# ADMINISTRATION OF MEDICINES

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Administration of Medicines in Schools

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Administration of Medicines

Introduction

This document has been developed for use in schools within the Local Authority. However, as it has been produced in association with health professionals whose roles cover all maintained schools in Derbyshire, its content applies equally to all maintained schools and it is therefore recommended to all maintained schools.

The administration of medicine is the responsibility of parents/carers. School staff have a professional and legal duty to safeguard the health and safety of pupils. They will wish to do all they can to enable children to gain the maximum benefit from their education and to participate as fully as possible in school life.

Children with medical needs have the same rights of admission to a school or setting as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however, have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis.

Others may require medicines in particular circumstances, such as children with severe allergies who may need an adrenaline injection. Children with severe asthma may have a need for daily inhalers and additional doses during an attack.

Most children with medical needs can attend school or a setting regularly and take part in normal activities, sometimes with some support. However, staff may need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk.

An individual health care plan can help staff identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk.

Children have a right to an education and should not be excluded purely as a result of requiring medication.

This does not imply a duty on Headteachers or staff to administer medication. The Local Authority wishes to point out to school staff, governors and parents that participation in the administration of medicines in schools is on a voluntary basis. Individual decisions on involvement must be respected. Punitive action must not be taken against those who choose not to volunteer.

Schools may wish to consider when employing Support Staff placing the managing and administration of medicines within their job description to ensure a sufficient number of staff are employed to carry out this role.

All staff are advised to consult their trade union branch or regional officer or representative for further advice if needed.

These guidelines and codes of practice for specific treatments/medications have been produced to support and protect staff to undertake the administration of medicines and to enable staff to act in an emergency.
The following paragraph outlines the Council’s position on indemnifying its staff. Schools not within the control of the Local Authority should clarify their own position regarding indemnifying their staff.

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

This document has been prepared in consultation with health professionals from North and South Derbyshire, along with teacher associations and recognised trade unions. It supersedes all previous guidance on administration of medicine contained within the “Control of Communicable Diseases for Schools and Day Nurseries” document and the previous Administration of Medicines document issued 1996.

**Access to Education and Associated Services**

Some children with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA defines a person as having a disability if he has a physical or mental impairment which has a substantial and long-term adverse effect on his abilities to carry out normal day to day activities.

Under Part 4 of the DDA, responsible bodies for schools (including nursery schools) must not discriminate against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips and school clubs and activities. Schools should be making reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in their practices and procedures and in their policies.

Schools are also under a duty to plan strategically to increase access, over time to schools. This should include planning in anticipation of the admission of a disabled pupil with medical needs so that they can access the school premises, the curriculum and the provision of written materials in alternative formats to ensure accessibility.

Early years and child care settings not constituted as schools, and working in the Private, Voluntary and Independent Sector including childminders that are covered by Part 3 of the DDA. Part 3 duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child. This includes disabled children with medical needs. Like schools, early years and child care settings should be making reasonable adjustments for disabled children including those with medical needs. However, unlike schools, the reasonable adjustments by early years settings will include alterations to the physical environment as they are not covered by the Part 4 planning duties.

All early years and child care settings should have copies of the DfES guidance and briefing documentation to accompany it.

The National Curriculum Inclusion Statement 2000 emphasises the importance of providing effective learning opportunities for all pupils and offers three key principles for inclusion:
Short-Term Medical Needs

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

Long-Term Medical Needs

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

The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child’s educational needs rather than a medical diagnosis that must be considered.

Schools and settings need to know about any particular needs before a child is admitted, or when a child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. It is often helpful to develop a written health care plan for such children, involving the parents and relevant health professionals.

This can include:

- details of a child’s condition;
- special requirement e.g. dietary needs, pre-activity precautions;
- what constitutes an emergency;
- what action to take in an emergency;
- what not to do in the event of an emergency;
• who to contact in an emergency;
• the role the staff can play

Further details on health care plans are contained within this guidance.

1. **Medicines Policy**

The School should have a very clear medicines policy which is understood and accepted by staff, parents and children. Schools are advised to adopt and where necessary adapt the guidance in this document to form their own policy, which should be regularly reviewed and updated as necessary.

The policy should be clearly communicated to parents and should ideally be included as part of the school prospectus. As well as indicating the policy for administering medicines it should also make it clear that pupils who are **unwell** should not be sent to school and that administration of medicines will be for pupils who are:

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

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

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

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

- be aware that a three times daily dosage can usually be spaced evenly throughout the day and does not necessarily have to be taken at lunch time;
- ask the family doctor if it is possible to adjust the medication to avoid school time doses.

