Supporting Pupils with Medical Conditions Policy

Safeguarding Statement

Everyone at Horton Grange shares an objective to help keep children and young people safe by contributing to:

Providing a safe environment for children and young people to learn in school and;
Identifying children and young people who are suffering or likely to suffer significant harm, and taking appropriate action with the aim of making sure they are kept safe both at home and in school.

Reviewed date: Sept 2026
Next review date: Sept 2027

Contents

Contents 1

Introduction 2
- Useful Documents 2
- Useful Contacts 2-4

Roles and Responsibilities 5
- Responsibility of Parents 5
- Responsibility of Health Care Professionals 5
- Responsibility of School Staff 6
- Day Trips, Residential Visits and Sporting Activities 7
- Liability and Indemnity 8

General Procedures 8

Refusal or Forgetting to Take Medication 10

Non-prescribed Medication 10

Individual Healthcare Plan 11

Practical Advice for Common Conditions 12

Anaphylaxis 13

Asthma 17

Emergency Salbutamol Inhalers in Schools 20

Diabetes 25

Epilepsy 28

Unacceptable Practice 31

Complaints 32

Appendices 32

Introduction

The County Council's Corporate Health and Safety Team has prepared this model policy in consultation with paediatricians from Northumbria Healthcare NHS Foundation Trust. The content is based upon the Department for Education's (DfE) document entitled 'Supporting pupils at school with medical conditions' which was published in December 2015.

What's been added?

A review of the County Council's model policy has been undertaken to take account of guidance issued by the Department of Health (DoH) on the use of adrenaline auto-injectors (AAI) in schools.

From 1 October 2017 the Human Medicines (Amendment) Regulations 2017 were amended to allow schools to purchase spare adrenaline auto-injector (AAI) devices, without a prescription, for emergency use in children who are at risk of anaphylaxis, in instances where their own device is not available or not working (e.g. because it is broken, or out-of-date). Even when a child has not been prescribed an AAI, in certain circumstances it is now permissible to administer the school's emergency AAI. The DoH document "Guidance on the use of adrenaline auto-injectors in Schools" dated September 2017 provides detailed advice to schools that wish to keep a spare emergency AAI on site. The decision to keep spare AAIs lies with the school, it is not a mandatory requirement.

Dec 2019 – introduction to changes regarding over the counter medication.

Sept 2020 – school have completed a risk assessment to cover returning to school during the COVID-19 pandemic which references changes in school and what has been put in place to keep children with medical conditions safe.
Children who are clinically vulnerable or clinically extremely vulnerable have individual risk assessments

Sept 2021 – risk assessments have been adapted for the new guidance in place for COVID 19

Sept 22 – School are following government guidelines regarding COVID

Jan 2023 – Additional steps in general procedures and Appendix 16 – Record of Medication In/Out of School

Sept 2023 – Change to school procedure for administering Calpol, Ibruprofen and antihistamines

Useful Documents

Document	
Supporting pupils at school with medical conditions (DfE)	Supporting pupils at school with medical conditions
Guidance on the use of emergency salbutamol inhalers in school' (DoH)	Guidance on the use of emergency salbutamol inhalers in school'
Guidance on the use of adrenaline auto-injectors in Schools (DoH)	Guidance on the use of adrenaline auto-injectors in Schools
Reasonable Adjustments for Disabled Pupils Guidance for Schools in England (Equality and Human Rights Commission) *(NB Applicable to all children and young people with additional needs, not just physical and health needs*)	https://www.equalityhumanrights.com/sites/default/files/reasonable_adjustments_for_disabled_pupils_1.pdf
Data protection: a toolkit for schools *(DfE)* (*p74 - information on record retention periods for medical records)*	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747620/Data_Protection_Toolkit_for_Schools_OpenBeta.pdf
School risk assessment for vulnerable children	See school policies

Useful Contacts

Further information, including details of those services mentioned in the table below, can be found on the following websites:

Northumbria Healthcare NHS Foundation Trust
Northumberland County Council

Children's health services in Northumberland were moved over to the Harrogate and District Foundation Trust in October last year October 21.

Name	Contact Details
Public Health Nurse (School Nurse)	Child Health Centre, Wansbeck Hospital, Ashington – 01670 564048 Eddie Ferguson House, Blyth – 01670 629670 Corbridge Health Centre, Hexham – 01434 636939 Prudhoe Health Centre, Prudhoe – 01661 832512 Tweedmouth Clinic, Berwick – 01289 356962 Broomhill Health Centre, Amble- 01670 761908 Morpeth NHS Centre – 01670 500939 Can assist with anaphylaxis, continence training and support
Children's Community Nurse	01670 564070
Community Paediatrician Service	**Morpeth/Ashington/Berwick** Wansbeck Child Health Centre - 01670 564030 **Blyth/Cramlington** Paediatric secretaries - 01670 396467 **Tynedale/Hexham** Hexham General Hospital - 01434 655395
Special School Nurse	Team Lead, Elaine Davies – 0191 643 2591 Hexham Priory School – 01434 613440 Barndale School – 01665 602541 The Centre, Josephine Butler Campus – 01670 844322 The Grove School, Berwick Upon Tweed – 01289 306390
Specialist Epilepsy and Diabetes Nurse	Contact via switchboard at North Tyneside General Hospital Tel: 0344811 811

Designated Clinical Officer	Sam Barron Tel: 01670 622747 Email: Samantha.Barron@northumberland.gov.uk
Special Education Needs and Disabilities (SEND)	sen@northumberland.gov.uk
High Incident Need Team (HINT)	Northumberland Inclusive Education Services Aesca House South View Ashington NE63 OSF
Occupational Therapist	Children's physical disability occupational therapy service Northumbria Healthcare NHS Foundation Trust Child health Woodhorn Lane Ashington NE63 9JJ Tel: 01670 564050
Physiotherapist	sylvia.tingate@northumbria-healthcare.nhs.uk
NCC Corporate Health and Safety Team	01670 623854
Asthma UK and Beat Asthma (see resource for Schools)	
Epilepsy Society	
Epilepsy Action	
Diabetes UK	
Anaphylaxis Campaign	

Roles and Responsibilities

Responsibility of Parents

In modern terminology the term 'parent' is understood to mean not just a parent but anyone who has parental responsibility for the care of a child. Parents have the principal responsibility for the administration of medication to their children, who have the right to be educated with their peers, regardless of any short or long-term needs for medication whilst at school.

