the school has consented to do this within the guidelines.)

- understand the nature of the condition, where they have pupils with medical needs in their class and be aware of when and where the pupil may need extra attention
- be aware of the likelihood of an emergency arising and what action to take if one occurs
- be aware of the staff who have volunteered and are trained to support the child and the alternative arrangements if responsible staff are absent or unavailable
- be aware of the times in the school day where other staff may be responsible for pupils e.g. in the playground.
- Inform parents when the medication is due to be out of date or to run out. The parents will need at least one week's notice.

***NB: only the correct paperwork included in these guidelines should be used when devising care plans and when administering medication etc. Staff should not devise their own paperwork***

#### 4.5 The Health Service

Health services have a statutory duty to:

- purchase services to meet local needs
- cooperate with LAs and school governing bodies to identify need, plan and coordinate effective local health provision within available resources
- designate a medical officer with specific responsibility for children with SEN, some of whom will have medical needs.

The health service should:

- provide information and communicate effectively with parents and schools to help them understand the child's medical condition
- provide advice and appropriate training to school staff to support pupils with medical needs
- confirm competence of school staff to carry out specific procedures/treatments

- provide guidance on medical conditions and specialist support for children with medical needs
- advise on the circumstances in which pupils with infectious diseases should not be in school, and the action to be taken following an outbreak of an infectious disease .

## 4.6 The school health nurse

Each school has a designated school health nurse/nursing team. There is also a designated health visitor for each nursery who undertakes the roles shown below for children up to the point they enter the reception year. Contact details are shown in Appendix 11

The school health nurse should:

- be accessible as the school's first point of call for information about medical needs
- liaise with other health professionals if necessary to gather information about a child's medical needs
- notify the school when a child has a medical condition which will require support in school and on the need for a child to have a healthcare plan, when they become aware of that child.
- draw up individual health care plans for pupils with medical needs in collaboration with the parents, school, and if necessary other health professionals. (There are specific plans required for Anaphylaxis / Diabetes / Epilepsy – see section 13 on the individual conditions).
- advise on training and support for school staff, who volunteer to support children with medical needs. (The school health nurse may provide this training and support herself, or may enlist the help of other nurses/doctors to do this)
- review certain children with medical needs in school regularly where indicated by their condition/progress,
- give advice to parents and staff about health issues
- work with regard to data protection regulations.

## 4.7 The therapy team

Some children have complex medical needs/disabilities and have physical/feeding problems that require input from physiotherapy/occupational therapy/speech therapy professionals. These needs require individual care plans and training of support staff in school.

## 4.8 The school doctor/paediatrician:

A consultant paediatrician or paediatric registrar is available to advise schools and school health nurses about specific medical

conditions/health care plans etc. In some instances it is appropriate for schools to contact this doctor directly if indicated by the school health nurse.

**The paediatrician should:**

- work closely with the school health nurse and notify them when a child is identified as having a medical condition that will require support in school, when they become aware of the child
- provide information about a child's medical needs
- Advise the school of the need for a Health and Care Plan for a particular child, and where necessary contribute to this
- assess/review children with medical needs in school, or in a paediatric clinic if necessary
- work with regard to data protection regulations.

**4.9 The community children's nurses**

The community children's nurses provide support and care for children with medical conditions and their families in the community, in special schools and in some cases in mainstream schools.

- ensure that accurate records are kept regarding children with medical needs
- complete the Individual Health Plans for those children they are involved with in partnership with the school health nurse and school staff.
- annually review, with the school health nurse, the specific medical needs of children in the school including the need for an Individual Health Plans and training for staff
- provide expertise and advice to the school staff and other professionals about the child's medical needs
- provide and advise on training and support for school staff, who volunteer to support children with significant medical needs



- work closely with consultant paediatricians and other health professionals to ensure that the child receives the optimum care required to enable them to be in school
- provide advice in an emergency situation as agreed with the school, such as the gastrostomy button falling out.

#### **4.10 The general practitioner**

The child's GP will have an overview of their health needs. The school health nurse will be able to consult the GP about a child's medical needs. In some instances it is appropriate for schools to contact the GP directly if indicated by the school health nurse.

##### **The GP should:**

- inform the school/school health nurse when asked about a child's medical condition, where consent has been given by the parent or the child
- liaise with the school health nurse (with the parent's consent) when they know of a child with a significant medical problem.

#### **4.11 Clinical commissioning groups (CCGs)**

The CCGs should:

- commission other healthcare professionals such as specialist nurses and specific health care packages
- ensure commissioning is responsive to children's needs, and the health services are able to cooperate with schools supporting children with medical conditions
- comply with their duty to cooperate under Section 10 of the Children Act 2004 i.e. with governing bodies and LAs, to improve the wellbeing of children with regard to their physical and mental health
- strengthen links between health services and schools
- consider how to encourage health services in providing support and advice.

#### **4.12 The parents/carers**

Parents should:

- ensure their child is well enough to attend school

- provide the head teacher with information about their child's medical condition and treatment or special care needed at school (when a child joins the school the parent/carer should be asked to complete form SS12; the form should then be completed on an annual basis).
- agree jointly with the head teacher and school health nurse on the school's role in helping with their child's medical needs
- complete consent forms detailing their child's medical needs.

If medication is to be given in school, parents should:

- update the school in writing of any changes in their child's condition or medication
- provide sufficient medication and ensure that it is correctly labelled and in its original packaging
- replace supplies of medication as required if this runs out or is out of date
- dispose of their child's unused medication by returning to the issuing pharmacy
- give permission where their child is self-administering medication

## 5. Developing a school policy

**Since September 2014 schools must have a policy in respect of supporting pupils with medical conditions following the DfE statutory guidance. Follow the link to the document**

[Supporting pupils at school with Medical Needs DfE](#)

## 6. Management of medications

When dealing with medications in school head teachers must bear in mind the need for risk assessment as detailed in health and safety guidelines.

### 6.1 Arrangements to give medication in school

A parental request form should be completed each time there is a request for medication to be administered (Appendix 4). The arrangement must be agreed by the head teacher.

Where a child is self-administering medication there should still be a written request.

If there is any doubt about the need to give a particular medication this should be discussed with the school nurse. It should be stressed that, other than asthma inhalers, it is unusual to have to give medication in school (most antibiotic courses can be given outside school hours)

Where medication is long-term, a letter must accompany the request from the child's GP or consultant. The school must maintain a health care plan when administering long term medication. Where the medication is short-term parents will include instructions about use on the request form

A confirmation form, signed by school and parent/carer must be kept on file, with a copy of the confirmation form retained by the parent/carer (Appendix 5). See Section 6.11: Record keeping. NB there are specific forms required for Diabetes; Asthma; Epilepsy – see section 13 under specific conditions.

Changes to instructions should only be accepted when received in writing. **Verbal messages must not be accepted.**

## 6.2 Receiving medication in school

No medication should be accepted into school unless it is clearly labelled with:

- The child's name.
- The name and strength of the medication.
- The dosage and when the medication should be given.
- The expiry date.
- Any special storage arrangements
- The date the medication has been issued by a chemist

All medication must come into school in the original, labelled, child proof container from the chemist. Where a child requires two types of medication each should be in a separate container. On arrival at school all medication should be handed to the designated member of staff. A few medicines may be needed by the pupils at short notice e.g. asthma inhalers. In most cases pupils must be allowed to carry inhalers with them to ensure easy access. Any medication kept by the child should be recorded (see 6.11 below).

## 6.3 Storage of medication

Any medication received into school must be stored in a locked wall mounted cabinet and the key kept in an accessible place known to designated members of staff. The cabinet must be located in a designated area of the school e.g. school office. Some medication may need to be stored at low temperatures and must therefore be kept in a lockable fridge located in a designated area of the school. It is essential that staff involved with a child who may need access to medication are aware of the storage arrangements.

In the case of senior school pupils it may be appropriate for them to carry emergency medication with them – schools should make such decisions based on individual circumstances in liaison with the family and school health team

In most cases pupils will be allowed to carry asthma inhalers with them to ensure easy access.

## 6.4 Administering medication

Teachers' conditions of employment do not include the administering of medication or the supervision of pupils who administer their own medication. This is also true of most non-teaching staff found in schools. Some staff may, however, volunteer to administer medication. Staff must not give prescription medicines or undertake healthcare procedures without appropriate training. A child who has been prescribed a controlled drug may legally have it in their possession if competent to do so. However passing it to another child for use is an offence. Schools should keep controlled drugs that have been prescribed for a pupil securely stored in a non-portable container and only named staff should have access. In some cases a, written instructions from the parent or on the medication container, dispensed by the pharmacist may be sufficient. This is for the school to decide, having taken into consideration the training requirements as specified in a pupil's health care plan. A first aid certificate does not constitute appropriate training in supporting children with medical conditions. (Para. 27. 'Supporting pupils at school with medical conditions', September 2014)

Children may self-administer some medications e.g. asthma inhalers. It should be clear in the forms relating to medications in school whether the child needs supervision or not. It is good practice to record when a child has a dose of medication even if he or she is self-administering (6.10 below).

## 6.5 Emergency medication

This type of medication (e.g. Adrenalin auto-injector such as epipen for anaphylactic reactions) must be readily available in an emergency. A copy of the consent form must be kept with the medication and must include clear, precise details of the action to be taken.

The procedures should identify:

- where medication is to be stored
- who should collect it in an emergency
- who should stay with the child
- when to arrange for an ambulance/medical support
- recording systems

- supervision of other pupils nearby
- support for children witnessing the event

If the child is carrying their own emergency medication the procedure for administration should also be with the medication.

## **6.6 Analgesia (pain killers)**

Where pupils regularly require analgesia (e.g. for migraine) it is advisable for them to have a health care plan detailing under what circumstances they may take analgesics. An individual supply of their medication should be kept in school and the above guidelines on consent/record keeping etc. should be followed.

It is not good practice to keep general supplies of analgesia e.g. Paracetamol, in school. However when an individual school feels it is necessary to do this they must have a clear policy in place regarding the circumstances under which they would use it. Parental consent must always be obtained before giving non-routine doses of analgesic, and the administration should be recorded as below (6.11).

**School aged children should never be given aspirin or any medicines containing aspirin.**

## **6.7 Generic bronchodilator inhaler for asthma**

Since October 2014 the national guidance allows schools to purchase a generic bronchodilator inhaler and spacer to use in an emergency in a severe asthma attack where a child is known to have asthma and use inhalers but does not have one available in school. It is up to the school to purchase these from a pharmacy should they feel it advisable for their school.

Written agreement from the parent for the use of such medication is required.

## **6.8 Over the counter medicine (e.g. cough mixture, hay fever remedies.)**

These should only be accepted in exceptional circumstances, and be treated in the same way as prescribed medication. Parents must clearly label the container with the child's name, dose and time, and complete a consent form.

## 6.9 Controlled drugs for ADHD

Ritalin and other similar controlled drugs are sometimes prescribed for children with attention deficit hyperactivity disorder (ADHD). The standard drug is short lasting and children **will** need a dose at lunchtime in school. There is now a long acting version but this is not suitable in all cases. When administering these drugs, schools must follow the above guidelines re use with particular attention to locked storage, and careful recording of administration and amount of drug kept in school. A child who has been prescribed a controlled drug may legally have it in their possession if they are competent to do so, but passing it to another child for use is an offence. Monitoring arrangements may be necessary.

## 6.10 Homeopathic medicines

Many homeopathic medicines need to be given frequently during the day and often at short intervals. This is difficult to manage in a school situation. It is strongly advised that schools only agree to administer medicines which have been prescribed by a general practitioner.

In the event of a parent wishing a child to administer homeopathic medicines not prescribed by the GP - if this is agreed to by the head teacher -the school should ask the school health nurse to check the contents of the medication with the prescriber and if necessary a pharmacist.

## 6.11 Record keeping

A parental request form should be completed each time there is a request for medication to be administered (Appendix 4). This form must detail all valid information and **must be carried out by two members** of staff from checking through to administration include:

- child's name;
- reason for request;
- name and strength of medication provided;
- clear dosage instructions;
- date and time the medication should be given;
- up to date emergency contact names and telephone numbers.
- that the date of expiry and issue of medicine has been checked

A confirmation form, signed by school and parent/carer must be kept on file, with a copy of the confirmation form retained by the parent/carer (Appendix 5).

A pupil medicine record must be kept, which includes the name of the medicine(s), the date received by the school and the quantity received. This record must also include the time(s) of the administration and the person responsible for the administration (Appendix 6).

Reasons for not administering regular medication should be recorded and parents informed as soon as possible. A child should never be forced to accept medication.

Changes to instructions should only be accepted when received in writing from the parent/carer, **verbal messages must not be accepted.**

Where a child is self-administering medication there should still be a written request. Self-administration may require supervision and the child should always tell a designated member of staff when they are taking medication so that a record can be kept as above.

Records should be kept in a designated place in school and all staff should be aware of this. The school health nurse should also keep a copy with her records.

On off-site visits the teacher in charge should carry copies of any relevant Individual Health Plan Plans/medication details.



## 6.12 Staff and visitors requiring medication

If staff need medication during the course of the working day they are required to bring this to school with them. Staff who require medication should self-administer.

Any medication brought into school should be kept in a suitable locked cabinet/cupboard. (For staff this will usually be in the secure place they keep their belongings.) This should be separate to the location of pupil's medication.

In an emergency, first aid procedures should be adhered to.

In some circumstances where staff require medication at a specific time, appropriate arrangements will need to be made.

**NB:** 'Staff' in this case includes all teaching, non-teaching, contract staff, visitors and volunteers.

## 6.13 Safe disposal of medicines

There should be a written procedure covering the return or disposal of a medicine. Medicines should be returned to the child's parents and a receipt obtained and filed when:

- the course of treatment is complete;
- labels become detached or unreadable;
- instructions are changed;
- the expiry date has been reached;
- the term or half-term ends.

At the end of every half-term a check should be made of the lockable medicine cabinet. Any medicine, which has not been returned to parents and is no longer required, out of date, or not clearly labelled should be disposed of safely by returning it to the issuing pharmacy.

All medication returned, even empty bottles, must be recorded. If it is not possible to return a medicine to parents it must be taken to the issuing pharmacy for disposal and a receipt obtained and filed.

No medicine should be disposed of into these waste system or into refuse bags. Current waste disposal regulations make this practice illegal.

#### **6.14 Safe disposal of medicines requiring injection – Sharps**

If a school has a child who requires injections it is the parents' responsibility to provide the equipment required in order that these can be given. Parents must also provide the school with an empty Sharps container, which must be used to dispose of any needles following use.

Sharps containers must be used for disposal of any sharp implements, which may have become contaminated with bodily fluid. Sharps containers must be kept in the designated medical area of the school.

- It is mandatory that schools have a policy on the correct procedure for disposal and collection of clinical waste.
- Clinical waste includes any items that have been soiled with bodily fluids. If this includes sharp items, a specific box for sharps needs to be maintained.
- When a sharps box is 3/4 full it should be sealed and arrangements made for the container to be collected and replaced.
- Schools can make their own decision on who collects their clinical waste.