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

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

Young people may consult the doctor and receive medication without the parents/guardians permission/knowledge when the doctor considers they have sufficient age and understanding. There is no fixed age for this (often it is over 16). In this case the school may have to deal directly with the pupil. No child under 16 should be given medicines without the parent’s written consent. NB Children over 16 may give consent with or without parental permission. Therefore parents should not be routinely informed of medicines administered or self administered in school e.g. analgesic for period pains or headaches.

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

The other option is for parents to ask the prescriber for two prescriptions, one to cover home and the other to cover school.

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

The “Medicines Policy” should cover the following:-

- procedures for managing prescription medicines which need to be taken during the school day;
- procedures for managing prescription medicines on trips and outings;
- a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines;
- a clear statement on parental responsibilities in respect of their child’s medical needs;
- the need for prior written agreement from parents for any medicines to be given to a child;
- the circumstances in which children may take any non-prescription medicines;
- the school or setting policy on assisting children with long-term or complex medical needs;
- policy on children carrying and taking their medicines themselves;
- staff training in dealing with medical needs;
- record-keeping;
- safe storage of medicines;
- access to the school’s emergency procedures;
- risk assessment and management procedures;
- the need to administer medicines only out of the original container labelled with the prescriber’s instructions.

It is the responsibility of the headteacher to ensure that the school has a policy and that appropriate systems are in place to ensure the policy is understood and followed.

2. **Prescription and Non-Prescription Medicines**

**Prescribed Medicines**

Medicines should only be taken to school or settings when essential; that is where it would be detrimental to a child’s health if the medicine were not administered during the school or setting ‘day’. Schools and settings should only accept medicines that have been prescribed by a doctor, dentist, or qualified non medical prescriber (nurse, pharmacist, podiatrist, optometrist and physiotherapist). Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber’s instructions for administration. They should also be accompanied by a fully completed parental consent form 2.

**Schools and settings should never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions. Any changes to dosages must be authorised by a medical practitioner or responsible prescriber.**
It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable them to be taken outside school hours. Parents could be encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

The Medicines Standard of the National Service Framework (NSF) for Children recommends that a range of options are explored including:

- Prescriber’s consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours;
- Prescriber’s consider providing two prescriptions, where appropriate and practicable, for a child’s medicine: one for home and one for use in the school or setting, avoiding the need for repackaging or relabelling of medicines by parents.

**Controlled Drugs**

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. Some may be prescribed as medication for use by children, e.g. methylphenidate.

Any trained member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber’s instructions and these guidelines.

A child who has been prescribed a controlled drug may legally have it in their possession to bring to school. Once the controlled drug comes into a school or childcare setting it should be securely stored by the school.

Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes.

A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

Controlled drugs likely to be prescribed to children which may need to be administered in schools and other educational settings are for example methylphenidate and dexamfetamine for ADHD or possibly morphine/fentanyl for pain relief.

**Non-Prescription Medicines**

Non-prescription medicines are those which can readily be bought “over the counter”. It is recognised that certain pupils may need to take non-prescription medicine for conditions such as dysmenorrhea (period pains). Many pupils will possibly keep and administer their own medication of this type with no reference to the school. This however could lead to problems should a pupil be seen taking a tablet the school is
unaware of or if pupils are carrying significant numbers of “paracetamol” which could be open to abuse by themselves or others.

It is therefore advised that schools and other education settings should have very clear rules in place regarding non-prescription medicines. Non-prescription medicines should be accompanied by a parental consent form 2, Appendix 1 (which can be filled in by over 16’s for themselves) even if the pupil intends to keep them themselves. Only sufficient medication for one day’s dose should be allowed into school for non-prescription medicines.

If staff are required to help supervise or administer non-prescription medication due to a child’s age or ability to be responsible for their own storage and administration of the medicine then the procedures for administering medicines by a trained member of staff set out in the following section must be followed fully.

Non-prescription medicines should only be allowed into school in their original containers which clearly state what they are and maximum dose and dose frequency. This may need parents to take out and keep at home medication so that only one day’s dose comes into school in its original container.

Staff should never give a non-prescribed medicine to a child unless there is specific written permission from the parents on the appropriate form, and it is the medicine supplied by the parent. Staff should not give pupils their own medicine or that belonging to another pupil and schools and settings should not keep stocks of non-prescription medicines to give to pupils.

NB A child under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor. Parents should be made aware of this via the prospectus and that staff will refuse to give it unless prescribed.

3. **Procedure for Administration of Medicines in Schools**

(See Flow Chart – Appendix 2)

The following procedures are recommended as examples of best practice.