Wherever possible, medication should be given at home by parents. If prescribed medicines are to be taken three or more times per day, parents should ask the prescribing doctor if the administration of the medication can occur outside normal school hours. Non-prescription medication (such as cough medicines) can now be administered in school as Northumberland GP's will no longer prescribe medications that can be bought over the counter.

The parents have the principal duty to inform the school of their children's medical conditions and to make a request for the Head or Medication Officer to make arrangements for medication to be administered in school. This can occur if the child:

- has been newly diagnosed
- is due to return after a long absence and has a chronic illness or long-term complaints, such as asthma, diabetes, epilepsy or another condition
- is recovering from a short-term illness and is well enough to return to school whilst still receiving a course of antibiotics or other medication.
- has needs that have changed
- is due to attend a new school

Responsibility of Health Care Professionals

In situations where the condition requires a detailed individual healthcare plan or specific specialist training is required for school staff, this will often require direct input from Healthcare Professionals with clinical responsibility for the child. Examples include community or specialist nurses and, in the case of children with mobility needs, occupational therapists or physiotherapists.

Often the specific details in an individual healthcare plan can only be provided by professionals who have access to the confidential notes that the Consultants and other healthcare professionals working with the child in question have prepared.

The role of the Occupational Therapists and physiotherapists are clear; schools can contact these services via the contact information provided previously.

The School Nursing Team is able to provide training on anaphylaxis and continence issues and can provide a 'signposting role' should schools have difficulty accessing professional medical assistance or if there is uncertainty about which consultant to contact.

The specialist nurses employed by the Northumbria Trust are hospital-based and work directly with the relevant consultants. They provide training for diabetes and epilepsy and can offer the necessary assistance with healthcare plans for these conditions.

Responsibility of School Staff

Each request for medicine to be administered to a pupil in school should be considered on its merits. The Head should give consideration to the best interests of the pupil and the implications for the school.

It is generally accepted that school staff including teachers, TA's and SLT may administer prescribed medication, providing they have had the correct training, whilst acting in loco parentis. However, it is important to note that this does not imply that there is a duty upon these workers to administer medication and the following should be taken into account:

No member of staff should be compelled to administer medication to a pupil – named First aiders include:

In EYFS Sarah Anderson, Wendy Cochrane, Carly Clasper, Amy Coates, Daniella Cochrane, Chloe Webley and Bianca Racela
In KS1 Karen Adam, Lisa Mills, Angela Blake,Rebecca Southern and Suzanne Yeo
In KS2 Joanne Dyson, Debra Barren, Lauren Gillen, Julia Storey, Margaret Scott, Stephanie Hobbs, Ariane Gibbard, Lisa Chrisp, Carly Foggin, Jordan Plunkett and David Hansen
SBM – Kelly McNally

Staff administering medicines should do so in accordance with the prescriber's instructions. Schools should keep a record of all medicines administered to individual children, stating what, how and how much was administered, when and by whom.

- No medication can be administered in school without the agreement of the Head or her nominated representative which is Mrs McNally.

- Mrs McNally is the Medication Coordinator and will have overall responsibility for the implementation of this policy. In addition to this, the school's emergency asthma kits or emergency AAIs, will have 2 members of staff ensuring this equipment is maintained correctly.

- Separate registers will be compiled defining those pupils who are permitted to use emergency inhalers and emergency AAI.

- Parents requesting administration of medication for their children can be referred to the school's web page where they can access a copy of this document. They will be asked to complete Part 1 of the form 'Administration of Medication to Pupils – Agreement between Parents and School', a copy of which can be found in Appendix 1. Completion of this form safeguards staff by allowing only prescribed medication to be administered

- School staff may consult with the prescriber to ascertain whether medication can be given outside of school hours.

Day Trips, Residential Visits and Sporting Activities

School staff should be aware of how a child's medical condition will impact on their participation in such events however there should be enough flexibility for all children to participate according to their abilities and with any reasonable adjustments. The only exception would be in cases where evidence from a clinician, such as a GP or specialist consultant, states that participation is not possible.

To determine the reasonable adjustments required, the school should complete a personalised risk assessment. This will ensure that planning arrangements take account of any steps needed to ensure that pupils with medical needs are included. The risk assessment will require consultation with parents and pupils and advice from the relevant healthcare professionals to ensure that pupils can participate safely. In certain situations, it may also be appropriate to consult the intended activity providers.

The specific arrangements for a child attending an off-site visit should be recorded with the relevant visit specific information and logged on the EVOLVE system, together with supporting information, such as the risk assessment. These arrangements enable the child to participate fully in such activities and ensure social inclusion, as recommended by the Outdoor Education Advisory Board's National guidance 3.2e 'Inclusion'.

In general, the arrangements detailed in this policy for the safe storage and administration of medication should also apply when taken off site. Medication should be stored in a locked bag or box and held by a designated member of staff who is trained to administer it. Associated documentation, such as the personalised risk assessment and Healthcare plan should also be available and securely stored with the medication or on an encrypted digital device (which does not rely on a data signal to access it).

The EVOLVE system has a facility which allows a visit form along with all associated attachments to be downloaded electronically to a Compressed (zipped) folder to a digital device. This may assist those schools wishing to store documents on an encrypted digital platform.

Emergency medication, such as inhalers, AAIs etc, should be readily available and not locked away. A record of any medication administered should be kept (see Appendix 5).