Schools should contact **Sandwell Contract Centre** regarding companies that provide a collection service for Sharps on 0121 569 6625

See also section 9 on infection

## **7. Children with physical/personal care needs**

Some children with medical needs (for instance those with cerebral palsy) will have physical and personal care needs. Therapy, nursing, and medical staff can advise about these children individually and devise care/therapy programmes to be carried out in school. However it is not the nurses' role to write a care plan for changing continence products

Individual Health Care Plans are required for these children

See links below to toileting and manual handling guidelines

[\*\*Guidance to promote personal development in relation to toileting and continence\*\*](#)

[\*\*Guidance for moving and handling children and young people who have physical difficulties\*\*](#)

If you are from a school or service that cannot access Sandwell's Virtual Office please, contact the SEN Service on 0121 569 8240

## **8. Storage, use and transportation of oxygen cylinders**

It is rare for oxygen to be required in school. If this is necessary it is essential to carry out a risk assessment and have appropriate written protocols to ensure appropriate storage, arrangements for supply use and maintenance, and training.

Such children will always be under the care of a Specialist Children's Service at a hospital. The hospital will be able to help with these arrangements and should be involved in the risk assessment and health care planning

## 9. Infection control

### 9.1 Spillage of bodily fluid

Where there is a likelihood of coming into contact with bodily fluids, the following minimum precautions must be adopted, regardless of whether a risk of infection has been identified:

- Disposable non-seamed, powder-free latex or vinyl gloves and a disposable apron must be worn.
- Open wounds on anyone handling spillage must be covered with a waterproof dressing (without visible air holes).
- Generally a body fluids spill should be soaked up first with paper towels or some other absorbent paper. The used paper towels (and other items used to clear up the spill) should be placed in an airtight plastic bag (or clinical waste sack/container if one is available) and the top knotted to seal it.
- The area should then be cleaned using appropriate cleaning tools and substances. It may be appropriate to dispose of or clean the tools used afterwards.
- For full information on dealing with spillages of blood or body fluids see **Body Fluids and Needlestick Injuries Guidance**.
- Single application body spills kits are available across the council through a central contract (The Supply of Cleaning Chemicals, Janitorial Hardware and Paper) and are included in the purchasing catalogue.
- Splashes of blood or body fluid on the skin should be washed off immediately with soap and water. Splashes in the mouth, nose and eyes should also be rinsed out.
- If clothing becomes contaminated with blood or other body fluids, it should be sponged with cold water then laundered separately in a hot wash. The sponge should be disposed of in a sealed airtight plastic bag (or clinical waste container).

- Clean up spillage with an approved cleansing product. Schools should follow health and safety procedures for different types of spillage. Soiled paper towels, protective clothing, gloves etc should be discarded into a yellow bag (used for clinical waste).
- If there is broken glass involved, never pick it up with fingers, even if wearing gloves. A paper or plastic scoop must be used. Dispose of the glass/any injection materials in a sharps container (if available or wrap securely in a drinks carton, newspaper etc;
- If a needle stick injury occurs follow the LA Health and Safety Guidance via the link below.
- The first sharps box may be supplied to the school by the parents. School should contact their service provider for subsequent collection of full sharps boxes and delivery of empty boxes.

The link below takes you to the guidance from Sandwell Health and Safety with regard to body fluids and needlestick injuries

[Body fluids and needlestick injuries guidance](#)

Managers or employees with questions or requiring further advice and guidance should contact the Health and Safety Unit  
0121 569 3807

## 9.2 Prevention of cross infections

In order to avoid cross infection the following procedures must be followed:

### **Hand washing:**

- before and after all medical contact: If skin not soiled, use alcohol gel and allow to dry naturally on the hands.
- after skin is contaminated with bodily fluid: Use Liquid soap, and hand hot water the hands should be dried thoroughly with a paper towel and may be followed with an alcohol gel.

NB: Equipment should be available in the child's class, not the nearest toilet. The correct technique should be used to wash hands, ensuring the finger webs, nails and palms are fully cleaned.

### **Protective clothing:**

- wear gloves for direct contact with body fluids
- wear plastic apron to protect clothing
- change protective clothing between procedures

### **Keep cuts covered:**

- always cover cuts/skin lesions with a waterproof dressing.
- Use yellow clinical waste bags for infected waste. Do not ask other children to help with cleaning wounds.

## 9.3 Children with personal care needs

Some children in school will require assistance with their personal care. This may include feeding and toileting needs. These situations will present a risk of cross infection.

Where children require assistance with toileting and/or feeding it is important that the following good hygiene procedures are adopted.

With regards to the cleaning and sanitising of equipment used for assisting children to eat and drink, procedures should be carried out in accordance with the procedures/guidance laid down by catering managers, (colour coded cloths etc.). Disposable tissues/wipes should be used to cleanse children's skin and should be disposed of

hygienically. For some children it may be necessary to use simple wipes and water rather than impregnated wipes, particularly if the child has Eczema, allergy or broken skin. Children should be assisted and/or encouraged to wash their hands before eating or drinking.

With regards to the cleaning and sanitising of equipment used for assisting children with toileting and personal hygiene, personal protective equipment should be used by professionals and any materials used can be disposed of in an appropriate way after one use. Sanitizer spray and disposable medical roll/ hard surface wipes should be used for wiping surfaces. When using a changing bed, in the interests of safety and to show respect for the child, it is good practice to use a new sheet of disposable medical bed roll for each child, each time they are changed. This can then be disposed of appropriately. All surfaces and equipment can be sanitised at the end of each day according to cleaning guidelines laid down by local and national, policy and procedures.

The links below will take you to:

**[Guidelines for Moving and Handling Children and Young People \(Pupils\) who have Physical Disabilities](#)**

**[Policy and Practical Guidance to Promote Personal Development in relation to Toileting/Continence](#)**

If you are from a school or service and cannot access Sandwell's Virtual Office, please contact the SEN Service on 0121 569 8240

## **Infectious illnesses**

There are standard periods of exclusion for infectious illnesses. The commonest requiring exclusion are diarrhoea (exclusion 48 hours from last episode of diarrhoea for most cases) and chicken pox (exclusion till all spots crusted over which is at about 5 days). For advice contact the school nursing team, and check the information available from Public Health England – link below.

**[Guidance on infection control in schools](#)**

## 10. First aid

Under the Health and Safety (First Aid) Regulations 1981 employers are required to provide for employees adequate and appropriate equipment, facilities and qualified first aid personnel. The Regulations do not oblige employers to provide first aid for non-employees but Health and Safety Guidance to the Regulations recommends that organisations such as schools should provide for pupils and other visitors to the school and include them in their risk assessments.

The DfE document 'Guidance on First Aid in Schools 2000' (updated in 2014) says:

"In the light of their legal responsibilities, schools should consider carefully the likely risks to pupils and visitors, and make allowances for them when drawing up policies and deciding on the number of first aid personnel."

How much first aid provision a school has to make depends on its own circumstances. There are no levels or fixed ratios. Schools need to consider:

- workplace hazards and risks;
- the size and nature of the school and whether the school is on split sites;
- the nature and distribution of staff and pupils;
- whether staff and pupils have special needs or disabilities;
- the remoteness of the school from emergency medical services;
- the needs of any remote or lone working staff;
- annual leave and absences of first aiders and appointed persons

Before taking up first-aid duties, first-aiders must hold a valid certificate of competence in either:

- (a) First Aid at Work (FAW), issued by a training organisation approved by the governing body
- (b) Emergency First Aid at Work (EFAW), issued by a training organisation approved by the governing body
- (c) Schools will need to have staff trained in paediatric first aid.

FAW and EFAW certificates are valid for three years. Schools will need to arrange retraining before certificates expire. Where first-aiders attend the relevant course within three months prior to certificate expiry, the new certificate will take effect from that date of expiry. Retraining can be



undertaken earlier than this three-month period, in which case the new certificate will take effect from the date the course is completed. Where retraining has not been undertaken before certificate expiry, it should be completed no more than 28 days beyond the expiry date. The new certificate will be dated from the expiry date of the previous certificate. If retraining is not completed by the end of this 28-day period, the individual will need to undertake a full FAW course or EFAW course, as appropriate, to be re-established as a first-aider.

HSE strongly recommends that first-aiders undertake annual refresher training during any three-year FAW/EFAW certification period. Although not mandatory, this will help qualified first-aiders maintain their basic skills and keep up to date with any changes to first-aid procedures.

Communication is important for effective first aid and all schools should prepare and publish the following:

- Names of qualified first aiders indicating where they may be contacted.
- Contact details for emergency services.
- Siting of first aid boxes and first aid rooms his information should be sited next to each internal and external telephone and other key sites in the school
- Emergency planning guidance re calling an ambulance should be accessible (see Appendix 13).

It is recommended that a record be kept of any treatments given by first aiders and these records should include:

- the date and time of the incident;
- the name (and class) of the injured person;
- details of the injuries/illness and the first aid given;
- what happened to the injured/ill person immediately after treatment

The first aider administering the first aid should record this on a form (see Appendix 7 for suggested format)

## **First Aid in schools**

## **11. Invasive procedures**

For some children the treatment required for their condition may be invasive in nature. Where this is the case particular care should be taken to maintain the child's dignity and privacy at all times.

This would include for instance, administration of emergency medication for prolonged seizures, also those requiring adrenaline, auto-injector e.g. epipen injection for anaphylaxis

See sections on "information about specific conditions" for more details

## 12. Emergency situations

Teachers and other staff are expected to use their best endeavours at all times in emergencies. In general the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency. Advice and training is available from the School Health Nurse Team regarding possible medical emergencies. These are mainly related to three conditions:

- Prolonged epileptic seizures requiring buccal midazolam, rectal diazepam or rectal paraldehyde.
- Anaphylactic reaction requiring adrenaline delivered by adrenaline auto-injector e.g. epipen
- Acute asthmatic attack requiring more inhalers/attention than usual routine doses.

The Children's Community Nurse Team will give training and advise on:

- hypoglycaemia, gastrostomy devices or obstruction of tracheostomy
- Gastrostomy device coming out of its stoma – in this situation the school staff are not expected to try and replace the device but must get in touch immediately with the relevant health service contact, given in the child's health care plan, since it must be replaced urgently to avoid the stoma tightening and making this impossible.
- Diabetic hypoglycaemic attack requiring glucose (glucose tablets or glucogel).

More detailed guidance on any of these conditions is given in the following pages.

### Defibrillators

Sudden cardiac arrest is when the heart stops beating and, whilst rare in children, it can happen to people of any age without warning. Modern defibrillators are easy to use and inexpensive. Schools are advised in the. 'Supporting pupils at school with medical conditions' (Statutory guidance September 2014 para 42, page 18) to consider purchasing a defibrillator as part of their first-aid equipment. This is **not mandatory**, however If schools decide to install a defibrillator for general use, they

should notify the local NHS ambulance service of its location. Schools must carry out a risk assessment when considering the purchase and use of a defibrillator.

Staff members appointed as first aiders should already be trained in the use of CPR and may wish to promote the use of these techniques more widely in the school amongst both teachers and pupils.

## **Guidance for schools on using defibrillators - DfE**

### **Jehovah's Witnesses**

Families who are Jehovah's Witnesses may not want their child to receive a blood transfusion. It must be clarified in advance what procedure would be followed in an emergency situation where a blood transfusion would normally be required. This decision should be made in consultation with the consultant paediatrician and the family. This is particularly relevant in relation to offsite activities.

## **13. Information about specific conditions**

### **13.1 Anaphylaxis**

#### **General information about anaphylaxis**

Anaphylaxis is an acute, severe allergic reaction needing immediate medical attention. It can be triggered by a variety of allergens, the most common of which are foods (especially peanuts, other nuts, eggs, cow's milk, fish/shellfish), certain drugs such as penicillin, and the venom of stinging insects (such as bees, wasps or hornets).

In its most severe form the condition is life-threatening.

Not all children with allergies/food sensitivities have severe reactions requiring adrenaline injection, however, it remains appropriate to have a Health Care Plan documenting the type of reactions they experience and how to prevent and manage these.

#### **Symptoms of an allergic reaction**

Symptoms, which usually occur within minutes of exposure to the causative agent, may include:

- itching, hives anywhere on the body, generalised flushing of the skin
- swelling of the lips/eyelids
- a strange metallic taste in the mouth swelling of the throat and tongue difficulty in swallowing
- abdominal cramps and nausea
- difficulty in breathing – due to severe wheezing or throat swelling
- increased heart rate, sudden feeling of weakness or floppiness
- collapse and unconsciousness.

Not all of these symptoms need be present at the same time or in every child.

## Anaphylaxis Care Plan

A child at risk of anaphylaxis should have a specific care plan (see below) as well as a standard health care plan drawn up between the school, the school nurse and the doctor supervising the child. This should give details of the symptoms experienced during an attack, the treatment required and who can administer it. The school nurse can help with training and education of school staff. The training competency documents in the training section (16) should be completed.

### Medication

A child at risk of anaphylaxis may be prescribed oral antihistamines, an inhaled bronchodilator, and/or an adrenaline injection (Adrenaline Auto-injector, e.g. Epipen®). This injection is in a pre-loaded syringe and is simple to administer. Designated staff who volunteer to support such a child in an emergency situation will be trained by the school health nurse.

Some organisations advise that 2 adrenaline auto-injectors are kept in school. This is because if there is no improvement in a child's condition 15-30 minutes after administering an adrenaline auto-injector a further dose can be given. Since Sandwell is an inner city area and ambulance response time is quick, it is not necessary to keep a second dose in school – however, additional doses should be considered for school trips.

### Day to day measures

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 school kitchen staff are employed by a separate organisation to the teaching staff, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements.

Appropriate arrangements for outdoor activities and school trips should be discussed in advance between the parents and the school.

Cookery and science experiments with food may present difficulties for a child at risk of anaphylaxis. Suitable alternatives can usually be agreed. The individual child and the family have a right to confidentiality. However, the benefits of an open management policy could be

considered. As with any other medical condition, privacy and the need for prompt and effective care are to be balanced with sensitivity.

### **Emergency care**

If contact with a product known to cause an allergic reaction has occurred, or the child is showing symptoms of a reaction, summon another member of staff.

Once in contact with the product the signs of a reaction occur usually within a few minutes and almost always within 30 minutes. Watch the child carefully during this period.

(a) **If *no reaction* occurs within 30 minutes:**

- continue to observe;
- do not leave the child alone for the following 3 hours in view of the possibility of late reaction;
- reactions after 30 minutes are uncommon, and unlikely to be as severe as true anaphylaxis;
- contact parents.

(b) **During a *mild reaction* the symptoms are likely to be:**

- red blotchy rash on face or hands (hives);
- mild swelling of face especially around eyes/mouth;
- tickly or tight feeling in throat/tingling in tongue;
- tummy ache/feeling sick;
- Irritability.

### **Treatment of mild reaction**

- Ensure that one person stays with the child and observes for further reaction.
- Give a dose of oral antihistamine medicine e.g. Piriton as indicated on the care plan
- Ensure that the adrenaline auto-injector box is brought to the child in case the reaction becomes severe, symptoms described below

- Get someone to contact parents.
  - Do not leave the child alone for the following 3 hours in view of the possibility of late reaction.
- (c) During a *severe reaction* the symptoms are likely to be:
- marked swelling of mouth, lips;
  - tongue swelling;
  - altered voice;
  - difficulty speaking;
  - difficulty swallowing;
  - difficulty breathing or wheezing;
  - feeling faint or loss of consciousness;

Treatment of severe reaction:

- Put the child in the recovery position if child becomes unconscious.
- Give **adrenaline injection** as detailed below
- **Dial 999** and state “**ANAPHYLAXIS**” child to be transferred to nearest accident and emergency department.
- Ensure that one person stays with child and observes for improvement or deterioration of the reaction
- Get someone to contact parents.