**Written Instructions**

All medicines that are to be administered in school must be accompanied by written instructions from the parent and/or the GP. Schools may wish to allow non-prescription medicines into school in accordance with the guidance earlier in this document e.g. paracetamol – if accompanied by a parental consent form. NB One day’s dose only.

The parental consent form 2 should be made readily available to parents.

Each time there is a variation in the pattern of dosage, a new form should be completed and it should be accompanied by written confirmation from a medical practitioner to confirm the variation, unless it is a completely new prescription at the end of an existing prescription.

No child under 16 should be given medicines without their parent’s written consent. Any member of staff giving medicines to a child should check:

- the child’s name;
• prescribed dose
• expiry date
• written instructions provided by the prescriber on the label or container.

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

Educational Settings, Schools and Early Years settings must keep written records each time medicines are given. Form 5 can be used for this purpose. Good records help demonstrate that staff have exercised a duty of care. In some circumstances such as the administration of rectal diazepam, it is good practice to have the dosage and administration witnessed by a second adult. Controlled drugs need TWO people to witness the administration.

Labelling of Medicines

On the few occasions when medicines have to be brought into schools, the original or duplicate container, complete with the original dispensing label should be used.

The label should clearly state:

• name of pupil;
• date of dispensing;
• dose and dose frequency (This may read “as directed” or “as before” if this is what is on the prescription. In this case the parental consent form 2 must give clear instructions);
• cautionary advice/special storage instructions;
• name of medicine;
• expiry date – where applicable.

The information on the label should be checked to ensure it is the same as on the parental consent form. Where the information on the label is unclear, such as “as directed” or “as before” then it is vital that clear instructions are given on the parental consent form. If the matter is still not clear, then the medicine should not be administered and the parents should be asked to clarify the problem.

Storage

Non Emergency Medicines

Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration. This should be easy if medicines are only accepted in the container as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child needs two or more prescribed medicines, each should be in a separate container.
Children should know where their own medicines are stored and who holds the key. The Head is responsible for making sure that medicines are stored safely.

Non-emergency medicines should generally be kept in a secure place not accessible to children. Criteria under the national standards for under 8s day care require medicines to be stored in their original containers, clearly labelled and inaccessible to children.

A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines.

**NB** Controlled drugs must be kept in a locked cabinet.

Local pharmacists can give advice about storing medicines.

**Emergency Medicines**

These are medicines which need to be readily available in an “emergency situation” and include medicines such as asthma inhalers and adrenaline pens. These should always be readily available to pupils as and when they need them. Many pupils will have the capacity to keep and administer their own medication of this type and where this is the case then that is an acceptable situation. Where pupils are deemed not to have this capacity then the medicines should be stored in such a way that they are readily accessible i.e. not locked away in a central store cupboard. Schools will need to decide how best to manage this. Examples may include a box on the teacher’s desk or in an unlocked teacher’s drawer. It is however, important that while these medicines are readily available to the pupil if needed they should still only be available to the pupil for whom they were prescribed. Schools should also have a system to ensure these emergency medications are readily available at times when the pupils may not be in the classroom (e.g. PE in the hall, lunch and break times and out of the classroom activities e.g. visits).
Administration of Medicines

There are three general situations which apply to the administration of medicines in schools. These are as follows.

1 The pupil self administers their own medicine of which the school is aware

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

It is good practice to support and encourage children, who are able, to take responsibility to manage their own medicines from a relatively early age and schools should encourage this. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility.

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent. Children develop at different rates and so the ability to take responsibility for their own medicines varies. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self-manage. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

2 The pupil self administers the medication but someone supervises the pupil

Where the Headteacher or staff are willing to be involved voluntarily, the headteacher is responsible for ensuring that as a minimum safeguard self administration of medicines that are safely stored is supervised by an adult. This involves ensuring:

- access to the medication at appropriate times. Where schools supervise self administration appropriate measures should be taken to ensure the medicine is appropriately stored to prevent any unsupervised self-administration of the medicine, as per the guidance on the storage;
- the medication belongs to the named pupil and it is within the expiry date;
- a record is kept in the appropriate form in Appendix 2 noting that the session was supervised but clearly indicating that medication was self administered by the pupil.

3 A named and trained volunteer at the school administers the medicine

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

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

To avoid the risk of double dosing in schools, the Headteacher must clarify who is responsible for administering medications. As an extra precaution staff who administer medication must routinely consult the record form before any medication is given.
All staff who participate in administering medication must receive appropriate information and training for specified treatments in accordance with the code of practice. In most instances, this will not involve more than would be expected of a parent or adult who gives medicine to a child. Training should be through the School Health Service, who will liaise as appropriate with those doctors responsible for the management and prescription of treatment, particularly in complex cases.