Parents will be asked to sign a form to say that non prescribed medications such as Calpol can be given if needed.

Liability and Indemnity

Members of staff administering medication in accordance with appropriate training or the details supplied by the parent may rest assured that they are indemnified under the conditions of the existing insurance policies. In such circumstances, any liabilities rest with the insured party (the County Council in the case of maintained schools).

General Procedures

1. If medication cannot be given outside of school hours, parents should fill in the aforementioned request form (Appendix 1) giving the dose to be taken, the method of administration, the time and frequency of administration, other treatment, any special precautions and signed consent.

2. The parent (not the pupil) should bring all essential medication to school. It should be delivered personally to office staff and signed by Mrs Irving, Mrs McNally or other members of SLT before administration. Only the smallest practicable amount should be kept in school.

3. All prescribed medication taken in school must be kept in a clearly labelled pharmacy bottle, preferably with a child safety top, which must give the owner's name, the contents and the dosage to be administered. Minor condition medication will be kept in school if the child needs it administered more than 3 times a day.

4. Whilst medication is in school it will be kept in a locked cupboard or fridge (if so required), In the event of an emergency it should be readily accessible to the named volunteer or young person, when required. The exceptions to this are inhalers, adrenaline auto-injectors and insulin. Auto-injectors will be carried in red bum bags by the adult in charge.

5. Medication to be taken orally should be supplied with an individual measuring spoon or syringe. Eye drops and ear drops should be supplied with a dropper. A dropper or spoon must only be used to administer medicine to the owner of that implement. The dropper or spoon must be cleaned after use and put back with the medication.

6. When medication is given, the name of the drug, the dose, the mode of administration, the time that treatment is required to be given and date of expiry should be checked. A written record should be kept of the time it was given and by whom and then countersigned to avoid more than one person ever giving more than the recommended dose. This should be kept with the parental consent form. See form in Appendix 1. The parental consent form will be updated annually to take account of changes in a pupil's condition.

7. Where any change of medication or dosage occurs, clear written instructions from the parent should be provided. If a pupil brings any medication to school for which consent has not been given, school staff can refuse to administer it. In such circumstances the Head or Mrs McNally will contact the parent as soon as possible.

8. Renewal of medication which has passed its expiry date is the responsibility of the parent. Nevertheless, the school holds a central record of all medication and the expiration dates to ensure that out of date medication is not administered in error. If parents are unable to collect expired medication, then staff take it to the local pharmacy so that it can be disposed of safely. The medication must not be disposed of in any other way.

9. When medication is returned to a parent, the parent must come to Reception to collect from office staff. The office staff ensure the medication is the correct drug and has the correct name on the label before signing Appendix 16 and obtaining a countersignature from the parent. Appendix 16 will also be used for signing in short term use medication on a daily basis.

10. In all cases where, following the administration of medication, there are concerns regarding the reaction of the pupil, medical advice should be sought immediately and the parents informed.

11. A new duty on schools requires them to have procedures in place to cover transitional arrangements between schools. The existing school should make contact with the new school the child will be moving to and provide all relevant information. The timescale for doing this should take into account the need for the new school to have sufficient arrangements in place from day one (normally a few months ahead of time).

If members of staff are in doubt about any of the above procedures, they should check with the parents or a health professional before taking further action.

Refusal or Forgetting to Take Medication

If pupils refuse medication or forget to take it, the school should inform the child's parent as a matter of urgency. If necessary, the school should call the emergency services.

Non-prescribed Medication

Since Dec 2019 non-prescribed (over-the-counter) medication, such as cough medicines, can be administered including paracetamol.

At the discretion of the Head, paracetamol can be issued, provided the practice is strictly controlled by adopting the same standards as for prescribed medication. Once again, a formal agreement should be made between the school and the parents (Non prescribed medication form). The Head should authorise specific members of staff to dispense the tablets. In order to monitor and prevent the danger of any individuals overdosing on the medication the nominated member of staff should keep a record of when it was issued, giving such information as the name of the pupil and the time and the dose which was administered (see Appendix 5). This will always be countersigned. Before administering the medication members of staff should always ask the child whether any side effects or allergic reactions have been experienced.

CPOMS must not be the only way to record medication instructions as staff may not pick this up while teaching. This must also be communicated in person to staff members responsible for administering as well as logging in CPOMS. There is a Calpol medication form to be completed when parents know in advance it is needed. The form must make clear whether the instruction is Calpol is needed at regular times or to administer at given times regardless. This Calpol must be provided by parents and be labelled. Verbal consent is only accepted as a last resort when a child becomes in need of this in school and school Calpol is administered.

Medication, e.g. for pain relief, should never be administered without first checking maximum dosages and when the previous dose was taken. A record must be kept of the dose given, and a note sent home to the parents indicating the amount and frequency of the doses administered. Overall control of the administration of such analgesics can help in preventing pupils bringing their own supplies into school.

500mg paracetamol tablets are recommended for such problems as migraines and period pain. The paracetamol must be kept securely under lock and key and dispensed with care since over-dosage is dangerous. Paracetamol must not be kept in first-aid boxes.

In the main, children of Primary School age should only be given paracetamol in exceptional circumstances under the supervision of their GP. However, in certain circumstances, such as if a child has a raised temperature, the Head or Mrs McNally

can authorise the use of paracetamol via a formal agreement with the parent, as described above.

On no account should aspirin or preparations that contain aspirin be given to pupils unless a doctor has prescribed such medication.

Individual Healthcare Plan

This section of the policy covers the role of individual healthcare plans in supporting pupils at school who have long-term, severe or complex medical conditions. Miss Middleton and Mrs McNally alongside office staff are responsible for the development of these plans. **The school healthcare plan in Appendix 3 must always be completed by school staff, regardless of any other health care plan or other documentation provided by a healthcare professional.**

The governing body should ensure that there are robust school arrangements to:

- establish the need for a plan
- ensure that plans are adequate
- review plans at least annually or earlier if evidence indicating that the child's needs have changed is brought to its attention.