### **How to use an adrenaline auto-injector adrenaline injection**

The injection is in a pre-packed syringe. The dosage is set so no calculation is necessary. Administer the whole amount into the outer mid-thigh. Keep the syringe safe to be discarded in sharps box carried on ambulance.

**DO NOT** delay management by trying to contact parents/carers first.

If in doubt call ambulance and give medication and note the time, you can do no harm by giving it.

When ambulance arrives tell them what you have given and the time it was given.



## Health Care Plan for Management of Anaphylaxis

Photo
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<b>Name:</b>	
<b>DoB:</b>	
<b>NHS:</b>	

See standard Health Care Plan for contact details.

<b>Allergic reaction likely after exposure to:</b>
--

In the event of symptoms which indicate the child is suffering an anaphylactic reaction:

- Stay with the child (or get someone else to do this)
- Get medication/adrenaline injection
- Give treatment indicated below depending on the severity of the reaction
- Phone 999 for ambulance
- Report condition to teacher in charge/head teacher and contact Parents

<b>Usual symptoms of a mild reaction:</b>
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<b>Treatment required during mild reaction:</b>
---

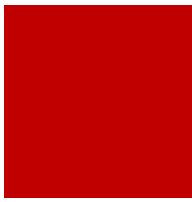
<b>Usual symptoms of a severe reaction:</b>
---

<b>Dose of adrenaline injection required during a severe reaction:</b>
--

**Care Plan Agreement:**

	Parent	Date: _____
	Head teacher	Date: _____
	School health nurse	Date: _____
	Doctor	Date: _____

<p><b>Data Protection Act, 1998</b>                  The information that you supply on this form will be used by Children's Services for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children's Service <b>For further information visit: <a href="#">Department for Education</a></b></p>
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## 13.2 Asthma

### General information about asthma

About one in ten children have asthma at some time in childhood but not all of these will be severely affected enough to require inhalers to be kept in school. A few children will have severe asthma and will require regular medication in school to prevent them from getting symptoms. For children requiring inhalers in school a Health Care Plan is appropriate (document at Appendix 2).

### Asthma medication

Asthma medication is usually given by inhalers. There are various different types and the doctor prescribing the inhaler should ensure that it is possible for the child to use it properly. Because of the coordination needed, children under 12 often find it difficult to use the aerosol spray inhalers properly without a spacer. Also if a child or young person is having a severe attack, it is easier and more effective for them to use a spacer. Spacers will often be needed in school. (Occasionally tablets are used in addition to inhalers but these are only given once or twice a day and will not be required in school).

#### Reliever (bronchodilator) inhalers

Relievers are usually blue. This is the inhaler that children need to take immediately when asthma symptoms appear. Relievers work quickly to relax the muscles around the airways. As these muscles relax, the airways open wider and it gets easier to breathe again.

- Children should always be prescribed their own inhalers and should bring these into school so that they are available if needed.

**In an emergency, if they do not have their reliever inhaler in school it is possible to have a dose of a generic reliever inhaler (Ventolin). Schools can purchase an inhaler and spacer for this purpose.**

If this is done it is necessary to get written agreement from the parent that they are willing for their child to have the generic inhaler. The dose given should be whatever usual dose they are prescribed

for an acute attack of asthma and this should be on their health care plan.

## **Preventer inhalers**

Preventers may be brown, orange, or sometimes other colours but **not** blue. They are only required two or three times a day and do not have any immediate effect on wheeze/cough. They should not therefore be required in school.

- Where should the school keep reliever medication?

Immediate access to reliever medication is essential. Delay in taking reliever treatment, even for a few minutes, can lead to a severe attack and in very rare cases has proved fatal.

As soon as a child is able, allow them to keep their reliever inhaler with them at all times, in their pocket or in an inhaler pouch. The child's parents, doctor or nurse and teacher can decide when they are old enough to do this (usually by the time they are seven).

Keep younger children's inhalers in an accessible place in the classroom. Make sure they are clearly marked with the child's name. At break time, in PE lessons and on school trips make sure the inhaler is still accessible to the child.

Children should not be prevented from taking part in physical activities because they have asthma. If a child is consistently unable to take part because of symptoms – cough, wheeze, breathlessness, and tiredness – you should ask the school nurse to check their treatment. It should almost always be possible to manipulate this so that a child is not incapacitated by their asthma.

## **Management of an asthmatic attack**

### **Classroom first aid**

- Ensure that the reliever inhaler is taken immediately.
- Stay calm and reassure the child.
- Encourage the child to breathe.

Encourage the child to breathe slowly and deeply. Most children find it easier to sit upright or lean forward slightly. Lying flat on the back is not recommended. Ensure tight clothing is loosened.

- Record the dose(s) of medication given
- After the attack: Minor attacks should not interrupt a child's involvement in school. As soon as they feel better they can return to normal school activities.
- The child's parents must be informed about the attack.

### **Emergency situation**

#### **Dial 999 and call an ambulance urgently if:**

- the reliever has no effect after five to ten minutes
- the child is either distressed or unable to talk
- the child is getting worse/exhausted
- you have any doubts at all about the child's condition.
- Continue to give reliever medication as per the Health Care Plan, every few minutes until help arrives.

A child should always be taken to hospital in an ambulance. School staff should not take them in their car as the child's condition may deteriorate very quickly.

### **Staff training**

If staff will be involved in managing a specific child's asthma, and supervising/giving medications the training competency documents in the training section (16) should be completed. Training is available from the school health nursing team



## 13.3 Diabetes mellitus

### General information about diabetes mellitus

Diabetes is the most common chronic metabolic disorder in the paediatric population. The annual incidence is rising and estimated to be around 18.5/100,000 in England. This reflects approximately one child in every 350 school aged children being diagnosed with diabetes. Type I diabetes which is autoimmune diabetes accounts for over 90% of all childhood diabetes in young people aged less than 25 years. It is due to beta cell destruction and absolute insulin deficiency. Increasingly children with other types of diabetes are being recognised.

The majority of school aged children with diabetes have type 1 diabetes. As you may be aware diabetes is a lifelong condition and therefore cannot be cured but can be effectively treated and managed with injections of insulin, blood glucose monitoring and careful dietary modification. The aim of this treatment is to keep blood glucose levels as close to the normal range as possible without prolonged spells of high blood sugars (hyperglycaemia) or low blood sugars (hypoglycaemia).

### Definitions

**Type 1 diabetes** - Immune mediated diabetes mellitus associated with *B*-cell destruction usually leading to absolute insulin deficiency and a requirement to have insulin injections for life irrespective of age at diagnosis.

**Type 2 diabetes** - A condition in which the aetiological factor may range from predominantly insulin resistance with relative insulin deficiency to a predominantly defect with insulin deficiency. These children may require treatment ranging from dietary modification up to insulin injection regime.

### Health care team

Children and adolescents are cared for by a multi-disciplinary team specialising in childhood diabetes. At Sandwell Hospital this consists of (at 26/02/15):

<b>Title</b>	<b>Name</b>	<b>Phone numbers</b>
Consultant Paediatrician	Dr Agwu	0121 553 1831
Database Coordinator and Dr Agwu's Secretary	Julie Oliver	0121 553 1831
Paediatric Diabetic Nurse Specialist (PDSN)	Lizbeth Hudson	0121 507 3476 07979756463
Diabetic Nurse Specialist (DSN)	Amanda Whitehouse	07528969853
Diabetic Nurse Specialist (DSN)	Sammie Bissell	
Paediatric Psychologist	Dr A Reynolds	0121 553 1831
Senior Dietician	Lorna Rows	0121 607 3521

At diagnosis and at any other point in the child's school life the PDSN will be available to give advice, develop care plans and train staff in meeting the diabetic needs of the children in their care.

### **Diabetic treatment regime**

All children diagnosed with type 1 diabetes will require injections of insulin irrespective of age. Historically children were treated with twice daily injections of insulin. This however has now been superseded by a more physiological insulin regime of multiple daily injections. Most children will be on 4 injections a day and therefore require injections at lunch time while in school. Evidence shows that this is a more effective way of maintaining normal blood glucose levels if given alongside a meal. In the majority of cases children will have been taught to inject themselves but will require close supervision and possible assistance during this time. Some children, however, will not be able to inject themselves and will require staff to do this for them. Where children are unable to do injections for themselves, specific training will be given to the staff in order to enable them to inject the child. There will be a specific individualised care plan formulated for that child. Insulin is administered by means of an injection pen and injected to the leg, stomach or the arm dependant on age. The dose of insulin given at meal times is calculated on both the blood glucose level and carbohydrate level of the food eaten. Some children will administer insulin via an insulin pump (continuous subcutaneous insulin infusion).

## **Audit standards**

- 100% of schools will receive training into general care of the diabetic child in school. The training competency documents in the Training section (16) should be completed.
- 100% of school staff who have agreed to inject in school will receive specific training and will be signed off as competent. The training competency documents in the training section (16) should be completed.
- 100% of children with diabetes will have an individual care plan which states their insulin regimen, frequency of injection and blood glucose testing (see format below).
- 100% of children in school who require help with insulin injection will have a signed contract allowing staff to inject (see form to document parental agreement for designated staff to give insulin below).

## **Insulin injection recommendations**

- If able, considering age and ability, children will be taught to do injections themselves.
- Most children will require supervision or a chaperone present during insulin injection.
- A private room with hand washing facilities must be available to inject in.
- A sharps box put in place for safe disposal of used sharps. If supplied by the school, the school will arrange disposal and renewal. If the school do not supply a sharps box, then each parent will supply their own child's sharps box and the parents will replace when full.
- Staff who will be performing insulin injections will have specific training needs assessment completed by the PDSN. They will be assessed as competent at performing injections before injections can be undertaken.
- Parents must sign a contract agreeing to allow staff to inject, and accept responsibility for informing staff any alteration of dosage in writing (see below)
- Parents must have their telephone on for easy contact by staff

- Dose of insulin must be checked by two staff and recorded and signed in book provided or using suggested insulin administration record below
- Safety needles for the insulin injections and safety lancets to perform the blood testing will be supplied by the parents.

### **Continuous subcutaneous insulin infusion (insulin pump)**

Some children use an insulin pump for delivery of insulin rather than an insulin injection. In such cases they will wear their insulin pump at all times except during contact sports or swimming. Most children on an insulin pump will be able to press the appropriate buttons to deliver insulin. Younger children may need a chaperone or supervision. If the child suspects the insulin pump is blocked, they will need a private room with wash hand basin to enable them change their infusion set. All children on an insulin pump need to carry with them an insulin injection device in case of emergency. This will be stated in their care plan.

### **Insulin pump recommendations**

- If able, considering age and ability, children will be taught to be able to press the necessary buttons to administer their insulin. The older children will be taught how to change their infusion set.
- Young children will require supervision or help in pressing the appropriate button.
- A private room with hand washing facilities must be available in case child needs to change infusion set. If a younger child needs to change their infusion set, the parents must be called in to carry out this procedure.
- A sharps box put in place for safe disposal of used sharps. Staff who will help in pressing the appropriate buttons to administer insulin will have specific training needs assessment completed by the PDSN. They will be assessed as competent at performing this task before it can be undertaken.
- Parents must sign a contract agreeing to allow staff to administer insulin via the insulin pump, accept responsibility for informing staff any alteration of dosage in writing. (see form below).
- Parents must have their telephone on for easy contact by staff.



- Dose of insulin administered must be checked by 2 staff and recorded and signed in book provided or using suggested insulin administration record below.

### **Blood glucose testing**

Children with diabetes have to ensure that their blood glucose levels remain stable and will need to check their blood sugar at least at lunch time at school and possibly during a hypoglycaemic episode (see separate section) or before activity such as PE sessions. As with injections most children will be able to do this procedure themselves however, they may need help to interpret these results and know exactly what to do.

### **Blood glucose testing recommendations**

- A private room with hand washing facilities should be available.
- Parents will provide the blood glucose meter, test strips, finger pricker lancets and sharps box.
- The individualised care plan will indicate how to interpret blood glucose levels obtained in testing. Specific training and competence of staff involved will be assessed with regard to blood glucose monitoring.
- All blood glucose results should be entered into the insulin administration and blood glucose record (see form below).

### **Hypoglycaemia and its treatment**

Hypoglycaemia stands for low blood sugar and has to be seen as a normal part of the life of a diabetic child. Common causes of “hypos” are a missed or delayed meal or snack, cold or very hot weather, stress, mismanaged activity or too much insulin. Children may describe many differing symptoms for their own hypo signs and staff should talk to parents to ask about specific hypo signs for the children. Hypoglycaemia must be treated immediately because if untreated the child may become unconscious and may have a seizure. If the child’s blood sugar is low, they should not be left alone until it is treated.

### ***Hypoglycaemia recommendations***

- Common hypo signs are confusion, wobbly, feeling of hot or cold, headache, blurred vision, going very pale, sleepy drowsy and hunger, however, children may describe hypos in many differing ways so clarification on specific individual signs should be obtained from parents and indicated on the individual care plan.
- All children with diabetes in school will have specific “hypos” information contained in their individualised care plan.
- All children with diabetes will have a supplies box within school with supplies contained within to treat hypoglycaemia.
- Every child with diabetes should have a “hypo” emergency box in school (either in the classroom in the case of primary schools, or in the medical room/ reception in secondary school).
- Contents of this box will be provided by the parents and will include Lucozade bottle, dextrose tablets, glucogel and biscuit snacks. Specific advice will be given by the PDSN.
- All staff dealing with diabetes in school will have specific training about the recognition and treatment of hypoglycaemia in children.

### ***Mild hypoglycaemia -recognition and treatment***

- Mild hypo management – child is conscious
- Check blood sugar if available to do so If below 4mmols treatment is required
- Lucozade 50ml OR
- Sugary drink (coke or similar) 150mls or
- Fresh fruit juice 100mls or
- Dextrose tablets x3

Following this, wait for 10-15 minutes for this to take effect.

- Recheck blood glucose if above 4 mmols follow up with a starchy snack such as biscuits.
- If remains below 4 mmols or if still feeling unwell repeat the above. This can be repeated until the child is feeling better and then follow up with a biscuit snack.

***Moderate hypoglycaemia - management – child is conscious but either very drowsy or unable to cooperate***

- Glucogel should be used. Glucogel comes as a tube containing a sugary gel and is squeezed into the side of the mouth. This will bring the blood glucose levels up and the child will wake up. Specific training will be given by the PDSN regarding the use of glucogel.
- When awake follow above management for mild hypo management.

**Severe hypoglycaemia management – child is unconscious and able to swallow**

- Never give the unconscious child anything orally

Steps to follow:

- Place the child in the recovery position
- Call 999 and ask for the ambulance service.
- Report diabetic child in hypo crisis.
- Keep someone with the child.
- Inform the child's parents and await emergency services.

**Hyperglycaemia – recognition and treatment and testing for ketones**

Hyperglycaemia means raised sugar in the blood. This could lead to a number of symptoms however the most recognised are increased thirst and an increased need to go to the toilet. Any child showing these symptoms should have this mentioned to parents. If the blood sugar is greater than 14mmol then the child should test their blood sugar for ketones. A meter and strips will be provided by parents.

**Treatment:**

- Extra insulin can be given if the child is on multiple daily injections. Correction doses of insulin are calculated as extra amounts of insulin to be given to the child along with their usual lunchtime dose in order to bring the blood glucose down.