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

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

Each person who administers medication must:

- receive a copy of these guidelines and code of practice;
- read the written instructions/parental consent form for each child prior to supervising or administering medicines, and check the details on the parental consent form against those on the label of the medication;
- confirm the dosage/frequency on each occasion and consult the medicine record form (Appendix 2) to ensure there will be no double dosing;
- be aware of symptoms which may require emergency action, e.g. those listed on an individual treatment plan where one exists;
- know the emergency action plan and ways of summoning help/assistance from the emergency services;
- check that the medication belongs to the named pupil and is within the expiry date;
- record on the medication record form (Appendix 2) all administration of medicines as soon as they are given to each individual;
- understand and take appropriate hygiene precautions to minimise the risk of cross-contamination;
- ensure that all medicines are returned for safe storage;
- ensure that they have received appropriate training/information. Where this training has not been given, the employee must not undertake administration of medicine and must ensure that the headteacher is aware of this lack of training/information.

4. **Health Care Plan (Individual Treatment Plan)**

**Purpose of a Health Care Plan**

The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short written agreement with parents may be all that is necessary. Individual health care plans are generally required for people with specific medical needs requiring specialised or emergency medication.

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

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

Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child. Form ….. can be used or adapted.

In addition to input from the school health service, the child’s GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a health care plan include:

- the headteacher or head of setting;
- the parent or carer;
- the child (if appropriate);
- early years practitioner/class teacher (primary schools)/form tutor/head of year (secondary schools);
- care assistant or support staff (if applicable);
- staff who are trained to administer medicines;
- staff who are trained in emergency procedures.

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

Co-ordinating Information

Co-ordinating and sharing information on an individual pupil with medical needs, particularly in secondary schools, can be difficult. The headteacher should decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies.

Information for Staff and Others

Staff who may need to deal with an emergency will need to know about a child’s medical needs. The head should make sure that supply staff know about any medical needs.

Off-Site Education or Work Experience

Schools are responsible for ensuring via the existing service level agreements, that work experience placements are suitable for students with a particular medical condition. Schools are also responsible for pupils with medical needs who, as part of key stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or further education college. Schools should consider whether it is necessary to carry out a risk assessment before a young person is educated off-site or has work experience.
Schools have a primary duty of care for pupils and have a responsibility to assess the general suitability of all off-site provision including college and work placements. This includes responsibility for an overall risk assessment of the activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

Where students have special medical needs the school will need to ensure that such risk assessments take into account those needs. Parents and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

**Staff Training**

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

**Confidentiality**

The head and staff should always treat medical information confidentially. The Head should agree with the child where appropriate, or otherwise the parent, who else should have access to records and other information about a child. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

5. **Refusing Medicines**

If a child refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in an individual child’s health care plan. Parents should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the school or setting’s emergency procedures should be followed.

6. **Hygiene and Infection Control**

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment. Ofsted guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.
7. **Educational Visits**

It is good practice for schools to encourage children with medical needs to participate in safely managed visits. Schools and settings should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. This might include reviewing and revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medical needs. It might also include risk assessments for such children.

Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child’s GP.

The national standards for under 8s day care and childminding mean that the registered person must take positive steps to promote safety on outings.

8. **Sporting Activities**

Most children with medical conditions can participate in physical activities and extra-curricular sport. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child’s ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers. More details about specific health conditions can be found in Chapter 5. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

9. **Home To School Transport**

Local Authorities arrange home to school transport where legally required to do so. They **must** make sure that pupils are safe during the journey. Most pupils with medical needs do not require supervision on school transport, but the Local Authorities will provide appropriate trained escorts if they consider them necessary.

Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they **must** receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles, responsibilities and liabilities.
Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. Schools will be well placed to advise the Local Authority and its transport contractors of particular issues for individual children. Individual transport health care plans will need input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training. Additionally trained escorts may be required to support some pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

Some pupils are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

10. **Special Schools, Enhanced Resource Schools and Pupils Support Centres**

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

11. **Residential Schools**

Residential schools should develop a specific medicines policy based on these guidelines. Clear guidelines will need to be in place to ensure medication is given at correct times and that this is recorded. Administration of medicines should be the specific responsibility of identified posts to avoid the possibility of incorrect doses or additional doses being given. Provision will need to be made for a deputy in case the person nominated is absent for any reason.

12. **Employee Medicines**

An employee may need to bring their medicine into school. All staff have a responsibility to ensure that their medicines are kept securely and that pupils will not have access to them, e.g. locked desk drawer or staff room.