Healthcare plans should be developed with the child's best interests in mind and the school should ensure that it assesses and manages risks to the child's education, health and social well-being and minimises disruption. Personalised risk assessments, moving and handling risk assessments, emergency procedures and other such documents should be used to supplement the individual healthcare plan, as appropriate.

A healthcare plan template is given in Appendix 3. To ensure compliance with the statutory guidance the following issues have been taken into account:

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

- the pupil's resulting needs, including medication (with details of dose, side-effects and storage arrangements) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage his/her condition, dietary requirements and environmental issues such as crowded corridors, travel time between lessons

- specific support for the pupil's educational, social and emotional needs – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions

- the level of support needed, (some children will be able to take responsibility for their own health needs), including in emergencies. If a child is self-managing

their medication, this should be clearly stated with appropriate arrangements for monitoring

- who will provide this support, their training needs, expectations of their role and confirmation of their proficiency to provide support for the child's medical condition from a healthcare professional, together with an indication of the arrangements for cover that will be available when those supporting are unavailable

- who in the school needs to be aware of the child's condition and the support required

- the need to establish arrangements which enable written permission from parents and the Head to be drawn up, thus authorising a member of staff to administer medication or allowing the pupil to self-administer during school hours

- the designated individuals to be entrusted with information about the child's condition where the parent or child has raised confidentiality issues

- what to do in an emergency, including whom to contact, and contingency arrangements. Some children may have an emergency healthcare plan prepared by their lead clinician that could be used to inform development of their individual healthcare plan.

- the separate arrangements or procedures required for school trips, educational visits or other extra-curricular activities.

Practical Advice for Common Conditions

A small number of children need medication to be given by injection, auto-injectors or other routes. The most appropriate arrangements for managing these situations effectively are best determined by agreement between the school, parent, school nurse (where there is one) and the doctor who prescribed the medication. Experience suggests that it is helpful to have a meeting of all interested parties in school, as it is essential that parents and teaching staff are satisfied with the arrangements that are made.

Members of staff willing to administer medication should be made fully aware of the procedures and should receive appropriate training from competent healthcare staff. More information on training requirements is given below in the sections of this policy covering common medical conditions. The majority of parents will be aware of the contact details for their child's specialist nurse or consultant. Schools should contact them directly in the first instance. The School Nursing Team can be contacted for advice and is able to direct staff to other health agencies, where necessary. An

individual healthcare plan for each pupil with a medical need must be completed and conform to the procedures described on pages 11 and 12.

The medical conditions in children that most commonly cause concern in schools are asthma, epilepsy, diabetes and anaphylaxis. Essential information about these conditions is provided within this policy.

Anaphylaxis

What is Anaphylaxis?

Anaphylaxis is an extreme allergic reaction that occurs rarely in people who have an extreme sensitivity to a particular substance known as an allergen. It can affect the whole body, including the airways and circulation. Often it occurs within minutes of exposure to the allergen, though sometimes it does not arise until many hours later. **Anaphylaxis is potentially life threatening - delays in giving adrenaline are a common finding in fatal reactions.**

What Causes it?

Common causes of anaphylaxis include:

- Edible triggers, such as peanuts, tree nuts, fish, shellfish, dairy products, wheat, sesame, soya and eggs
- Other triggers, such as latex, the venom of stinging insects (for example wasps, bees and hornets), medication such as penicillin, antibiotics, ibuprofen and other drugs or injections

Anaphylactic shock is the most severe form of allergic reaction. This occurs when the blood pressure falls dramatically and the patient loses consciousness.

What are the Signs of the Condition?

Common signs of anaphylaxis in children include:

- swelling in the throat, which can restrict the air supply thus causing breathing difficulties.
- severe asthma
- dizziness

- itchy skin, generalised flushing of the skin, tingling or itching in the mouth or hives anywhere on the body

- swelling of the lips, hands and feet

- abdominal cramps, nausea and vomiting.

What is the Treatment for the Condition?

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine) into the muscle of the upper outer thigh via an adrenaline auto injector (AAI), such as an epiPen, anapen or jext. An injection should be given as soon as a reaction is suspected.

Anaphylaxis is potentially life threatening - delays in giving adrenaline are a common finding in fatal reactions. It should always be regarded as a medical emergency which requires an ambulance to be called immediately. Always make it clear to the emergency operator that the child is showing symptoms of anaphylaxis so that they can prioritise the call. A useful poster on emergency arrangements to be taken is provided in Appendix 9.

What Arrangements are in Place at our School?

Healthcare Plan

Procedures in school include:

- awareness among all members of staff that the child has this particular medical condition

- awareness of the symptoms associated with anaphylactic shock

- knowledge of the type of injector to be used

- labelling of injectors for the child concerned, for example adrenaline, antihistamine

- knowledge of the locations where the injector is stored - all are either kept in red bum bags carried by responsible adults or in corridor first aid cabinets

- Spare AAI's are kept, if available, in the appropriate key stage first aid cabinet

- the provision of appropriate instruction and training to nominated members of staff

- familiarity with the names of those trained to administer treatment

- an understanding of the need to keep records of the dates of issue
- knowledge of emergency contacts

This type of information should be suitably displayed in the areas where the medication is to be kept. This information should include the name of the child and, ideally, a photograph. Care must be given to ensure confidentiality. The information should be accessible but not publicly displayed. The information should accompany the medication on school trips including swimming and sporting activities.

Collectively, it is for the Head, the child's parents and the medical staff involved to decide how many adrenaline devices the school should hold, and where they should be stored.

Where children are deemed sufficiently responsible for carrying their own emergency treatment with them, it is nevertheless important that a spare set should always be kept safely on site. This should be accessible to all staff and stored in a secure place. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location. In an emergency situation it is important to avoid any delay.