- Each child will have individualised correction doses on their care plans. These correction doses will change from time to time and will have to be updated.
- Any changes to correction doses will be updated in writing by parents
- If blood ketones are checked and the result is more than 0.6 mmol, advice should be sought from parents or the diabetes team

### **Hyperglycaemia standards**

- All children will have correction doses indicated on their individual care plan if appropriate.
- Any extra insulin injected as correction dose should be indicated on the insulin administration form and parents informed.
- All staff that have a responsibility for diabetes care in school will have teaching regarding hyperglycaemia and its management including the use of correction dosage.

### **Illness management in a child with diabetes in school**

A diabetic child may get childhood illnesses just like any other child however; special arrangements have to be put into place if a child with diabetes becomes unwell. Blood ketones must be checked if the child is unwell, and if they are more than 0.6mmol, advice should be sought from parents or the diabetic team.

- If the child with diabetes is vomiting or unable to eat their meals due to nausea or illness inform the parent immediately to collect their child from school.
- If possible check blood glucose, if high call diabetes nurse specialist for specific advice
- If blood glucose is low encourage the child to slowly sip on Lucozade until parents can come to collect him/her. If the child is vomiting and has low blood glucose, the risk is that blood glucose levels may fall further, so slowly sipping on Lucozade will help prevent this until parents arrive to collect the child.
- Parents must inform school of any illness if the child is still going to school.
- Parents to ensure that school has contact details and that these are up to date.

- School health care plans should have the contact details for the PDSN

## **Dietary needs in school**

The diet for any diabetic child is based on a well-balanced varied diet which is low in fat, salt and especially sugar. Meals and snacks should have a proportion of carbohydrates in them. Examples include items such as bread, rice, potatoes and pasta. Note: Some children with diabetes also have coeliac disease and therefore will require more specialised diet e.g. gluten free diet.

### **Dietary recommendations:**

- Close liaison with parents to formulate diet plans.
- Close supervision of younger children to ensure that they are eating the required amount of food at meal times.
- Avoidance of sugary or sweet desert.
- Further advice and support should be sort from the dietician at the hospital.

## **Exercise management**

Children with diabetes can and should be encouraged to participate in all aspects of physical activity that the school has to offer. Exercise should be encouraged as it improves fitness levels, encourages healthy lifestyles, and ensures that they do not feel like a special case and different from their peers and also helps to improve the action of insulin and will enhance blood glucose control.

### **Exercise recommendations**

- Prior to activity the child should check a blood glucose level and treat according to the individual care plan.
- Individual care plan should highlight what snacks or sweet snacks should be taken prior, during, or after exercise.
- “Hypo” boxes should be available during PE sessions. (see section on hypoglycaemia)
- Following activity a further blood glucose level may be taken and treatment given according to the level.

- All PE staff to receive training regarding general diabetes management.
- 100% of children with diabetes will have a specific understanding of how to manage exercise effectively.

## **School outings and residential trips**

Any school day outing or residential trip for the diabetic child should be encouraged. School day trips are largely without problems as they are usually to somewhere close by and follow the usual school day routine. Residential trips however do require care full planning.

### **School outings and residential trip recommendations**

- Early contact with the PDSN to discuss any outing and residential trip.
- Specific care plan to be drawn up regarding the trip.
- Parents to provide all of the medical and “hypo” supplies for the duration of the outing or trip. Parents to ensure that adequate insulin supplies are provided for the duration of the trip.
- Residential activity trips have to be carefully planned and close liaison with parents is vital.
- Schools to include taking the child with diabetes in their risk assessment of the trip.

### **School outings standards**

- All children to be offered school outings and residential trips as appropriate.
- All staff who are involved with the running and staffing of the trip will have specific training into diabetic needs prior to taking any child with diabetes on a trip.

Specific care plan drawn up for the trip.

- Parents to supply extra food, hypo treatment and sufficient insulin, needles and blood glucose testing equipment for the duration of the trip.

### **Safe storage of insulin and safe disposal of sharps**

If insulin is to be kept in school for use at lunch times it has to be correctly stored. Sharps also have to be carefully looked after and disposed of correctly.

### **Safe storage of insulin and sharps disposal recommendations**

- Insulin remains the responsibility of the child and parents.

- All insulin should be placed in a container indicating the child's name, insulin name and date of opening.
- Any unopened insulin has to be stored in a refrigerator.
- Any insulin currently in use can be kept at room temperature but must be stored in a dry cupboard and out of direct sunlight.
- Sharps box to be supplied to school from the parents.
- All used sharps to be put directly in the sharps box provided.
- The first sharps box may be supplied to the school by the parent school should contact their service provider for subsequent collection of full sharps boxes and delivery of empty boxes.
- When  $\frac{3}{4}$  full the box is to be close shut and contact made with the sharps collection dept. who will arrange collection and delivery of a replacement box (this is subject to alteration following on from discussion from pct.).

### **Safe storage of insulin standards**

- All staff who have a responsibility for insulin administration or supervision will receive specific training about insulin storage.
- School to ensure that a refrigerator is available for insulin storage.
- All children will have access to a sharps box in school.

### **Staff training**

The training of staff involved in the care of children with diabetes is of paramount importance in order to ensure the child is adequately cared for while in school.

### **Training recommendations**

General training:

- This is designed for those staff who have exposure to the diabetic child.
- General training includes information on what diabetes is, how it is treated and specific information on hypoglycaemia recognition and treatment, exercise and illness management and dietary needs.



## **Intensive training**

- This is designed for those staff who will be undertaking interventions with the child such as the administration or the supervision of insulin injections.
- Staff will be identified and training will take place over three sessions.
- These sessions will include the general training as above and also include insulin administration theory and practical and blood glucose testing and interpretation of results.
- Staff will be assessed by the PDSN to ensure that the necessary competency is achieved before the individual staff member can practice.

## **Training standards**

- All staff in school who require general training will have this provided.
- Identified staff in school who will be administering or supervising insulin injections will have intensive training provided.
- Assessment and competence must be achieved prior to being allowed to practice.
- Written competency document will be retained by the staff member and the school (See section 16 on training for forms).
- Home/school consent document to be signed and retained by the school allowing insulin injections in school to be given (form below).

**SCHOOL/NURSERY STAFF DIABETES TRAINING**

NAME.....

SCHOOL/NURSERY.....

<b>COMPETENCY</b>	<b>TRAINED (SIGNATURE of Trainer and Trainee)</b>	<b>DATE</b>	<b>COMPETENT (SIGNATURE of Assessor and Assessed)</b>	<b>DATE</b>
<b>INSULIN</b>				
What is insulin?				
How does it work				
Storage of insulin				
Time of injection/s				
Injection technique				
Rotation of sites				
Carb Awareness				
<b>BLOOD MONITORING</b>				
Why monitor blood glucose?				
Normal blood glucose levels				
Use of meter				
Diabetes routine				
Blood ketone testing				
When to seek advice				
<b>EXERCISE</b>				
How to manage exercise				
<b>HYPERGLYCAEMIA</b>				
What is hyperglycaemia				
Causes				
Symptoms				
Treatment				
<b>HYPOGLYCAEMIA</b>				
What is hypoglycaemia				
Causes				
Symptoms				
Treatment				

## **SCHOOL/NURSERY STAFF TRAINING INSULIN PUMP SKILLS**

NAME.....

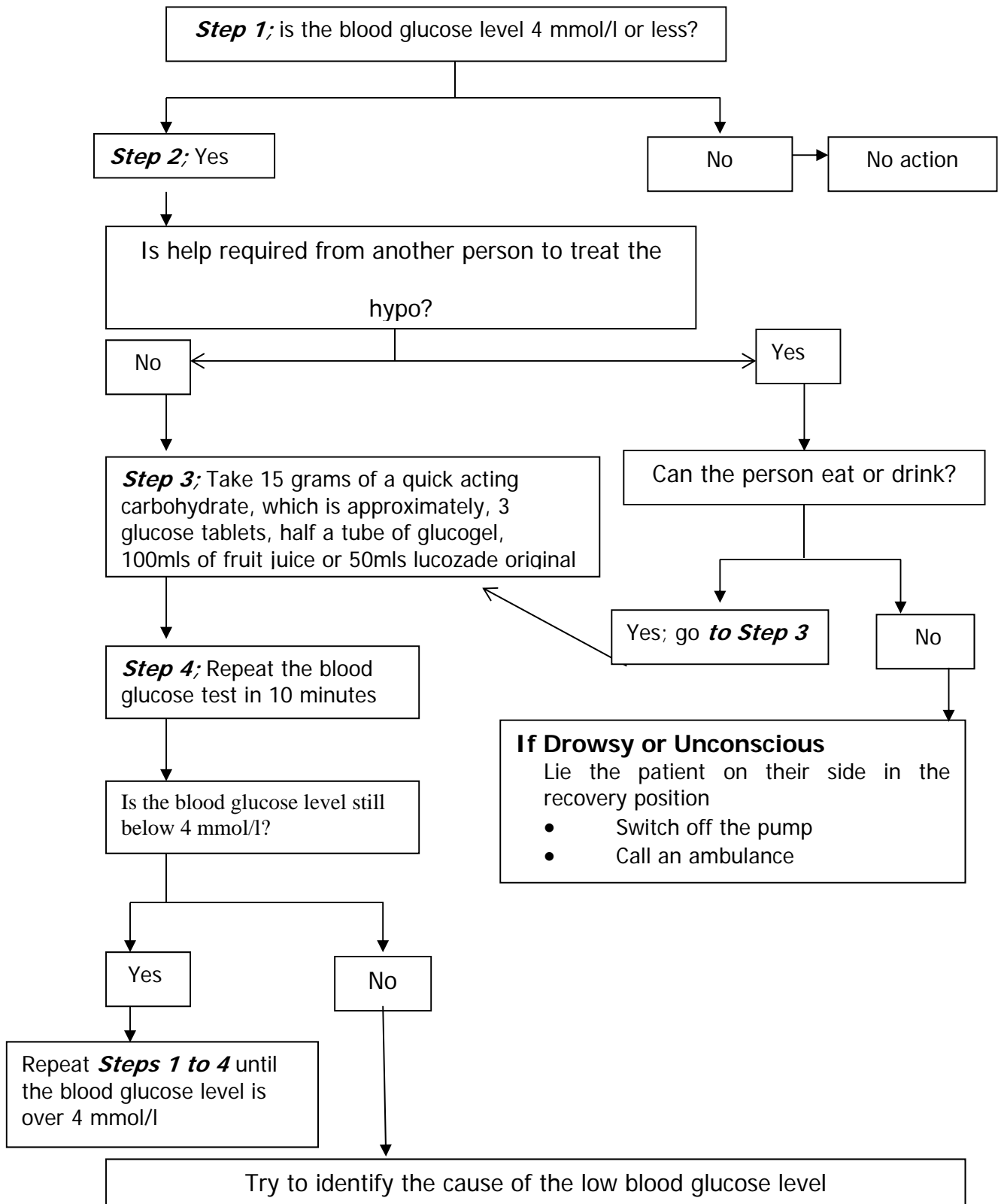
SCHOOL/NURSERY.....

<b>COMPETENCY</b>	<b>TRAINED (SIGNATURE of Trainer and Trainee)</b>	<b>DATE</b>	<b>COMPETENT (SIGNATURE of Assessor and Assessed)</b>	<b>DATE</b>
<b>INSULIN</b>				
What is insulin?				
How does it work				
Storage of insulin				
Time of Bolus				
Wizard/ EZ Carb Bolus calculator				
Use of pen device				
Supplies in school				
Carb Awareness				
<b>BLOOD MONITORING</b>				
Why monitor blood glucose?				
Normal blood glucose levels				
Diabetes routine				
Blood ketone testing				
When to seek advice				
<b>EXERCISE</b>				
How to manage exercise				
<b>HYPERGLYCAEMIA</b>				
What is hyperglycaemia				
Causes				
Symptoms				
Treatment				
Understanding the flow chart for hyperglycaemia				
When to seek advice				
<b>HYPOGLYCAEMIA</b>				
What is hypoglycaemia				
Causes				
Symptoms				
Treatment				
Understanding the flow chart for hypoglycaemia				



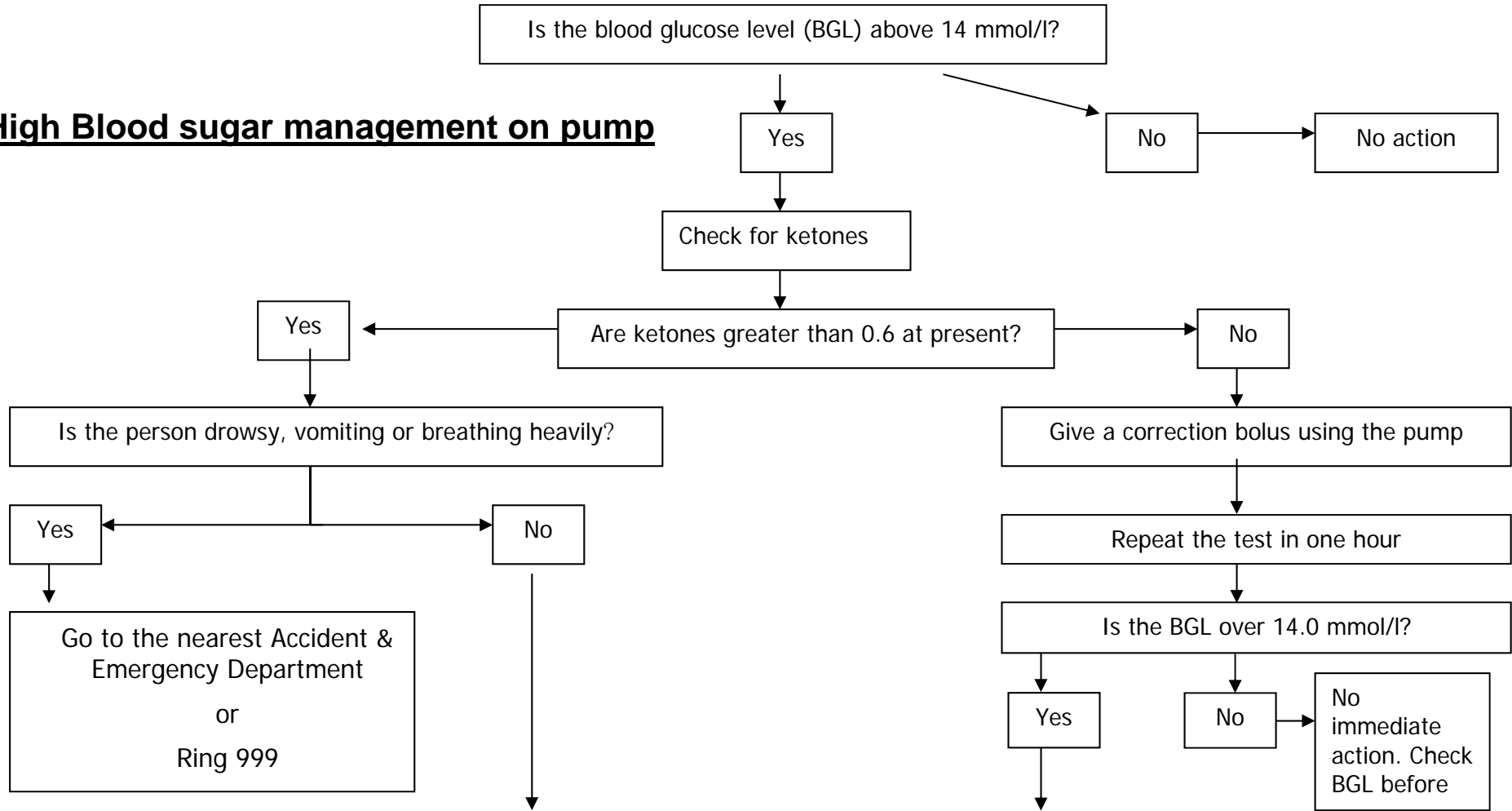
## Guidelines for the Treatment of Hypoglycaemia (Low Blood Glucose)