Adequate safeguards must be taken by employees, who are responsible for their own personal supplies, to ensure that such medicines are not issued to any other employee, individual or pupil.
13. Emergency Procedures

As part of general risk management processes all schools and settings should have arrangements in place for dealing with emergency situations. Other children should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. Guidance on calling an ambulance in provided in Form 1. All staff should also know who is responsible for carrying out emergency procedures in the event of need. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

Staff should never take children to hospital in their own car; it is safer to call an ambulance. In remote areas a school might wish to make arrangements with a local health professional for emergency cover. The national standards require early years settings to ensure that contingency arrangements are in place to cover such emergencies.

Individual health care plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

Where children have conditions which may require rapid intervention parents must notify the Headteacher of the condition, symptoms and appropriate action following onset. The Headteacher may wish to discuss this with the School Health Service.

The Headteacher must make all staff aware of any pupil whose medical condition may require emergency aid.

It is essential that all staff (including supply staff, lunchtime supervisory staff etc) are able to recognise the onset of the condition and take appropriate action ie. summon the trained person, call for ambulance if necessary etc.

Training and practical advice on the recognition of the symptoms can usually be offered by the School Doctor/Nurse.

All schools should devise an emergency action plan for such situations after liaising with the School Health Service. Planning should take into account access to a telephone in an emergency in order to summon medical assistance or an ambulance.

This has implications for school journeys, educational visits and other out of school activities.

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

14. Unusual Occurrences, Serious Illness Or Injury
All parents/guardians should be informed of the school’s policy concerning pupils who become unwell while at school, or on authorised educational visits, trips etc. This should be contained within the school’s Information to Parents booklet (prospectus).

It is vital to have not only the pupils’ home telephone numbers, but parents'/guardians' daytime numbers and other emergency numbers such as those of relatives, in order to make contact.

If parents and relatives are not available when a pupil becomes seriously unwell or injured, Headteachers should, if necessary call an ambulance to transport the pupil to hospital.

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

### 15. Notifiable Diseases

Heads should be aware of and make available the document “Guidance on infection control in schools and nurseries” available from the Health Protection Agency website. [www.hpa.org.uk/infections/topice-az/schools/default.htm](http://www.hpa.org.uk/infections/topice-az/schools/default.htm). If Heads are unsure of any issue relating to notifiable diseases they should seek advice from the Health Protection Team (01623 819000).

### 16. Disposal Of Medicines

Any medication which has reached its expiry date should not be administered.

Medicines which have passed the expiry date should be returned to parents/guardians for disposal. Parents should be advised that the medicines are out of date and should be asked to collect them. Parents should also be advised that out of date medicines can be returned to the pharmacy for safe disposal. Out of date medicines should not be sent home with pupils.

Provision for safe disposal of used needles will require appropriate special measures, e.g. a “sharps box”, to avoid the possibility of injury to others. This “sharps box” must be kept secure with no access for pupils or unauthorised persons. This should be disposed of in a safe way using a specialist licensed contractor.

### 17. Codes Of Practice

These codes of practice have been drawn up with advice from Health Authorities and paediatricians both community and hospital based.

Each individual code is set out in a similar format.

It is important when receiving any written parental consent/instruction to examine and identify any variation from the detail contained in the relevant code of practice to avoid any confusion at a later date.

The codes of practice are set out in a standard format and provide:
• detailed guidance and sources of further information and;
• at-a-glance "what to do" guides for emergency situations, where appropriate.

The codes must be readily available and within easy reach of a storage facility used for administering medicines or for providing specific treatments.
Children with Complex Health Needs

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

- Maintain optimal health during the day
- Access the curriculum to the maximum extent

Examples of care of health needs for which children might require additional support in school include:

- Restricted mobility
  For example a child with physical impairments who uses a wheelchair

- Difficulty in breathing
  For example a child with a tracheostomy who requires regular airway suctioning during the day

- Problems with eating and drinking
  For example a child who requires a gastrostomy feed at lunch time

- Continence problems
  For example a child who requires assistance with bladder emptying and needs catheterisation at each break time or to follow a toileting plan to aid continence of bladder and bowels

- Susceptibility to infection
  For example a child who is receiving steroid therapy

This list is provided for illustrative purposes only and is not comprehensive.

In supporting children with complex needs in schools and early years settings there are a number of clinical procedures which education staff may be trained to undertake. In the main such training is undertaken by Children’s Community Nurses, Specialist Nurses or School Community Nurses.

A detailed Individual Health Plan should be completed by the nurse, parents and child (if appropriate) and reviewed at regular intervals.