Severe anaphylaxis is an extremely time-critical situation. Delays in administering adrenaline have been associated with fatal outcomes. School ensures that all AAI devices are kept in a safe and suitably central location where the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. They should not be located more than 5 minutes away from where they may be needed.

Storage and Care of the AAI

First aiders in school have responsibility for ensuring that:

- on a monthly basis the AAIs are present and in date.
- that replacement AAIs are obtained when expiry dates approach (this can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer).
- The AAI devices should be stored at room temperature (in line with manufacturer's guidelines), protected from direct sunlight and extremes of temperature.

School requires parents to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Disposal

Once an AAI has been used it cannot be reused and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the paramedics on arrival or can be disposed of in a pre-ordered sharps bin.

School trips including sporting activities (also see page 8)

School will conduct a risk-assessment for any pupil at risk of anaphylaxis taking part in a school trip, in much the same way as they already do so with regard to safeguarding etc. Pupils at risk of anaphylaxis should have their AAI with them, and there will be staff trained to administer the AAI in an emergency. Schools may consider whether it may be appropriate, under some circumstances, to take spare AAI(s) on some trips.

Food Management

All kitchen staff will be aware of children with allergies and the procedures to follow. We are a nut free school.

Training

Staff will:

- be trained to recognise the range of signs and symptoms of an allergic reaction;
- understand the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;
- appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);
- be aware of the anaphylaxis policy;
- be aware of how to check if a pupil is on the register;
- be aware of how to access the AAI;

Where members of staff have volunteered to inject adrenaline in an emergency, the School Nursing Team at Northumbria Healthcare no longer provide training but have provided the useful video.
https://www.youtube.com/watch?v=_9mk5GrFAdc
Colleagues can be reassured that these devices are simple to administer.

Asthma

What is Asthma?

People with asthma have airways which narrow as a reaction to various triggers. The narrowing or obstruction of the airways causes breathing difficulties.

What Causes it?

There are many things that can trigger an asthma attack. Common examples include:

- viral infections
- house dust mites
- pollen
- smoke
- fur
- feathers
- pollution
- laughter
- excitement
- stress

What are the Signs of the Condition?

The most common symptoms of an asthma attack include:

- coughing
- wheezing
- difficulty breathing
- nasal flaring
- a tight feeling in the chest (younger children may express this as ‘tummy ache’ or feeling like someone is sitting on their chest)
- Inability to talk or complete sentences (some children will go very quiet).

What is the Treatment for the Condition?

The main types of medicines used to treat asthma are discussed briefly below:

Relievers

Usually it is a reliever that a child will need during the school day. Relievers (usually blue inhalers) are medicines that are taken immediately to relieve the symptoms of asthma during an attack. They quickly relax the muscles surrounding the narrowed airways thus allowing them to open wider, making it easier for the child to breathe. They are sometimes taken before exercise.

Preventers

Preventer inhalers can be brown, red or orange in colour and can sometimes be in the form of tablets. Preventers are usually used out of school hours and it is rare for them to be needed during the school day.

Preventers protect the lining of the airways, help to calm the swelling and stop the tubes in the lungs from being so sensitive.

Spacers

Both kinds of inhalers are often used in combination with spacers which help deliver medicine to the lungs more effectively. Where prescribed, the spacer should be individually labelled with the child's name and kept with the inhaler.

Nebulisers

A nebuliser is a machine that creates a mist of medicine that is then breathed through a mask or mouthpiece. They are becoming increasingly less common. Pupils with asthma should not normally need to use a nebuliser in school. However, if they do have to use one then members of school staff will need to receive appropriate training from a healthcare professional.

Training

Since emergency treatments vary in each case, the parents will often be best placed to inform schools of the child's treatment regime. There may be a specialist nurse from the local NHS Trust who can deliver training and will have access to the medical advice that has informed the healthcare plan.

Children with asthma will often be looked after solely by their GP or Asthma Nurse. Although the GP would be unable to provide training it is likely that they will provide the information that would help school staff to complete the healthcare plans. Children with complex conditions may have access to a specialist nurse with expert knowledge in oncology, nephrology, gastroenterology, urology or cystic fibrosis, who may be able to assist.

Designated Members of Staff

First aiders and teachers are trained in:

- recognising asthma attacks (and distinguishing them from other conditions with similar symptoms)
- responding appropriately to a request for help from another member of staff
- recognising when emergency action is necessary
- administering salbutamol inhaler through a spacer
- keeping appropriate records of asthma attacks.

ALL Members of Staff

In addition to this, it would be reasonable for **ALL** members of staff to be:

- trained to recognise the symptoms of an asthma attack and, ideally, how to distinguish them from other conditions with similar symptoms
- aware of this policy
- aware of how to check if a child is on the asthma register
- aware of how to access the emergency inhaler and who the designated members of staff are, and the policy on how to access their help

Asthma UK has produced demonstration films on using a metered-dose inhaler and spacers suitable for staff and children.
http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

Beat Asthma also has a useful resource page specifically aimed at schools: http://www.beatasthma.co.uk/resources/schools/

What Arrangements are in Place at our School?

Healthcare Plan

Pupils with asthma have an individual healthcare plan agreed with parents of children with asthma how to recognise when their child's asthma gets worse and what action needs to be taken at that time. This is imperative with younger children as in early years it is foreseeable that the younger children will not have the ability to convey to members of staff that their symptoms are getting worse or identify what medicines they need to take and when.

Asthma Register

A register of children who have been diagnosed with asthma or prescribed a reliever inhaler will be kept.

The asthma register is easy to access, and allows for a quick check to take place to establish if a child is recorded as having asthma and that consent for an emergency inhaler to be administered has been obtained. This record in Horton Grange is kept in the office.