To be used in conjunction with the advice from your diabetes team



**REMEMBER TO TREAT YOURSELF FIRST AND WORRY ABOUT THE PUMP LATER**

**High Blood sugar management on pump**



- Give a correction bolus using an insulin pen or syringe, not the insulin pump
- When ketones or an infection are present extra insulin is usually required, discuss this with parents or the health care team
- Change the infusion set and reservoir (syringe)
- Drink plenty of liquids that contain no calories, for example a glass of water every thirty minutes
- Try to identify the cause of the high reading
- Repeat the flow chart until the blood glucose level is under 14 mmol/l

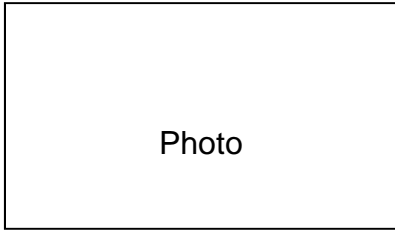
## Insulin Administration Record

Name:

Type of Insulin:

Date/Time	Blood Sugar	Dose of Insulin	Site of Injection	Staff Signature	Witness Signature





## INJECTION CARE PLAN

Name:

Date of Birth

Current Year/Class:

Staff member


See standard Health Care Plan for contact details

### Ensure that 2 people:

- Confirm the name of the insulin to be injected (e.g Novo Rapid),
- Confirm the current dose (It is the duty of parents to inform school of any changes to the dose of insulin).
- Confirm that the insulin pen-fill cartridge is suitable for use and has not been opened for more than 28 days (Date the insulin cartridge was opened needs to be recorded in a diary). It is recommended a spare cartridge is stored in a fridge at school.
- Injections can be done into upper arm, thigh or abdomen, and to be rotated on a daily basis. If giving injection to a young child, safety needles must be used to prevent needlestick injury.
- Prime needle by doing an “air-shot” of 2 units. Repeat until insulin is observed at the end of the needle.
- Dial up desired dose double checking with another member of staff. Insert the needle into skin, push plunger to expel the insulin and ensure the dial is back to zero, count to ten then take the needle out.
- Needle to be discarded after every injection. (Sharps bin is on prescription from GP)  
Injection is to be signed in a blood sugar diary once dose has been given by both members of staff.

<b>Two people check dose</b>	
<b>Insulin is in date</b>	
<b>Awareness of storage of insulin</b>	
<b>Correct calculation of dose</b>	

<b>Aware of appropriate injection sites</b>	
<b>Prime needle</b>	
<b>Needle disposed of appropriately</b>	

**Parental Agreement for Designated Staff to Administer Insulin via Injection**

Name of School:	<input type="text"/>
Name of Child:	<input type="text"/>
Date of Birth:	<input type="text"/>
Class Group:	<input type="text"/>
Medical Condition:	Diabetes Mellitus

**Insulin to be given**

Name of Insulin:	<input type="text"/>
Dose:	<input type="text"/>
Given at (time)	<input type="text"/>
Injection Site	<input type="text"/>



### Contact Details of Parents/Diabetes Specialist Nurse

Name:	<input type="text"/>
Relationship:	<input type="text"/>
Daytime tel no:	<input type="text"/>
Address:	<input type="text"/>

Child's Diabetes Nurse Contact Name and Number:
---

### Contract

It has been agreed that (*child's name*) will have injections of insulin at school administered by specifically trained staff. Any change in dose to be given will be the responsibility of the parents to inform school in writing.

Only specifically trained staff who have been signed off as competent can perform the procedure. All injections must be recorded on the specific sheet

Signed:	<input type="text"/>	Date:	<input type="text"/>	Head Teacher
Signed:	<input type="text"/>	Date:	<input type="text"/>	Parent/Guardian
Signed:	<input type="text"/>	Date:	<input type="text"/>	Diabetes Nurse



## Diabetes Care Plan

Photo	Name:	
	Date of Birth:	
	School	
	Current Year/Class:	

**See standard Health Care Plan for contacts**

### Hypoglycaemia

Children with diabetes may experience hypoglycaemia (low blood glucose levels). Look out for the following symptoms: Hunger/sweating/trembling or shakiness/drowsiness/pallor/glazed eyes/lack of concentration/mood changes, especially angry or aggressive behaviour, irritability or becoming upset.

Typical symptoms for .....are: (to be completed in consultation with the parents /carers)

### Treatment

**Pupil's name** should not be left alone until fully recovered from a hypo. Sugary food should be given immediately, examples can be used of these are Lucozade, non-diet fizzy drink (eg Coke/Tango), fruit juice, glucose tablets, honey or jam.

1. If blood sugar is less than 4mmols treat
2. Wait 10-15 mins & recheck blood sugar, if above 4mmols give long acting carbohydrate, e.g. biscuit or piece of toast
3. If still below 4mmols retreat and retest in 10-15mins
4. Retreat and retest until above 4mmols.

**Sugary food for this child: Give 50ml Lucozade or 3 dextrose tablets, then give a biscuit or a piece of fruit. Should the child become confused or uncooperative glucogel may be used as instructed by the specialist nurse. Do not use if unconscious or has no swallowing reflex, dial 999.**

**Information collected will be regarded as confidential and will only be shared within limits of the Data Protection notification between services**

## Health Care Plan for a Child with Medical Needs

Photo	Name:	
	Date of Birth:	
	School	
	Current Year/Class:	

Medical Condition(s): **Type 1 Diabetes**

### Contact Information

#### Family Contact 1

Name	
Address	
Telephone	
Mobile Phone:	
Relationship:	

#### Family Contact 2

Name	
Address	
Telephone	
Mobile Phone:	
Relationship:	

#### GP

Name:	
Address	
Telephone:	

#### Sandwell Hospital Clinic Contact

Lizbeth Hudson	07979756463
Amanda Whitehouse	07528969853
Office	0121 507 3476



## Health Care Plan for a Child with Medical Needs continued

### Details of medical symptoms: (including any regular medications)

Insulin Novorapid		Insulin to carbohydrate ratio before breakfast
		Insulin to carbohydrate ratio before lunch
		Insulin to carbohydrate ratio before tea
Lantus		Units before bed

Insulin dosages will be adjusted according to need. Parents must notify school of any changes in medication doses

### Ketone testing

If the blood sugar is greater than 14mmol then the child should test their blood for ketones. A meter and strips will be provided by parents. If blood ketones are checked, and the result is more than 0.6 mmol, advice should be sought from parents or diabetes team.

### Correction Doses

At school, If blood sugar at lunchtime is:-

<b>If blood sugar is more than .mmols</b>	Add...unit extra to the usual dose.
<b>If blood sugar is more than ..mmols</b>	Add... unit extra to the usual dose.
<b>If blood sugar is more than ..mmols</b>	Add ...unit extra to the usual dose.

### Lifestyle:

It is important to follow a healthy diet which should be low in fat and sugar and high in fibre, and to avoid diabetic products. Please contact Dietitian for any food related queries

### Regular requirements: (eg PE lunchtimes)

- A quiet room where ....can check their blood sugar levels and give their injection of insulin
- A safe place to keep the sharps receptacle, Parents will collect and replace the sharps bin. 1 bin is required for each child disposing of sharps.
- Before a PE lesson ... will have their usual snack.



- Before swimming ... will have a snack or a reduction in insulin dose prior to swimming. (This is individual to each child. Please discuss with the family).
- **PLEASE NOTE IF PE OR SWIMMING ARE OFF SITE THE CHILDS EMERGENCY DIABETES BOX WILL HAVE TO GO WITH THEM AT THE PITCH SIDE OR POOL SIDE.**
- Regular Lunchtimes.

### **What constitutes an emergency, and actions that should be taken:**

Should \_\_\_\_\_ become unconscious due to low blood sugars place them in the recovery position, check airway is clear. Call 999 for the Paramedics and inform parents.

Never give any liquids or food by mouth if unconscious.

### **Management of Hyperglycaemia (high blood glucose levels)**

- High blood glucose levels should be identified before they cause problems at school if the child is monitoring their blood glucose levels as advised. Though, unfortunately this does not always occur.
- Symptoms of high glucose are those which precede diagnosis i.e. thirst, passing urine frequently and lethargy. It may also lead to nausea and vomiting. Open access to toilets and drinks of water should be allowed.
- Seek immediate advice from the child's parents or health care professional if nauseous and vomiting.

### **Management of Illness**

If the child with Diabetes is vomiting or unable to eat their meals due to nausea, their parents should be informed immediately.

Whilst waiting for their parents to arrive the child should not be left alone and may be encouraged to sip a small amount of fruit juice to prevent low blood glucose.

### **School Trips**

School trips should be discussed in advance with the parents, the Diabetes Specialist Nurse and teacher involved to prevent any problems occurring.

The information required will include:

- Duration of trip

- Journey plans
- Timing of activities
- Timing of meals
- Provisions available

**Detentions**

Education should continue as normal for the child with diabetes and this may at times include being disciplined like anyone else. Prior warning of any detentions must always be given to allow any necessary adjustment for provision of snacks/ extra food to be made.

**Care Plan completed by:**

<b>Name</b>			
<b>Signature</b>			
<b>Designation</b>			
<b>Date of next review:</b>			

**Copies of plan to be signed by:**

<b>School:</b>		
<b>Family:</b>		
<b>School Nurse:</b>		



## Health Care Plan For a Child with Medical Needs using insulin pump.

Photo
-------

<b>Name:</b>			
<b>School:</b>			
<b>DoB:</b>		<b>Yr/Class</b>	

**Medical Condition(s): Type 1 Diabetes**

### Contact Information Family Contact 1

Name:	
Home address:	
Telephone No	
Mobile No	
Relationship	

### Contact Information Family Contact 2

Name:	
Home address:	
Telephone No	
Mobile No	
Relationship	

### GP

Name:	
Address	
Telephone:	

### Hospital Clinic Contact

<b>Name:</b>	Lizbeth Hudson	07979756463
	Amanda Whitehouse	07528969853
<b>Office:</b>		0121 507 3476

## **DESCRIBE CONDITION AND GIVE DETAILS OF INDIVIDUAL SYMPTOMS:**

Pupil has Type 1 diabetes, meaning he/she can no longer produce insulin because the cells in the pancreas that produce it have been destroyed. Without insulin, the body cannot use glucose.

Diabetes cannot be cured, but it can be treated effectively. The aim of the treatment is to keep the blood glucose level close to the normal range (4–7mmol, rising to no higher than 10mmol two hours after a meal) so it is neither too high (hyperglycaemia) nor too low (hypoglycaemia, also known as a hypo).

- Insulin (bolus) will be administered via pump with any carbohydrate foods.
- Insulin (bolus) also needs to be delivered if blood glucose levels exceed 14mmol/L

If vomiting check blood glucose and treat as above if less than 4mmol/L, if blood glucose greater than 14mmol/L check ketones and contact family or diabetes team.

## **SPECIAL REQUESTS FROM PARENTS:**

- Supplies of insulin (in fridge), cannulas, reservoir, batteries, spare pen and blood glucose test kit need to be stored safely.
- PE management – option to disconnect for up to an hour with a safe place to keep the pump
- Personal plan for exercise

## **Glucose Monitoring**

The target range is  4-10 mmols

## **Usual times to check blood glucose are:**

1. Before meals
2. After pump disconnection for PE



**Times to do extra glucose checks:** (tick all that apply)

- |   |                          |  |
|---|--------------------------|--|
| 1. When student exhibits symptoms of hypoglycemia | <input type="checkbox"/> |  |
| 2. Prior to mid-morning or mid afternoon snack    | <input type="checkbox"/> |  |
| Can the student perform own blood glucose checks? | Yes                      |  |
|   | No                       |  |

**Results of any tests taken should be recorded in the diary and communicated with the parents at the end of each session. Any blood glucose level that is outside of the target range should be acted upon, following the instructions in this management plan.**

**Ketone testing**

If the blood sugar is greater than 14mmol then the child should test their blood for ketones. A meter and strips will be provided by parents. If blood ketones are checked, and the result is more than 0.6 mmol, advice should be sought from parents or diabetes team.

**What constitutes an emergency, and what action should be taken:**

Should pupil become unconscious due to low blood sugars place him/her in the recovery position, check airway is clear. Call 999 for the Paramedics and inform parents.

Never give any liquids or food by mouth if unconscious.

**Management of Illness**

If the child with Diabetes is vomiting or unable to eat their meals due to nausea, their parents should be informed immediately.

Whilst waiting for their parents to arrive the child should not be left alone and may be encouraged to sip a small amount of fruit juice to prevent low blood glucose.

**School Trips**

School trips should be discussed in advance with the parents, the Diabetes Specialist Nurse and teacher involved to prevent any problems occurring.

The information required will include:

- Duration of trip
- Journey plans
- Timing of activities
- Timing of meals
- Provisions available

**Detentions**

Education should continue as normal for the child with diabetes and this may at times include being disciplined like anyone else. Prior warning of any detentions must always be given to allow any necessary adjustment for provision of snacks/ extra food to be made.

**Care Plan completed by:**

**Name:**

**Signature**

**Designation:** Paediatric Diabetes Nurse Specialist

**Date due for review:**

---

**Copies of plan to be signed by:**

School

.....

Family

.....

School Nurse

.....



**Diabetes Care Plan for hypoglycaemic episodes**

Photo	Name:	
	Date of Birth:	
	School	
	Current Year/Class:	

**See standard Health Care Plan for contacts**

**Hypoglycaemia:**

**What constitutes an emergency, and what action should be taken: a blood sugar of less than 4mmol**

Children/young people with diabetes may experience hypoglycaemia (low blood glucose levels). Look out for the following symptoms: Hunger/sweating/trembling or shakiness/drowsiness/pallor/glazed eyes/lack of concentration/mood changes, especially angry or aggressive behaviour, irritability or becoming upset.

Typical symptoms for ..... are: (to be completed in consultation with the parents /carers)

..... should not be left alone until fully recovered from a hypo.

**Mild Hypoglycaemia,**

**Give 50ml Lucozade or 3 dextrose tablets, retest after 10-15 minutes and retreat if still below 4mmols follow the flow chart. Should the child become confused or uncooperative glucogel may be used as instructed by the specialist nurse. Do not use if unconscious or has no swallowing reflex, dial 999.**

**Moderate Hypoglycaemia:**

If drowsy and confused but able to swallow, **disconnect or suspend** the pump and then give **Glucogel**

Route: Oral  
 Dosage: 25 gram tube

Site for: - Squeeze small amount of the gel into the side of the mouth between the cheeks and the teeth and get the child to swallow it by massaging outer cheek

- Continue this until fully alert (this may take the whole tube)
- Once alert, give Lucozade/dextrose tablets as above

### **Severe Hypoglycaemia:**

#### **CARE IN AN EMERGENCY:**

Should ..... become unconscious due to low blood sugars,

- **Suspend pump – Select Suspend from main menu and press ACT**
- Suspend will flash on the screen Press Act again to stop the pump.