Some children with complex physical needs will require a range of specialist equipment to enable them to sit, stand and walk. This equipment should be assessed for by a trained health professional; (Children’s Occupational Therapist, Local Authority Moving and Handling Adviser, Physiotherapist or Community Nurse) and the appropriate Local Authority Moving and Handling Advisor or School Link Worker in accordance with the Derbyshire Inter Agency Group (DIAG) guidance document. The equipment should be adjusted to suit an individual child. On the rare occasion when one piece of equipment is used for more than one child, the health professional should supply written instructions, (or manufacturers instructions), on altering the equipment. Children may also require a Moving and Handling Plan, completed by school staff or a moving and handling advisor and a Therapeutic Variance Form attached to a Moving and Handling Plan, (completed by the therapist).
In order to promote physical well-being and optimise a child’s learning and integration opportunities, specialised equipment should be an integral part of a child’s day rather than seen as ‘therapy’.

Some children with complex communication needs may require assessment for a communication aid or other relevant specialist equipment.

The Speech and Language therapy Service should be involved in assessment procedures for communications aids.

Advice is available from the Speech and Language Therapist when a child is a communication aid user.

**Further information**

Managing complex health needs in school and early years settings - Council for Disabled Children, Dept of Ed & Skills 2005
CODE OF PRACTICE

TO BE READ IN CONJUNCTION WITH:

Royal Pharmaceutical Society - The Administration and Control of Medicines in Care Homes and Children’s Services; and Derbyshire County Council Children & Younger Adults Dept. - The Administration of Medicines

1. Allergy/Anaphylaxis
2. Attention Deficit Hyperactivity Disorder (ADHD/ADD) in school and other settings
3. Asthma
4. The asthma attack – What to do
5. Children with Diabetes needing insulin
6. Continence Management and the Use of Clean Intermittent Catheterisation (CIBC)
7. Epilepsy - Treatment of Prolonged Seizures
8. Action to be taken if a medicine administration error is identified
9. Controlled Drugs
10. Disposal of Medicines
11. Clinical procedures which might be undertaken by non-health qualified staff
12. Safe handling and storage of medical gas cylinders
13. Non-prescribed medicines/medicinal products
14. First Aid
1 Allergy/Anaphylaxis

This code of practice only applies when the acute allergic condition is known and notified to the school/service. It commonly occurs in response to certain foodstuffs, particularly peanuts, but can occur in response to insect stings. Many reactions are mild and do not require specific treatment but in reactions involving breathing difficulties or airway compromise/shock, urgent administration of adrenaline is required.

Types of Treatment

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

- An oral antihistamine (chlorphenamine)
- An adrenaline injection (epinephrine)

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

Written Instructions

An Individual Treatment Form must be completed by the Consultant Paediatrician or the General Practitioner.

In addition to the written instructions a form of indemnity must be signed by the parents which would indemnify staff in respect of their agreeing to undertake the task of administering an adrenaline injection where an acute allergic condition is known.

(See below)

An Individual Health Plan should be completed by the parents, school/social care worker and appropriate nurse, including contact details, specific symptoms and medication for the child.

The parent/guardian must agree to be responsible for ensuring that the school/service is kept supplied with injections which are ‘in date’.

The Headteacher/Person in Charge through the employer must ensure appropriate training and yearly updates are given to staff. The School Health Service following consultation with the prescribing paediatrician is responsible for arranging the appropriate information and training for a minimum of two responsible persons who have volunteered to administer adrenaline. It may be necessary for the Headteacher/Person in Charge to arrange for the teachers and other staff to be briefed about a child’s condition and about the arrangements contained in the written instructions. If there are no volunteers to administer the medication, then an ambulance must be called should a child suffer a reaction.

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

Appropriate arrangements must be agreed with parents/guardians for provision and safe handling of medication during educational visits away from the school/service.

In the event of the child showing any of the physical symptoms, staff are instructed to follow the agreed emergency procedure.
A Health Plan will indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor/guardians. This should be used in accordance with the training provided for that individual child.

*If adrenaline is administered then the emergency services/hospital must be given the used device for disposal and told the time of administration.*

**Labelling**

All medicines must be clearly labelled with the child’s name.

**Storage and Access**

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

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

**Administration of Medicines**

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

Although the administration of injections is considered to be a matter for medical staff the advice is that this process can be carried out with confidence after appropriate training. Training would be provided by the School Health Service or Children’s Community Nurse and legal liability assured by the Local (Education) Authority. It is recommended that training should be carried out/refreshed annually.

**Overdose/Misuse**

The adrenaline must only be used for the ‘named’ child.

Any injection held in reserve must not administered to another child – even if symptoms similar to an acute reaction are presented.