Carrying the Medication

Pupils with asthma will know where their inhalers are stored safely away if they don't carry them themselves and members of staff should witness the child taking them when the child needs the medication. For younger pupils with asthma who may not be able to use the inhaler without help or guidance trained staff will help children to take their medication.

If the child is too young or immature to take personal responsibility for his/her inhaler, members of staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.

All asthma medicine should be clearly labelled with the child's name. The expiry date of the medicines should be checked every six months.

Emergency Salbutamol Inhalers in Schools

As indicated above, schools are now permitted to keep a supply of salbutamol inhalers on site for use in an emergency. This is a sensible contingency arrangement in the event that children lose, forget or break their inhalers.

The emergency salbutamol inhaler should only be used by children:

- who have been diagnosed with asthma, and prescribed a reliever inhaler
- who have been prescribed a reliever inhaler
- for whom written parental consent for use of the emergency inhaler has been given.

Information on the use of the emergency inhaler should be recorded in a child's individual healthcare plan.

Schools are not required to hold an inhaler – this is a discretionary power enabling them to do so if they wish. Those which choose to keep an emergency inhaler should use the guidance below to establish a protocol for its use.

Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital and, potentially, save the child's life.

Protocol in school:

- Named First aiders are responsible for the supply, storage, care and disposal of the inhaler and spacers.
- School will maintain a register of pupils who have been diagnosed with asthma or prescribed a reliever inhaler. The register should confirm that parental consent has been obtained for use of the emergency inhaler and a copy of it should be kept with the emergency inhaler.
- School will obtain written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan. This consent can either be secured by amending the School/Parental Agreement Form (Appendix 1) to include this permission or by using the specific consent form for use of the emergency inhaler (Appendix 6) which should be updated regularly, ideally annually, to take account of changes to a child's condition.
- Mrs McNally will arrange appropriate support and training for staff in the use of the emergency inhaler in line with this policy.
- First Aiders will keep a record of use of the inhaler (including when and where the attack took place, how much medication was given and by whom) and

inform parents or carers that their child has used the emergency inhaler (this should be in writing so the parent can pass the information onto the child's GP – a sample letter is attached as Appendix 7)

The Medication Coordinator or Head should monitor the protocol to ensure compliance with it.

Supply

Schools can buy inhalers and spacers from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed. Schools can buy inhalers in small quantities provided it is done on an occasional basis and is not for profit.

A supplier will need a request signed by the Head (ideally on appropriately headed paper) stating:

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

Schools may wish to discuss with their community pharmacist the different plastic spacers that are available and what is most appropriate for the age-group in the school. They can also provide advice on use of the inhaler. Schools should be aware that pharmacies cannot provide inhalers and spacers for free and will, therefore, charge for them.

The Emergency Kit

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler
- at least two single-use plastic spacers compatible with the inhaler
- instructions on using the inhaler and spacer
- instructions on cleaning and storing the inhaler
- manufacturer's information
- a checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded
- a note of the arrangements for replacing the inhaler and spacers
- a register of children permitted to use the emergency inhaler as detailed in their individual healthcare plans
- a record of when the inhaler has been used
- a copy of the school protocol on the use of the emergency salbutamol inhaler

Salbutamol

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild, temporary and not likely to cause serious harm. The child may feel a bit shaky

or may tremble, or may say that they feel their heart is beating faster. The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential, therefore, that schools follow the advice previously given in relation to whom the emergency inhaler can be used by.

Children may be prescribed inhalers for their asthma which contain an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhalers are not accessible – it will still help to relieve their asthma and could save a life.

Storage and Care of the Inhaler

Schools should ensure that the inhaler and spacers are kept in a safe central location, such as the school office or staffroom, which is known to all members of staff, and to which they have access to at all times. However, the inhaler must be stored out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with the manufacturer's guidelines), usually below 30^{o}C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any individual child's inhaler; the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler. An inhaler should be primed when first used (for example, spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by spraying two puffs.

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use. The inhaler itself, however, can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place.

However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of.

The First Aiders have responsibility for ensuring that:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available
- replacement inhalers are obtained when expiry dates approach
- replacement spacers are available following use
- the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or replacements are available if necessary.

Disposal

Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled. Schools should be aware that to do this legally, they will need to register as a lower-tier waste carrier, as a spent inhaler counts as waste for disposal.

Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years. The hyperlink to enable schools to register is provided here: https://www.gov.uk/waste-carrier-or-broker-registration

However, following discussions, the Council's Waste Management and Disposal Team has determined that owing to the very small quantities of emergency inhalers which Northumberland schools will produce, a more sensible and pragmatic solution would be for each school to put them into its recycling and rubbish bins, as described below:

- If schools have an NCC recycling collection then the empty metal canister can be recycled via these bins, as the Council does permit empty aerosols to be added to its collections
- The plastic part of the inhaler should be placed into the rubbish bin, following which it will be sent with other waste to the 'energy from waste' plant

Schools requiring further information about this particular topic should call 0845 600 6400 and ask to speak to the Contracts and Commercial Team (Waste Management).

PE and Off-site Activities

Children with asthma should participate in all aspects of school life, including physical activities. They need to take their reliever inhaler with them on all off-site activities and these should also be available during physical education and sports activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work may need to be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

The emergency inhaler kit should be easily accessible should the child's primary inhaler not be available.

Action During an Attack

When a child has an attack they should be treated according to their individual healthcare plan or asthma card, as previously agreed. If the child does not have his/her prescribed reliever inhaler available, then the school's emergency inhaler can be used in the circumstances described previously. An ambulance should be called if:

- the symptoms do not improve sufficiently after 10 puffs on the inhaler
- the child is too breathless to speak
- the child is becoming exhausted
- the child has a blue/white tinge around the lips
- the child has collapsed

Because asthma varies from child to child, it is impossible to provide emergency guidance that will apply uniformly in every single case. However, the guidelines given in Appendix 8 may be helpful. Schools may wish to copy the information and display it as emergency guidance.