Place her in the recovery position, check airway is clear. Call 999 for the Paramedics and inform parents.

Never give any liquids or food by mouth if unconscious.

**Once recovered and blood glucose level above 4mmol/L restart pump by**

- **pressing act to suspend/resume**

**Information collected will be regarded as confidential and will only be shared within limits of the Data Protection notification between services**

## 13.4 Epilepsy

### Medication

Children known to be epileptic will be taking one or more anti-epileptic medications. These are only ever given two or three times a day and it is therefore very unlikely that they will need to be administered in school.

### **Buccal midazolam, rectal diazepam or rectal paraldehyde for prolonged seizures**

A few children who are prone to episodes of status epilepticus have a supply of medication to use during a prolonged seizure. It may be agreed that the emergency medication is kept in school. If this is the case a specific care plan for the child should be kept with instructions about when to give the midazolam/diazepam or paraldehyde, who can give it, where to keep it etc. (See section 6 re management of medicines; and care plan form below). Very few children use rectal diazepam / paraldehyde.

Buccal midazolam / rectal diazepam or rectal paraldehyde, are treatments for prolonged convulsions. They should only administered by a member of the school staff who has volunteered and has been trained for this task. Training of designated staff will be arranged via the school health nurse/community children's nurse and a record of this will be kept by the head teacher. (See training section 16 for competency forms) Training will be updated annually.

A specific care plan for the administration of these medications must be maintained (see below)

- (a) Buccal midazolam/rectal diazepam or rectal paraldehyde can only be administered in accordance with an up-to-date written prescription from a medical practitioner and a signed care plan. It is the responsibility of the parent if the dose changes, to obtain a new prescription from the GP. The old prescription should then be destroyed, and the care plan must be updated.
- (b) The care plan should be reviewed yearly by the school nurse who will check with the parents that it remains correct, and the dose of Buccal midazolam/rectal diazepam or Paraldehyde remains the same. The new care plan should then be issued. The care plan should also be reviewed if there is a change in the medication. Signatures should be obtained on an annual basis.

- (c) Each dose of buccal midazolam/rectal diazepam or rectal paraldehyde must be labelled with the individual child's name and stored in a locked cupboard. The keys should be readily available to all designated staff. A copy of the care plan must be kept with the medication.

Buccal midazolam/rectal diazepam or rectal paraldehyde can only be administered by designated staff who have received training from a school nurse/community children's nurse. A list of appropriately trained staff should be attached to the care plan. Training for school staff should occur on an annual basis or more frequently if requested by school staff.

- (d) The care plan must always be checked by two people before the medication is administered. The dose given must correlate with that on the care plan.
- (e) As with all other medications given in school the amount of buccal midazolam or rectal diazepam that is administered must be recorded and signed for by the two education staff who has given it.
- (f) It is primarily the schools duty to ensure that the medication kept in school is still in date. As a further safeguard, expiry dates of medication must be checked each term by the school nurse. If it is out of date it should be sent home for safe disposal by parents.

### **School activities**

Placing restrictions on children with epilepsy will only serve to make them feel and appear different. With adequate supervision no activity need be barred, although it is unwise to allow a child to climb ropes and wall bars if he has a history of frequent, unpredictable seizures.

Swimming is to be encouraged and should cause no problems provided there is a qualified and informed lifeguard in, or adjacent to, the water to affect an immediate rescue should it be necessary. Many schools adopt the "buddy" system for all children, which means that special attention need not be drawn to the child with epilepsy. The lifeguard should be informed about any child with epilepsy, and whether a buddy system is in operation.

## Essential information

It is recommended that teachers find out as much as possible about a child's epilepsy from the parents. Some questions to ask could include:

- what type of seizures a child has
- how long they last and what the child is like afterwards
- what first aid is appropriate and how long a rest the child may need
- any particular conditions or events that might trigger a seizure
- how often medication is taken and what side-effects may be experienced
- whether the child has a warning (aura) before the seizure
- what activities, if any, the parents or doctor require limiting
- whether the child has any other medical conditions.
- How does the child react to the emergency medication, do they carry on as normal or are they likely to sleep

Finally, it can be helpful to know how much understanding the child themselves has of their condition and its treatment.

## Management of epileptic seizures

Children who have epilepsy should have a health care plan giving details of the type of seizure they usually have, and what management of this is likely to be necessary in school. Some children may have an additional care plan for the administration of buccal midazolam/ rectal diazepam or rectal paraldehyde (see below).

There are different types of seizures. "Absence seizures" simply cause the child to become unresponsive for up to a few minutes, but do not cause falls or unconsciousness. Tonic-clonic seizures require first aid or, on some occasions, emergency care

There are different types of seizure

- Partial seizures such as absences which affect a part of the brain. They do usually last from seconds to a few minutes but a child can have repeated seizures over a period of time.

- Generalised seizure – these affect the whole brain and will cause the child to lose consciousness and shake. The child may appear to fall and trigger a seizure but it is more likely that the fall is part of the seizure. They can last for less than a minute to over 5 minutes. They are sometimes called tonic-clonic seizures.

### **Classroom first aid**

If a child has a tonic-clonic seizure, classmates will look to the teacher for guidance. Calmly reassure the other children and ensure that the child having the seizure cannot harm themselves. Only move the child if there is danger of sharp or hot objects or electrical appliances. Then follow these simple guidelines.

- (a) Cushion the head with something soft, e.g. a folded jacket, but do not try to restrain movements.
- (b) Do not put anything at all between the teeth or in the mouth.
- (c) Do not give anything to drink until the seizure is over.
- (d) Loosen tight clothing around the neck but remember to do this with care as it may frighten a semi-conscious child.
- (e) Do not call for an ambulance or doctor unless the seizure lasts more than 5 minutes (unless the child has a specific requirement in their care plan to deviate from this instruction) – see emergency care section.
- (f) As soon as possible, turn the child onto their side in the semi-prone (recovery) position. Wipe away saliva from around the mouth.
- (g) Be reassuring and supportive during the child's period of drowsiness or confusion which often follows this type of seizure. The child may need to rest quietly or sleep for a while, preferably somewhere private, but with adult supervision.
- (h) If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence.
- (i) Record the details of the seizure
- (j) Contact the parents.



It is not always necessary to send a child home after a seizure, but each child is different, and it depends on factors such as how often fits occur, whether the typical course is followed etc. Ideally, a decision will be taken in consultation with the parents when the child's condition is first discussed and a procedure established.

### **13.9 Emergency care**

Although the average convulsive seizure is not a medical emergency there are three exceptions of which a teacher should be aware:

- (a) When a seizure shows no sign of stopping after 5 minutes.
- (b) A series of seizures take place without the child properly regaining consciousness in between.
- (c) If a child who is not known to have epilepsy experiences a convulsive seizure – even if the seizure stops naturally after a few minutes. In such a case, the condition may be caused by some underlying infection or metabolic problem.

**If one of these situations occurs dial 999 and call for an ambulance.**  
Continue first aid as above whilst waiting for this to arrive.

## Care Plan for the administration of buccal midazolam/ rectal diazepam/rectal paraldehyde

Photo	Name:	<input type="text"/>
	DoB	<input type="text"/>
	NHS Number:	<input type="text"/>
	Yr./Class	<input type="text"/>

**Description of seizure requiring treatment with buccal midazolam/rectal diazepam/rectal paraldehyde\*:**

**NB:** If the child has a seizure which is different from the type shown above, and they do not lose consciousness, midazolam/rectal diazepam/paraldehyde may not be appropriate.

After onset of seizures: wait \_\_\_\_\_ minutes then, if seizure has not stopped:

- administer \_\_\_\_\_ mls volume buccal midazolam fluid (equivalent to \_\_\_\_\_ mgs)
- or administer \_\_\_\_\_ mls volume rectal diazepam (equivalent to \_\_\_\_\_ mgs)
- or administer \_\_\_\_\_ mls volume rectal paraldehyde (50% solution in olive oil)

**(Delete as applicable)**

- Wait \_\_\_\_\_ minutes. If seizure does not stop, then **call for ambulance**.
- Inform parents.

**Care Plan Agreement:**

	Parent	Date:	
	Head Teacher	Date:	
	School Health Nurse	Date:	
	Doctor	Date:	

**Data Protection Act, 1998**

The information that you supply on this form will be used by Children's Service for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC .All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification .Data may be shared within Children's Service

**For further information visit:** Department of Education

## 13.5 Sickle cell disease

Sickle cell disease is an inherited chronic illness which results in anaemia, episodes of pain and increased susceptibility to infections. Some symptoms, when mild, can be managed without requiring school absence, but severe symptoms need hospital care.

Overall this is not a common condition but it is much commoner in certain ethnic groups (particularly African Americans and Africans; and also Mediterranean and Middle Eastern groups)

Children should have a Health Care Plan which indicates what symptoms they usually get when unwell, when to call parents/hospital, and what treatments can be given in school for mild pain

### Preventing painful episodes

- Allow the child to keep well hydrated with water.
- Do not allowing the child to become over heated or exposed to cold temperatures.
- Because of their anaemia, children with sickle cell may tire before others and a rest period may be appropriate. Encourage gym and sports participation but allow the child or young person to stop without undue attention.

### When to seek medical attention

Medical attention is needed if any of the following occur:

Fever, headache, chest pain, abdominal pain, numbness or weakness  
A mild painful episode may be managed with increased fluid intake and paracetamol or Ibuprofen according to the child's Health Care Plan. The Health Care Plan should also clarify the steps that should be taken if a serious episode occurs regarding hospitalisation.

### Sickle cell trait

- This term is used where children have inherited only partial susceptibility to sickle cell formation. It is more common than sickle cell disease and since it very rarely causes any problems it is not usually classed as a medical disorder and it is not necessary to ask families about it.

## 13.6 Tracheostomy

### General information about tracheostomies

A tracheostomy is an artificial opening into the windpipe (trachea) that is held open by a tracheostomy tube. This helps the child to breathe more easily. This tube allows the passage of air to and from the respiratory tract, bypassing the nose and mouth and allows the removal of secretions; breathing is dependent on ensuring the tube remains patent.

There are a variety of reasons why a child may need a tracheostomy, ranging from a narrow airway to the need for long-term mechanical respiratory support from a ventilator. The specific details of the reason for the child's tracheostomy will be discussed as part of the training.

A tracheostomy needs extra care because it is a direct route into the lungs and therefore the air moving into the lungs will not have the benefit of the warming, moistening and filtering effect of the nasal passages. It is more difficult for a child with a tracheostomy to clear secretions adequately by coughing so the tube needs special care to prevent it blocking with secretions

**All staff involved in the care of a child/young person with a tracheostomy have a personal responsibility and accountability to ensure that they are trained in the safe care of tracheostomies, including basic life support. The details of tracheostomy care will depend on the child's individual needs and the type of tracheostomy tube in situ.**

All staff caring for the child must have completed the child specific competency training. This training will be provided by the Community Children's Nurses or Specialist nurse from discharging hospital.

### Tracheostomy Care Plan

A child with a tracheostomy should have a specific care plan, as well as a standard health care plan drawn up between the school, the school nurse, Community Children's Nurse and the doctor supervising the child. This should give details of routine and emergency care required for the child and who can give this care. The Community Children's Nurse/Specialist Nurse can help with training and education of school

staff. The training competency documents provided by the health professionals must be completed.

### **Day to day measures**

School staff will need to be competent in the following areas of care:

- daily care
- suctioning the tube
- care of equipment and supplies
- emergency care

### **Daily care**

A small filter device called a Thermovent is used to prevent anything going into the tube and to keep the airway/secretions from drying. This may need replacing a number of times during the day depending on the amount of secretions and the child's tolerance for the Thermovent. Changing the Thermovent is a 'clean procedure.

The tracheostomy is held in by tapes which should be changed at home on a daily basis by the carers. It is important that staff are trained to change the tapes in an emergency situation.

Having a tracheostomy can affect the child's speech. They will be seen by a SALT who will advise on what help/care is needed. Some children learn to speak around their tube and others will need a speaking valve or communication aids. The speaking valve fits onto the end of the tracheostomy tube.

Eating and drinking does not usually cause any problems. However a few children experience difficulties with swallowing which could cause them to choke. **Therefore all mealtimes should be supervised.**

### **Suction**

A tracheostomy needs extra care because it is a direct route into the lungs and therefore the air moving into the lungs will not have the benefit of the warming, moistening and filtering effect of the nasal passages. It is more difficult for a child with a tracheostomy to clear secretions adequately by coughing so the tube needs special care to prevent it blocking with secretions. Suctioning removes excessive secretions and keeps the airway patent. The frequency of suction will vary with each individual and the need must be continually assessed.

Suction is a clean technique and is done using a suction machine and a thin tube or catheter. This procedure can only be carried out by staff who have been trained and completed the competency documents.

### **Care of equipment and supplies**

A child with a tracheostomy has a list of equipment that needs to be immediately available to them **AT ALL TIMES**.

- Emergency tracheostomy changing kit
- Suction unit and suction equipment

Under no circumstance should this be left behind in a class room or when the child is out in the playground/at lunch/on a school trip, etc. This equipment is vital to ensure that the child maintains a patent airway. The kit will be supplied by the parent. It must be checked every day when the child comes into school and when they leave. Additional supplies can be obtained from the Community Children's Nursing Service.

### **Emergency Care**

An emergency situation is where the tracheostomy tube blocks so that the child cannot breathe or the tube becomes dislodged/falls out. In either of these situations it is essential that the tracheostomy tube is changed **immediately and an ambulance is called**.

The tracheostomy changing kit and suction equipment must be with the child at all times. Changing a tracheostomy is a two person technique – one person to hold the child and assist whilst the second person changes the tube. It is essential that enough people are trained to do this technique so that there is cover at all times. If no cover is available the child will not be able to come to school.

Specific training on how to change the tracheostomy tube and tapes will be given by the Children's Community Nurse/Specialist Nurse. The only people who can change the tube are those who have received the training and been deemed competent.

## **School outings and residential trips**

Any school day outing or residential trip for the child with a tracheostomy should be encouraged. School day trips are largely without problems as they are usually to somewhere close by and follow the usual school day routine. Residential trips however do require care full planning.

### **School outings and residential trip recommendations**

- Early contact with the Community Children's Nurse/Specialist Nurse to discuss any outing and residential trip.
- Specific care plan to be drawn up regarding the trip.
- Parents to provide all of the supplies for the duration of the outing or trip.
- Residential activity trips have to be carefully planned and close liaison with parents is vital.
- The child must be accompanied by two members of staff who have been trained to provide care and know the child well. It is not appropriate to train a member of staff specifically for the trip
- Schools to include taking the child with a tracheostomy in their risk assessment of the trip.

### **School outings standards**

- All children to be offered school outings and residential trips as appropriate.
- All staff who are involved with the running and staffing of the trip will have specific training into the child's needs prior to taking any child with a tracheostomy on a trip The child must be accompanied by two members of staff who have been trained to provide care and know the child well. It is not appropriate to train a member of staff specifically for the trip.
- Specific care plan drawn up for the trip.

## Restrictions to School Activities

Placing restrictions on children with a tracheostomy will only serve to make them feel and appear different. However there are a few activities which not advised for a child with a tracheostomy to undertake.