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

**Further Information**

Further advice and guidance can be obtained from:

- The Local School Health Service.
- The Named Nurse or Designated Doctor for Children in Care
- The author of the Individual Health Care Plan
- Guidelines Resource Pack
FORM OF INDEMNITY

Anaphylaxis

In consideration of staff at ................................................................. School/service
agreeing to administer an injection to ................................................... (name of child)
in the event of the said ..................................................(child) suffering from an anaphylactic
reaction whilst at ................................................................. School/service, or on associated
activities, we, ................................................................. parent(s)/guardian(s) of the said
..........................................................................................(child) hereby indemnify the Derbyshire County
Council, its servants and employees against all proceedings, costs, liabilities and damages
incurred as a result of any injury or damage caused to the said
..........................................................................................(child) by the administration of an injection of
adrenalin provided always that this indemnity shall not include injury resulting from or caused by or
materially attributable to the negligence of the Derbyshire County Council, its servants or
employees or the failure of the Derbyshire County Council to perform its common law or statutory
duties and liabilities.

Dated this .............day of ................................................. 20...

Signed ................................................................. Parent(s)/Guardian(s)
Attention Deficit Hyperactivity Disorder (ADHD)/ADD in School and other settings

Introduction

Attention deficit hyperactivity disorder/ADD are common problems in schools and other settings characterised by persistent and pervasive difficulties of concentration and attention control (ADD), frequently associated with hyperactivity (ADHD).

These children are easily distracted, have poor attention skills and lack the ability to concentrate for periods of time. They may also be impulsive and volatile resulting in actions they often find difficult to inhibit before it is too late. They are frequently therefore seen as “naughty”, “defiant” and “disruptive”.

Specific advice on management in schools is available via the Children & Younger Adults Department Educational Psychology Service pamphlet “Management of ADHD in schools”. ADHD/ADD may be associated with a wide range of other conditions including generalised learning difficulties, specific learning problems e.g. dyslexia and dyspraxia and in association with autism. It may also be secondary to emotional difficulties, neglect and other psychological problems.

Types of Treatment

2. Individual Education Plan (IEP) developed with advice of Special Educational Needs Care Officer (SENO), Local Inclusion Officer (IO) and Educational Psychologist.
3. A written care plan or specific behaviour management strategy under the supervision an experienced clinician such as a psychologist or child psychiatrist
4. Short acting medication e.g. methyphenidate, (“Ritalin”, “Equasym”), and dexamfetamine. These are controlled drugs.
5. Long activating medication e.g. ‘Concerta XL’ and ‘Equasym XL’ and atomoxetine (“Strattera”). These are controlled drugs

Written Instructions

All children should have a written treatment plan. Administration of medicines must be clearly documented. Any changes in child’s behaviour, concentration and attention should be documented carefully to allow monitoring of the treatment.

Labelling

Medicines will be clearly labelled with child’s name and dose to be given.

Storage and Access

Preparations of methyphenidate, (“Ritalin”, ‘Equasym’, ‘concerta XL’ and ‘Equasym XL’) and dexamfetamine are controlled drugs and must be kept in a locked cabinet and dispensed as prescribed by approved staff.
Administration of Medicines

Medication should be dispensed as prescribed. Methylphenidate treatment is short acting so timing of administration may be critical and may need to be adjusted to get maximum benefit with minimum side effects.

Variation of dosage must be notified in writing. Older children who are competent may self administer but must be supervised to ensure medicine has been taken. Administration should be recorded and witnessed by two people for controlled drugs.

Overdose and Misuse

High doses of methylphenidate may cause side effects such as irritability, drowsiness, emotional liability and tics (twitches). Any symptoms suggesting side effects should be documented carefully and reported to parents so the dose of medication may be adjusted accordingly.

Accidental overdose of treatment is unlikely to cause serious side effects. Any effects are likely to resolve quickly within hours of stopping treatment.

There is no evidence of drug dependency developing with Methylphenidate treatment.

Further Information

USEFUL CONTACTS and Literature

Parent Support Group
FLARE Derbyshire ADHD support service
01246 969012
flareadhd@aol.com
Introduction

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

Types of Treatment

The most effective way to take asthma medications is to inhale them. This may be via:

- pressurised aerosol
- dry powder device – e.g. Diskhaler, Turbohaler, Accuhaler

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

The use of a “Spacer” (holding chamber) with the pressurised aerosol overcomes some of the problems children have using inhalers alone and is the most efficient way of getting the treatment into the lungs.