Diabetes

What is Diabetes?

Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly.

What Causes it?

Diabetes is a disorder caused when the pancreas produces an insufficient amount of the hormone insulin or when insulin production is absent. There are two main types of diabetes which are discussed briefly below:

Type 1 Diabetes

Type 1 diabetes develops when the insulin-producing cells have been destroyed and the body is unable to generate any of the substance. It is treated with insulin either by injection or pump, a healthy diet and regular physical activity. The majority of affected children have Type 1 diabetes.

Type 2 Diabetes

Type 2 diabetes develops when the body does not produce enough insulin or the insulin that is produced does not work properly.

This type of diabetes is treated with a healthy diet and regular physical activity, though medication (and/or insulin) is often required.

In both instances each child may experience different symptoms and these should be discussed when drawing up the healthcare plan.

What is the Treatment for the Condition?

For most children diabetes is controlled by injections of insulin each day. Some children may require multiple injections, though it is unlikely that they will need to be given injections during school hours.

In some cases, the child's condition may be controlled by an insulin pump. Most children can manage their own injections, however, if doses are required at school then supervision may be required and a suitable, private place to inject will need to be identified.

It has become increasingly common for older children to be taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime and then insulin with breakfast, lunch and evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. The child is then responsible for administering injections and the regime to be followed would be detailed in the individual healthcare plan.
It is essential that children with diabetes make sure that their blood glucose levels remain stable. They may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs to be adjusted. The majority of older children will be able to undertake this task without assistance and will simply need a suitable place to do it. However, younger children may need adult supervision to carry out the test and/or interpret the results.

When members of staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional, usually a specialist nurse with clinical responsibility for the treatment of the particular child.

What Arrangements are in Place at our School

Children have an up-to-date health care plan.

Children with diabetes will be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Children will be encouraged to drink water regularly and visit the toilet when needed.

Blood sugar levels are monitored by the designated adult. Changes in behaviour is the biggest signpost and this is monitored by all staff in the provision.

Staff will record levels every time they are taken although many devices now log the information. This will be countersigned/checked.

At lunchtimes levels will be taken to adjust blood glucose levels based on the calorific intake of the food.

Children will be monitored before, during and after PE lessons.

Members of staff will be made aware that if a child should miss a meal or snack he/she could experience a hypoglycaemic episode (commonly known as a 'hypo') during which the blood glucose level falls too low. It is, therefore, important that staff should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. After strenuous activity a child may experience similar

symptoms, in which case the teacher in charge of physical education or other sessions involving physical activity should be aware of the need to take appropriate action.

What are the Signs of a Hypoglycaemic Episode?

Staff should be aware that the following symptoms, either individually or in combination, may be an indicator of low blood sugar:

- Hunger
- Sweating
- Drowsiness
- Pallor
- Glazed eyes
- Shaking or trembling
- Lack of concentration
- Irritability
- Headache
- Mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up individual healthcare plans.

Emergency Action

If a child experiences a 'hypo', it is very important that he/she is not left alone and that a fast acting sugar, such as glucose tablets, jelly babies, a glucose rich gel or a sugary drink is brought to the child and given immediately. Slower acting carbohydrate (around 10g), such as a digestive, piece of fruit and slice of toast, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- The child's recovery takes longer than 10-15 minutes
- The child becomes unconscious

Hyperglycaemia

Some children may experience hyperglycaemia, which is a high glucose level.

The underlying cause of hyperglycaemia will usually be from loss of insulin producing cells in the pancreas or if the body develops resistance to insulin.

More immediate reasons for it include:

- Missing a dose of diabetic medication, tablets or insulin
- Eating more carbohydrates than the body and/or medication can manage
- Being mentally or emotionally stressed
- Contracting an infection

The symptoms of hyperglycaemia include thirst and the passing of large amounts of urine. Tiredness and weight loss may indicate poor diabetic control. If these symptoms are observed members of staff should draw these signs to the attention of parents. If the child is unwell, is vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and he/she will require urgent medical attention.

Further information on this condition can be found on the Diabetes UK website.

Epilepsy

What is Epilepsy?

Epilepsy is characterised by a tendency for someone to experience recurrent seizures or a temporary alteration in one or more brain functions.

What Causes it?

An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons and can result from a wide variety of disease or injury.

Triggers such as anxiety, stress, tiredness and illness may increase the likelihood that a child will have a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. The latter is called photosensitivity and is very rare. Most children with epilepsy can use computers and watch television without any problem.

What are the Signs of the Condition?

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience.

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

Most seizures last for a few seconds or minutes, and stop of their own accord. In some cases, seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking

movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

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

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear `blank' or `staring', and sometimes there will be fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class.

What is the Treatment for the Condition?

The great majority of seizures can be controlled by anti-epileptic medication. It should not be necessary to take regular medicine during school hours.

What Arrangements are in Place at our School

Children with Epilepsy have an individual healthcare plan which details what should happen following an attack. This is different for individual children.

Responsible adults carry around medication, if needed, in a red bum bag.

All adults in school are aware of the children with epilepsy and are vigilant in the classroom and especially on the yard.

All trips etc are risk assessed for possible triggers and alternative activities are sought if necessary.

Parents and health care professionals should provide information to the school's Medication Coordinator so that it can be incorporated into the individual healthcare plan, detailing the particular pattern of an individual child's epilepsy. If a child experiences a seizure whilst at school, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – for example visual/auditory stimulation, anxiety or upset.
- any unusual 'feelings' which the child reported prior to the seizure
- the parts of the body demonstrating seizure activity, such as limbs or facial muscles
- the time when the seizure happened and its duration
- whether the child lost consciousness

- whether the child was incontinent

The above information will help parents to give the child's specialist more accurate information about seizures and their frequency. In addition, it should form an integral part of the school's emergency procedures and relate specifically to the child's individual healthcare plan. The healthcare plan should clearly identify the type or types of seizures, including descriptions of the seizure, possible triggers and whether emergency intervention may be required.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or participating in science lessons. The Medication Coordinator should discuss any safety issues with the child and parents as part of the healthcare plan, and these concerns should be communicated to members of staff.