- Playing with dry sand or other small particles which could get into the tracheostomy causing the risk of choking and infection. Wet sand is acceptable provided that there is close supervision.
- Swimming
- Playing with long haired pets
- Being in contact with clothing that sheds fibres.
- Playing with water because of the risk of splashing

## Essential information

It is recommended that teachers find out as much as possible about a child with a tracheostomy from the parents. Some questions to ask could include:

- What does the child understand about their condition and it's treatment?
- How long has the child had a tracheostomy?
- What are the plans around removal of the tracheostomy e.g. will be lifelong or for a number of years?
- How does the child communicate?
- What activities, if any, the parents or doctor require limiting
- Does the child have any other medical conditions?



## **13.7 Oral Suction**

### **General information about oral suction**

Oral suction is used to maintain a clear airway for a child/young person who would otherwise be unable to do so. This may be due to the child/young person having excessive amounts or thick secretions or that the child/young person has an unsafe swallow reflex. The excess secretions, if not cleared, can enter the airway and cause it to become blocked. Oral suction can also be used to keep the airway clear if a child/young person vomits and has difficulty clearing the airway.

Children require oral suction mainly because they have a poor cough or unsafe swallow due to poor muscle tone, sedation due to medication or neuromuscular involvement. This can often be worse when they have a cold/chest infection. The specific details of the reason for the child requiring oral suction would be discussed as part of the training.

All staff involved in the care of a child/young person requiring oral suction have a personal responsibility and accountability to ensure that they are appropriately trained and competent to carry out the care. The details of suction care will depend on the child's individual needs. The training will be provided by the Community Children's Nursing Service.

### **Oral Suction Care Plan**

A child that requires oral suction should have a specific care plan, as well as a standard health care plan drawn up between the school, the school nurse, Community Children's Nurse and the doctor supervising the child. This should give details of routine and emergency care required for the child and who can give this care. The Community Children's Nurse can help with training and education of school staff. The training competency documents provided by the health professionals must be completed.

### **Day to day measures**

School staff will need to be competent in the following areas of care:

- Recognizing need for oral suction
- Alternative methods of clearing secretions
- Undertaking oral suction using a Yankeur sucker and suction unit

- How to operate suction unit

It is essential that enough people are trained to do this technique so that there is cover at all times. If no cover is available the child will not be able to come to school.

## **Suction**

Oral Suctioning removes excessive secretions and keeps the airway patent. The frequency of suction will vary with each individual and the need must be continually assessed.

Ideally oral suction is used as a last resort as it can be unpleasant for the child.

Initially the child would be encouraged to cough and clear the secretions themselves by other means, such as by change of position or by chest physiotherapy. The methods used will be individual to the child.

Suction is a clean technique and is done using a suction machine and a Yankeur sucker. The Yankeur must not go beyond the back of the teeth as it may cause trauma or cause the child to vomit.

**There are other types of suctioning, such as deep suction or nasopharyngeal suction. At present education staff are not covered to do this type of suction.**

## **Care of equipment and supplies**

A child requiring oral suction must have the suction unit and supply of suction equipment with them at all times.

Under no circumstance should this be left behind in a class room or when the child is out in the playground/at lunch/on a school trip, etc. This equipment is vital to ensure that the child maintains a patent airway. The equipment will be supplied by the parent. It must be checked every day when the child comes into school. Additional supplies can be obtained from the Community Children's Nursing Service

## **Emergency Care**

An emergency situation is where the child cannot clear their airway, even with oral suction, resulting in the child being unable to breathe. In this situation **an ambulance must be called immediately**.

## **School outings and residential trips**

Any school day outing or residential trip for the child with a tracheostomy should be encouraged. School day trips are largely without problems as they are usually to somewhere close by and follow the usual school day routine. Residential trips however do require care full planning.

## **School outings and residential trip recommendations**

- Early contact with the Community Children's Nurse to discuss any outing and residential trip.
- Specific care plan to be drawn up regarding the trip
- Parents to provide all of the supplies for the duration of the outing or trip.
- Residential activity trips have to be carefully planned and close liaison with parents is vital.
- Schools to include taking the child requiring oral suction in their risk assessment of the trip.
- Identify how the suction unit charge will be maintained during the trip

## **School outings standards**

- All children to be offered school outings and residential trips as appropriate.
- All staff who are involved with the running and staffing of the trip will have specific training into the child's needs prior to taking any child requiring oral suction on a trip. The child must be accompanied by two members of staff who have been trained to provide care and know the child well. It is not appropriate to train a member of staff specifically for the trip.
- Specific care plan drawn up for the trip

## **Restrictions to School Activities**

Placing restrictions on children requiring oral suction will only serve to make them feel and appear different.

### **Essential information**

It is recommended that teachers find out as much as possible about a child who requires oral suction from the carers. Some questions to ask could include:

- What does the child understand about their condition and it's treatment?
- How long has the child needed oral suction?
- When is the child likely to need suction?
- How does the child communicate that they need suction?
- What activities, if any, require limiting?
- Does the child have any other medical conditions?

**Staff who work in academies need to check with their insurance provider to ensure they are covered to carry out the procedures to support children with diabetes and those with tracheostomies**

## 14 Offsite/out of hours activities

### **Cross reference with Sandwell LA document: "Guidelines for offsite/out of hours educational activities" 2003**

Risk assessments undertaken before arranging offsite/out of hours activities must include consideration of participating pupils' medical needs. See section on pupils with medical needs in the "Guidelines for offsite/out of hours educational activities" for details of what to check.

If a child has specific needs it must be clear how these are going to be met during the activity (this may include the need for a trained member of staff or parental attendance).

A parental request form for administration of medication or treatment during an offsite/out of hours activity should be completed (this includes a section for treatments other than medication) (see Appendix 8a)

A parental consent form must be completed for all pupils involved in an offsite/out of hours activity (from the LA Document: "Guidelines for offsite/out of hours educational activities"). There are separate forms for onsite out of hours; off-site non-residential; and offsite residential activities. (see Appendices 8 b, c, d).

The group leader should have details of a child's medical needs including copies of the above form and any other health care plans

It is essential that all staff members who will be involved with a child with medical needs during an event are informed of the child's requirements

School procedures for administering medicines must be followed. It should be clear whether the child is competent to self-administer medication or not. If this is not the case it will be necessary to either train a member of staff to do this or ask the parent to accompany the child

Medication required can be carried by the child if this is normal practice (e.g. asthma inhalers). If not, then the head teacher or group leader should decide how medication will be carried during the activity by a member of staff, or the parent if present.

All teachers supervising activities should be aware of procedures to follow in an unexpected medical emergency.

## **15 Children in out of borough placements**

Children in out of borough schools will usually be subject to the Management of Medical Needs Policy used by the school and the local health team. It is up to the LA and school health team in Sandwell to check that suitable arrangements are in place when making such placements.

## 16 Health service organisations

(See Appendix 11 for contact details)

### **Nurses**

- School health nurses are based in teams, all of which work from a central base at the Lyng Centre for Health in West Bromwich. Each mainstream school will have a designated team to call upon for advice and support.
- School nurseries will have a nominated attached health visitor who should be able to provide advice about any medical issues which have been noted before a child attends nursery
- The Orchard and Meadows Special Schools have Community Children's Nurses' onsite. Westminster School, St. Michael's Senior School and Crockett's Community Primary School have additional nursing support. These staff have a high level of expertise in managing complex medical needs and they are part of the wider Community Children's Nursing Service.
- The Community Children's Nurses Service also has a team based at Sandwell General Hospital who are involved with a small number of children with complex medical needs in the community. They may be involved in support and training for school staff themselves and act as a resource for the mainstream school nurses.
- The school nurse is the first point of contact for school staff requesting medical advice, support or training. A specific form to request information about a child's medical needs is suggested at Appendix 1.

### **Therapists**

- Speech and language therapists are based in health centre around Sandwell and are directly accessible to schools
- Physiotherapists and occupational therapists are accessible if children are felt to have significant motor difficulties. Parents can refer their children to Children's Therapy Services, as well as other health professionals
- All therapists are able to visit schools to offer advice and provide training

## Doctors

- All children will be registered with a G.P. who will be able to provide general information about a child's needs
- Children with medical issues significant enough to be causing difficulties in school will either be under the care of a paediatrician, or will need referring to one to investigate their problems
- Paediatricians visit Orchard and Meadows special schools. Crockett's Community Primary School and St Michael's Senior School regularly and occasionally see children in other mainstream schools. There are also clinics in health centres and at Sandwell Hospital
- Consultant paediatricians can be contacted by school staff directly if necessary and as long as parental permission has been sought, by phoning the paediatric secretaries at Sandwell General Hospital (**see appendix 11**)

## CAMHS

The child and adolescent mental health service can be directly accessed by schools - **contact details in Appendix 11.**



## 17 Training of Staff

In supporting children with complex health needs in schools and early years settings there are a number of clinical procedures which non-health qualified staff may be trained to undertake. In the main such training is undertaken by School Health Nurses or Community Children's Nurses/Specialist Nurses who are employed by various NHS organisations. The Royal College of Nursing in 2005 provided the following advisory list of procedures which may be safely taught and delegated to non-health qualified staff. (This is meant to show examples and other procedures may be taught if mutually agreed.)

- administering prescribed medicine in pre-measured dose via nasogastric tube or gastrostomy tube
- giving bolus or continuous feeds via a nasogastric or gastrostomy tube
- tracheostomy care including suction and emergency change of tracheostomy tube
- injections (intramuscular or subcutaneous) with pre-filled syringe/pen device (e.g. adrenaline or insulin)
- Oral suction using a Yankeur sucker
- intermittent catheterisation and catheter care
- care of a supra-pubic mitrofanoff catheter
- stoma care
- inserting suppositories or pessaries with a pre-packaged dose of a prescribed medicine
- rectal medication with a pre-packaged dose
- administration of buccal midazolam
- emergency treatments covered in basic first aid training
- assistance with inhalers, insufflation cartridges and nebulisers
- assistance with oxygen administration
- basic life support/resuscitation

The Royal College of Nursing has also advised that the following tasks should not be undertaken by non-health qualified carers

- re-insertion of nasogastric tub

- re-insertion of gastrostomy tube
- injections involving: drawing up injection fluid from a vial/bottle into a syringe; administering intravenous drugs; giving controlled drugs (other than the single doses provided daily for ADHD if necessary).
- programming of syringe drivers

These lists are provided here as a general guide only and it is important to acknowledge that for children with complex health needs creative and innovative solutions are sometimes required.

It is absolutely imperative that any delegation of clinical tasks to non-health qualified staff is undertaken within a robust governance framework including arrangement for:

- initial training and preparation of staff
- assessment and confirmation of competence of staff
- conformation of arrangements for on-going support, updating of training and re-assessment of competence of staff

Training should take place at two levels:

- general training about the child's medical condition(s). This may be applicable to all staff working with the child.
- training regarding specific procedures or care that child will require for the staff who will need to perform them.

A competency assessment should be completed and signed by both trainee and trainer (see forms below). These forms are for fairly generic competencies such as use of an Adrenaline Auto-injector such as Epipen, which may be applicable to more than one child – More child - specific competencies are needed for some skills which vary between individual children and the nurses doing this training will use alternative forms when necessary

## Staff Training Record

Name of School/Setting:

Name of Staff Member:

Type of training received:

Date training completed:

Training provided by:

Profession and Title:

### Child(ren) this training relates to:

Name:	<input type="text"/>	D.O.B	<input type="text"/>
Name:	<input type="text"/>	D.O.B	<input type="text"/>
Name	<input type="text"/>	D.O.B	<input type="text"/>

### Trainer Declaration

I confirm that \_\_\_\_\_ has received the training detailed above and is competent to carry out this treatment/procedure.

Trainer's signature:  Date:

### Trainee Declaration

I confirm that I have received the training detailed above.

Staff signature:  Date:

.....

### Training Update: (must be updated annually, or more often)

Training must be updated by:

### Employers of non-NHS trainees Declaration

We will use our best endeavours to ensure that our employee/staff members delivers care to the person(s) named within the boundaries of this competency as outlined below:

Name:

Designation:

Signature:  Date:

## Persons Trained to Carry Out Procedures

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

# Competency Assessment

This competency is for (procedure):

This competency expires on:  (max duration 12 months)

This competency certifies carer (Name):

## Required skills and knowledge:

Areas Covered	Signature Trainee	Signature Trainer
Basic anatomy and physiology	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Psychological implications	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Demonstration of skill	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Complications and trouble shooting	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Safety routines	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Record keeping	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Privacy and dignity	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>

Levels of competency	Signature Trainee	Signature Trainer
Initial teaching	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Supervised practice	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Safe to practice	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>
Competent/confident practice	<input style="width: 180px; height: 25px;" type="text"/>	<input style="width: 180px; height: 25px;" type="text"/>

## Competency assessment completed by:

Name:  Title:

Signature:  Date:

I certify that the person named, as carer on this document is competent to carry out the procedure detailed above and that I have current NMC registration.

I the above named carer certify that I am happy to carry out the above procedure within the competencies detailed above. I understand the scope of these competencies. I will only use this training in respect of the child(ren) specifically named on the front of this form and I will not carry out procedures, which are contrary to or not covered by this training. I will seek further training if I have any concerns about my competency and in any event six weeks before the expiry date on the front of this form renew my training. Upon the date of expiry of this competency, if my training has not been renewed, or if I have concerns about my competency, I will discontinue undertaking the procedure detailed in this document and seek appropriate advice from a suitably qualified clinician and/or my employer. I will seek any necessary advice, guidance and further training needed from time to time in order for me to continue to operate within these competencies.

## Indemnity Form for the Administration of Medication in Schools

Name:

Signature:  Date:

You have agreed that you will, if called upon to do so, be prepared to administer medication to pupils in school in accordance with the guidance set out in the council’s policy document “Management of Children with Medical Needs in School” and in accordance with any relevant policy of the school.

In consideration of your said agreement, and on the terms which follow, the council agrees that it will indemnify you against any liability for damages or other compensation arising out of or connected with the administration of medication, including liability for omissions or for another person’s legal costs, and any sums paid on account of alleged such liabilities. The council will further indemnify you against any costs and expenses reasonable incurred by you in connection with any claim for damages or other compensation that may be made against you.

The council’s obligation to indemnify you in respect of any claim is conditional upon:-

- (a) Your notifying the council (NOTE – identify who should be notified) as soon as you are aware that any claim against you has been made or is being considered.
- (b) Your cooperating and continuing to cooperate fully with the council and/or its insurers in dealing with any such claim, whether or not you remain in the employment of the council: and
- (c) Your not having made any admissions of liability or any payments on account of any alleged liability without first receiving the written agreement of the council or its insurers.

Where you claim the benefit of this indemnity, the council or its insurers may at their own expense conduct or take over the conduct of any litigation against you (whether actual or contemplated), and shall have full authority to instruct solicitors and to settle or otherwise deal with such litigation as they think fit. The council shall have the benefit of any rights of contribution or indemnity against third parties to which you may be entitled. Without prejudice to the general obligation of cooperation, you agree to sign any consents, authorities or assignments which the council or its insurers may reasonably require.

For the avoidance of doubt, this indemnity extends to any liability for negligent acts and omissions on your part. It does not extend to any case in which you may be adjudged deliberately to have harmed any person, and in any event of any such finding by a competent court, the council or its insurers may recover from you any sums already expended by them pursuant to this indemnity.

This indemnity applies to the administration of medication in school, and also in the course of school trips and other official school activities which may take place off school premises or out of school hours.

Signed:

Post held:

Date:

Head  
Teacher:

School:

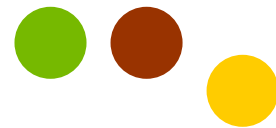
## Indemnity Statement – Points to be noted

This form would be in favour of members of school staff who agree to administer medication, and who work in community schools as employees of the council.

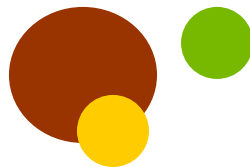
- Staff in voluntary aided and foundation schools will normally be employed by the governing body and it would be expected that any indemnity would therefore be given by the governing body.
- This indemnity should be a free standing document to be completed by the school when an individual agrees to be responsible for the administration of medication. However it should be noted that this would not cover staff who take such action on an emergency basis.
- This should not relate to professional duties, because the administration of medication is **not** a duty which the School Teachers' Pay and Conditions Document requires teachers to undertake.

It is our opinion that staff would not in practice permit a child to go without medication in an emergency. If a child suffered harm whilst at school because no arrangements were in place to administer medication, the child might have a claim under the Human Rights Act 1998. Schools would also need to be mindful of the requirements of the Disability Discrimination Act 1995 and the new provisions of the Special Educational Needs and Disability Act 2001 applying to schools, which mean schools have a duty not to discriminate and to make "reasonable adjustments. In some cases, pupils who need medication will be pupils who have a disability within the meaning of the legislation. These provisions should be kept in mind if any situation arises in which a pupil's need for medication results in that pupil being put under a disadvantage in any way





# Appendices



## Appendices

### Appendices

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- 2 Form SS12
- 3 Health care plan for a child with medical needs
- 4 Request for school to administer medication
- 5 Confirmation of agreement for school to administer medication
- 6 Pupil medicine record
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- 8 Standard information for offsite visits
- 8(a) Request for the administration of medication or treatment during an offsite activity
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## Appendix 1



### Referral into Sandwell School Health Nurse Service

#### Referral to service guidelines

1. Please complete referral form in full.
2. Please be specific about the reason for the referral.
3. Please consider if the relevant people have been informed of the referral.
4. Please include relevant background information including any cause for concern.
5. Please state if there is a reason that you are aware of why the School Health Nurse should not visit alone?
6. Please ensure that parents/carers have been informed of the referral. This is important as we usually mention where the referral has come from. If you do not want the parents/carers to be aware of the referral please give a valid reason.

**Referral to School Health Nursing Service**

Surname:  Forename:

DOB:  NHS No:

M  F  School:  GP:

Home Address:

Parent language Spoken / Written: English  Contact Number:

Parental consent obtained: Yes  No  Parent/Carer Name:

Parental consent should be obtained from the individual with parental responsibility for all referrals where a child or young person is not deemed Fraser Competent

Name of person obtaining consent (please sign and print name)

Other agencies involved include contact name and numbers:

Are there any additional needs identified? e.g. disability. If yes please state here:- Yes  No

Reason for Referral:

Referred By:	Designation:	Tel No:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Base:  Date:

**To School Health Nursing Team**

The Lyng Centre for Health & Social Care  
Frank Fisher Way  
West Bromwich  
B70 7AW  
0121 612 2974  
Secure FAX: 0121 612 2940  
Secure Generic E mail: BCHNT.SHNSANDWELL@nhs.net

Birmingham Community Healthcare  
NHS Foundation Trust



**Reply Slip**

Date:  
Plan of Action or Outcome:

Signed:

Print Name:

Designation:

Contact Number:

**Data Protection Act, 1998**  
The information that you supply on this form will be used by the Children and Young Peoples Services for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification.  
For further information visit: [Department for Children, Schools and Families \(Every Child Matters\)](#)

**Please Ensure that this Form is kept Confidential**

This form should be completed by PARENTS or persons with parental responsibility in respect of every pupil on entry to the school, and annually.

**Section A – Child's Details:**

Surname:	<input type="text"/>	Date of Birth:	<input type="text"/>
Forenames:	<input type="text"/>		
Address:	<input type="text"/>		
Name of School:	<input type="text"/>		

I understand that there may be curriculum based activities which may take my child off school premises in the neighbourhood of the school e.g. swimming, field trips, sports activities, local parks - they may walk or go in a mini-bus or coach, public or private transport.(See note below.)

I understand that there may be occasions when my child may be taken by a member of the staff in his/her car to hospital or home or sporting fixtures and other activities.

I agree that my child (name)\_\_\_\_\_ be allowed to take part in these activities as indicated above.

**If you do not agree, your child will not participate in any of the above activities or be taken in a member of staff's car.**

**Note:**

In the event of certain other activities involving my child being away from school/home, I will be asked to complete an additional form for each activity.

**Section B – Medical Information**

This information will be shared with the School Health Nursing Service (SHN) to ensure that any medical needs your child may have in school are dealt with appropriately. If you wish to discuss this further please contact the SHN message taking service on 0121-612 2974.

## 1. Your Child's Family Doctor:

Name:	<input type="text"/>
Address:	<input type="text"/>
Tel:	<input type="text"/>
Medical Card No:	<input type="text"/>
	<input type="text"/>

2. Is your child on any regular medication? **Yes**  **No**

If yes, please give details:

3. Is your child under the care of any hospital, please give the Consultant's name and details:

4. Has your child had any of the following immunisations? (from your red book)

Age Due	Immunisation	Please tick the relevant boxes below and date as appropriate	
2 months	1st Diphtheria, Tetanus, Whooping Cough, HaemophilusInfluenzae (Hib), Polio, Men C	<input type="checkbox"/>	
3 months	2nd Diphtheria, Tetanus, Whooping Cough, HaemophilusInfluenzae (Hib), Polio, Men C	<input type="checkbox"/>	
4 months	3rd Diphtheria, Tetanus, Whooping Cough, HaemophilusInfluenzae (Hib), Polio, Men C	<input type="checkbox"/>	
12-18 months	Measles, Mumps, Rubella (1st MMR) (2nd MMR – usually at 3-5 years)	<input type="checkbox"/>	
3-5 years	Diphtheria, Tetanus, Whooping Cough, Polio Booster	<input type="checkbox"/>	
10-14 years	<b>BCG (only for children with identified risk factors)</b>	<input type="checkbox"/>	
14 years	Tetanus, Polio and Diphtheria Booster	<input type="checkbox"/>	

5. Does your child suffer from any of the following problems?

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Serious allergic reaction e.g. to medicines/ foods	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other significant conditions	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked any of the above please give details:

6. **Personal Accident Insurance**

The local authority does not provide Personal Accident Insurance for individual pupils.

Personal Accident Insurance can be taken out by parents if they think it necessary. They should consult the school to check whether this cover has been taken out on behalf of all school pupils before proceeding.

7. **Emergency Contact Telephone Numbers:** (Please give 2 if possible)



(1)  Name Daytime Tel No   
(2)  Name Daytime Tel No

8. **Home Language:**(include dialect if other than English)

Signed:  Date:   
(Parent or Guardian with parental responsibility)

**Data Protection Act, 1998**

The information that you supply on this form will be used by Children's Service for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children's Service.

**For further information visit: [Department for Education](#)**

**Please return this form as soon as possible to school**

## Appendix 3

### Health care plan for a child with medical needs

Photo  Photo	Name:	<input type="text"/>
	Date of Birth:	<input type="text"/>
	Current Year/Class:	<input type="text"/>
	Medical Conditions(s):	<input type="text"/>
	NHS No:	<input type="text"/>

---

#### Family Contact 1:

Name:	<input type="text"/>
Home Telephone:	<input type="text"/>
Work Telephone:	<input type="text"/>
Relationship:	<input type="text"/>

#### Family Contact 2:

Name:	<input type="text"/>
Home Telephone:	<input type="text"/>
Work Telephone:	<input type="text"/>
Relationship:	<input type="text"/>

#### GP:

Name:	<input type="text"/>
Telephone:	<input type="text"/>

#### Hospital Doctor/Paediatrician:

Name:	<input type="text"/>
Telephone:	<input type="text"/>

**Details of medical symptoms: (including any regular medications):**

**Regular requirements: (e.g. PE; lunchtimes)**

**What constitutes an emergency, and what action should be taken:**

**Review of Care Plan:**

Name:

Designation:

Date due for review:

**Copies of Plan to:**

<input type="checkbox"/> School	<input type="checkbox"/> Family	<input type="checkbox"/> School Nurse/CCN	<input type="checkbox"/> Paediatrician or GP
---------------------------------	---------------------------------	---	--

---

Health Care Plan reviewed on (date):

Persons reviewing plan:

**This Plan does not need changing**

Next review on (date):

*(The Care plan should be updated fully at least every 2 years)*

**Copies of Plan to:**

<input type="checkbox"/> School	<input type="checkbox"/> Family	<input type="checkbox"/> CCN	<input type="checkbox"/> Paediatrician or GP
---------------------------------	---------------------------------	------------------------------	--

**Data Protection Act, 1998**

The information that you supply on this form will be used by Children's Services for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children's Services

**For further information visit: [Department for Education](#)**

**Appendix 4****Request for school to administer medication**

The school will not give your child medicine unless you complete and sign this form, and the head teacher has agreed that school staff can administer medication.

Child's Surname:			
Forename(s):			
DOB:		M <input type="checkbox"/>	F <input type="checkbox"/>
NHS No:			
Address:			
Post Code:		Year/Class	
Condition/Illness:			

**Medication**

Name/Type of medication (as per dispensary label):
For how long will your child take this medication?
Date dispensed: Expiry date:
Dosage (amount) and method of administration:
Time(s) to be given:
Special precautions (if any):
Known side effects:

Self-administration: Yes  No

Procedures to take in any emergency:

**Contact Information**

**Family Contact 1:**

Name:	<input type="text"/>
Home Telephone:	<input type="text"/>
Work Telephone:	<input type="text"/>
Relationship:	<input type="text"/>

**Family Contact 2:**

Name:	<input type="text"/>
Home Telephone:	<input type="text"/>
Work Telephone:	<input type="text"/>
Relationship:	<input type="text"/>

**Parental Agreement:**

I understand that I must deliver the medicine personally to \_\_\_\_\_  
(name of staff member receiving medication) and accept that this is a service which the  
school is not obliged to undertake.

Signature:  Date:

Name (print):

Relationship to Pupil:

**Data Protection Act, 1998**

The information that you supply on this form will be used by Children's Services for the purpose of maintaining and improving the level of service given for young people within Sandwell MBC. All information is regarded as confidential and any data collected via this form will be processed or disclosed only within the limits of the data protection notification. Data may be shared within Children's Services

**For further information visit: [Department for Education](#)**

## Appendix 5

### Confirmation of agreement for school to administer medication

I agree that (*name of child*) \_\_\_\_\_ Date of birth \_\_\_\_\_

will receive: (*quantity and name of medicine*): \_\_\_\_\_

every day at (*time(s) medicine to be administered*) \_\_\_\_\_

Delete one

\* Medication will be given:

\* Supervision will occur whilst he/she takes their medicine:

Delete one

\* *Insert named member of staff*: \_\_\_\_\_

\* *see attached list of staff*

Delete one

\* This will continue until the end date of the course of medicine on \_\_\_\_\_

\* This will continue until instructed by parents

---

Authorised School Signature:

Position:

Name: (print)

Date:

Signature of Parent/Carer:

Relationship to Child:

Name: (print)

Date:

A copy of this form should also be given to the parent.



## Persons trained to carry out procedures

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

Name:

Date:

School:

Area trained in:

## Pupil medicine record

## Appendix 6

Name:

Date of Birth:

NHS No:

Medicine name and expiry date:

Dosage and Method of administration:

Timing:

Name of Administrator/Supervisor:

Self administered:

Yes

No

Date:	Time:	Dosage:	Expiry date of medication	Administered by:	Witnessed by:	Pupil administered (if appropriate)	Any checked

These are the recommended headings and formats to be used. Schools may wish to consider a file or bound book system for their records

**Appendix 7**

**Record of administration of first aid**

Date	Time	Name (of injured person)	Occupation or Class	Nature/location of Injury	First Aid administered	Outcome	Administered by:	Signature	Monitored by:

Date	Time	Name (of injured person)	Occupation or Class	Nature/location of Injury	First Aid administered	Outcome	Administered by:	Signature	Monitored by:

## Appendix 8

### Standard information for offsite visits Parental information forms

#### 1. Young people with medical needs

Additional safety measures to those already in place in the school/centre may be necessary to support young people with medical needs during visits. Arrangements for taking medication and ensuring sufficient supplies for residential visits may be required.

All staff supervising visits should be aware of a young person's medical needs and any medical emergency procedures. One way of achieving this is by having Summary Sheets held by all the staff. The sheets would contain details of each young person's needs and any other relevant information provided by parents. There must be **two volunteer** staff member who are trained to do checks and administer medication. If the young person's safety cannot be guaranteed, it may be appropriate to ask the parent or a care assistant to accompany a particular individual.

The group leader should discuss the young person's individual needs with the parents. Parents should be asked to supply:

- Details of medical conditions.
- Emergency contact numbers.
- The child's GP's name, address and phone number. Also details of hospital doctor /nurse where appropriate
- Information on whether the young person has spent a night away from home before and their ability to cope effectively.
- Written details of any medication required (including instructions on dosage/times) and parental permission to administer.
- Parental permission if the young person needs to administer their own medication or agreement for a volunteer staff member to administer.
- Information on any allergies/phobias.
- Information on any special dietary requirements.

- Information on any toilet difficulties, special equipment or aids to daily living.
- Special transport needs for young people who require help with mobility.

Enquiries should be made at an early stage about access and facilities for securing wheelchairs on transport and at residential centres etc. if appropriate.

If ramps are not going to be available in certain places, the organiser may wish to arrange to take portable ramps with them. The group leader should at an early stage assess whether manual-handling skills will be needed and, if so, whether training should be sought.

All staff supervising the visit should be given the opportunity to talk through any concerns they may have about their ability to support the child. Extra help should be requested if necessary, e.g. a care assistant.

If staff are concerned about whether they can provide for a young person's safety or the safety of other participants on a trip because of a medical condition, they should seek general medical advice from the school health service or further information from the young person's parents.

The group leader should check that the insurance policy covers staff and young people with pre-existing medical needs.

**The group leader should also check the LA policy document "Management of children with medical needs in schools".**

## 2. **Young people with special educational needs**

Schools/centres will already be familiar with the nature of a young person's special educational needs. Any limitations or problems the young person may have should be taken into account at the planning stage and when carrying out the risk assessment. Offsite visits may pose additional difficulties for a young person with SEN and the behaviour of some young people may prove challenging. The following factors should be taken into consideration:

- Is the young person capable of taking part in and benefiting from the activity?
- Can the activity be adapted to enable the young person to participate at a suitable level?
- Will additional/different resources be necessary?
- Is the young person able to understand and follow instructions?
- Will additional supervision be necessary?

It may be helpful to the young person if one of the supervisors already knows them well and appreciates their needs fully. The group leader should discuss the visit with the parents of young people with SEN to ensure that suitable arrangements have been put in place to ensure their safety.

### **Parental information forms**

Appendix 8(a)-	Request for the administration of medication during an activity onsite out of hours, or offsite
Appendix 8(b)-	Parental consent form AA for onsite out of hours activity
Appendix 8(c)-	Parental consent form AB for offsite non-residential activity
Appendix 8(d)-	Parental consent form AC for offsite residential activity