Emergency Action

Information regarding emergency management is given in Appendices 9 and 10. Appendix 10 covers the procedures to be followed with regard to first aid for all seizures, whilst Appendix 11 covers procedures to be followed if the casualty is known to have epilepsy and has been prescribed rectal diazepam.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured him/herself badly
- the child has problems breathing after a seizure
- a seizure lasts longer than the period identified in the child's healthcare plan
- a seizure lasts for five minutes and members of staff do not know how long the seizures usually last for a particular child
- there are repeated seizures, unless this is usual for the child, as described in the child's health care plan

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. Putting something soft under the child's head during a convulsive seizure will help to protect it from injury.

Nothing should be placed in the child's mouth. After a convulsive seizure has stopped, the pupil should be placed in the recovery position and a member of staff should stay with him/her until the child has fully recovered.

Status Epilepticus

Status epilepticus is a condition described as one continuous, unremitting seizure lasting longer than five minutes or recurrent seizures without regaining consciousness between them for greater than five minutes. It must always be considered a medical emergency.

A five minute seizure does not in itself constitute an episode of status and it may subsequently stop naturally without treatment. However, applying emergency precautions after the five minute mark has passed will ensure that prompt attention will be available if a seizure does continue. Such precautions are especially important if the child's medical history shows a previous episode of status epilepticus.

Any child not known to have had a previous seizure should receive medical assessment as soon as possible. Both medical staff and parents need to be informed of any events of this nature.

Emergency Medication

Two types of emergency medication are prescribed to counteract status, namely:

- Buccal (oromucosal) midazolam. This is the most common treatment for prolonged acute convulsive seizures, which is placed via syringe into the buccal cavity (the side of the mouth between the cheek and the gum).

- Rectal diazepam, which is given rectally (into the bottom). This is an effective emergency treatment for prolonged seizures.

These drugs are sedatives which have a calming effect on the brain and are able to stop a seizure. In very rare cases, these emergency drugs can cause breathing difficulties so the person must be closely watched until they have fully recovered.

Training in the administration of buccal midazolam and rectal diazepam is essential and is provided by the specialist nurse with clinical responsibility for the treatment of the particular child. Special training should be updated annually.

Administration of Buccal Midazolam and Rectal Diazepam

Any child requiring rectal buccal midazolam or diazepam should have his/her medication reviewed every year. As an additional safeguard, each child requiring buccal midazolam or rectal diazepam should have his/her own specific healthcare plan that will focus exclusively on this issue. All interested parties should be signatories to this document. An example is reproduced in Appendix 12.

Buccal midazolam and rectal diazepam can only be administered in an emergency if an accredited first-aider, trained in mouth to nose/mouth resuscitation, is easily accessible (that is only one or two minutes away). At least one other member of staff must be present as well.

Arrangements should be made for two adults to be present for such treatment, at least one of whom is the same sex as the child; this minimises the potential for accusations of abuse. The presence of two adults can also make it much easier to

administer treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

Staying with the child afterwards is important as buccal midazolam and diazepam may cause drowsiness. Moreover, those who administer buccal midazolam and rectal diazepam should be aware that there could be a respiratory arrest. If breathing does stop a shake and a sharp voice should usually start the child breathing again; if this does not work it will be necessary to give mouth to mouth resuscitation.

Unacceptable Practice

The DfE's statutory guidance makes it very clear that governing bodies should ensure that the school's 'Policy on Supporting Pupils with Medical Conditions' is explicit about what practice is not acceptable. Though most schools have for many years implemented exemplary practice to ensure that children with medical needs are fully supported, it is, nevertheless, recommended that they retain the information listed below which is taken from the DfE document. If nothing else, it will enable governors to demonstrate unequivocally to a scrutinising authority that they are not adhering to or advocating practices that are deemed unacceptable, prejudicial or which promote social exclusion.

Although school staff should use their discretion and judge each case on its merits whilst referencing the child's individual healthcare plan, it is not considered acceptable practice to:

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

Complaints

Similarly, to the stance adopted above, the DfE's statutory guidance requires that governing bodies ensure that the school's policy is crystal clear. It needs to set out how complaints concerning the support provided to pupils with medical conditions may be made and how they will be handled.

Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If, for whatever reason, this does not resolve the issue, they may make a formal complaint via the school's existing complaints procedure.

Appendices

Appendix 1 - Administration of Medication Pupils- Agreement between Parents and School (parental consent form)

Appendix 2 - Parental Request for Child to Carry and Self-administer Medicine

Appendix 3 - School Healthcare Plan for a Pupil with Medical Needs

Appendix 4 - Individual Staff Training Record – Administration of Medication

Appendix 5 - Record of Medication Administered in School

Appendix 6 - Parental Consent: Use of Emergency Salbutamol Inhaler

Appendix 7 - Specimen letter to inform parents that the emergency salbutamol inhaler was used

Appendix 8 - Emergency Action in the Event of an Asthma Attack

Appendix 9 - Emergency Action: Allergic Reaction/Anaphylaxis

Appendix 10 - Emergency Action: Epilepsy - First Aid for all Seizures

Appendix 11 - Emergency Action: First Aid for Children Known to Have Epilepsy and Prescribed Rectal Diazepam

Appendix 12 - Individual Care Plan for the Administration of Rectal Diazepam

Appendix 13 - Record of Use of Rectal Diazepam

Appendix 14 - Register of Children who have Allergies

Appendix 15 - Parental Consent: Use of Emergency Auto-Adrenaline Injector

Appendix 16 - Record of Medication In/Out of School