There are two types of treatment for asthma

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

- **“Preventers”**

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

  **Only “Reliever” inhalers need to be available in school and other settings.**
  
  “Preventer” treatments can all be prescribed in regimes that do not require these to be taken during school hours.

Children may be prescribed oral steroid tablets (prednisolone, betamethasone) if their asthma is poorly controlled. Generally if they require oral steroids they are probably not fit for school. However they only need to be taken once daily & should not be required to be given in school hours.

Written Instructions

Written instructions should be provided with details of the “reliever” inhaler type & dosage provided for school/services. Availability of a Spacer should be recorded & encouraged.

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

Labelling

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

If a Spacer is provided then this also needs to be labelled with the child’s name, again the pharmacist should be asked to add this information.

Storage and Access

Asthmatic children must have immediate access to their “reliever” inhaler at all times.

Where possible children of junior school age and above should carry their own inhalers. It is not necessary to lock the inhalers away for safety reasons.

Younger children should be encouraged to be responsible and carry their own inhalers also. However when this is not practically possible then parents may request after consultation with the headteacher/person in charge for inhalers to be kept with the supervising teacher/worker for safe-keeping and ease of access.

Where Spacers are required arrangements need to be made for appropriate storage and access to these devices as it is not practical for them to be carried around by the child.

Inhalers should be taken to swimming lessons, sports, cross country, team games etc and on educational visits and used accordingly. Some children benefit from taking a dose of their “reliever” prior to taking part in exercise and this should be supported and encouraged.

Administration of Medicines

Self-administration is the usual practice. Staff need to be alert to the possible over use of “reliever” inhalers and the Headteacher/person in charge should inform parents/guardians as appropriate. In circumstances where staff assist a child to use an inhaler, an individual treatment plan provided by the parents in consultation with the GP/asthma nurse should be followed. A record should be made in the Medicine Record Form – Appendix 2 – or equivalent.

Overdose/Misuse

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

In all suspected cases, note in the Medicine Record and the action taken to seek medical advice and advise parents.
Further Information

**Asthma UK** provide guidelines for school and other settings to help them develop a Schools Asthma Policy. They also provide a sample “School Asthma Card” to be completed by the parent/carer giving required details of asthma medication.

Asthma UK  
Summit House  
70 Wilson Street  
London  
EC2A 2DB

or

[www.asthma.org.uk](http://www.asthma.org.uk)

The organisation is funded by voluntary donations.

Further advice and guidance can be obtained from:

- The Local School Health Team
- Community Child Health
- The Nurse or Designated Doctor for Children in Care
- The author of an Individual Treatment Plan if one exists for a specific child
- The Child’s Family Doctor or Asthma Nurse
4 THE ASTHMA ATTACK – WHAT TO DO

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

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

1 Let the child take their usual “reliever” treatment (BLUE INHALER) immediately – using the Spacer if available for that child

If the child has forgotten their inhaler and you do not have prior permission to use another inhaler:
- Call the parents/guardians
- Failing that call the family doctor
- Check the attack is not severe – see below

2 Keep calm & reassure the child. It’s treatable.

3 Help the child to breathe
- Sit child upright – lean forward slightly (do not make them lie down)
- Encourage slow deep breaths
- Offer a drink of water

4 The reliever should work in 5 – 10 minutes

5 If the symptoms disappear, the child can go back to what they were doing

6 If the symptoms have improved, but not completely disappeared, call the parents and give another dose of the inhaler while waiting for them.

7 If the normal medication has had no effect, see severe asthma attack below

WHAT IS A SEVERE ATTACK?

Any of these signs mean severe:
- Normal relief medication does not work at all
- The child is breathless enough to have difficulty in talking normally
- The child is distressed or becoming exhausted
- The pulse rate is 120 per minute or more
- Rapid breathing of 30 breaths a minute or more

HOW TO DEAL WITH A SEVERE ATTACK

Either follow your school protocol or:
- Call an ambulance (or the family doctor if they are likely to be able to come immediately)
- Get someone to inform the parents while you stay helping the child
- Keep trying the usual reliever inhaler, preferably with a supplied Spacer, every few minutes and don’t worry about the possibility of overdosing as reliever medication is extremely safe.
5 Children with Diabetes needing insulin

Introduction

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

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

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

New Presentation of diabetes

Diabetes is becoming increasingly common in children.

Typical symptoms include:

- Excessive thirst, needing to pass urine more frequently, weight loss
- If any of these symptoms are noticed by the teaching staff, the concerns should be raised with the parents so they can seek medical advice.

Routine Care

Insulin

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

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

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

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

Each child should have an individualised care plan detailing:

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

Blood testing

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

Each child should have an individualised care plan detailing:

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

Food

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

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

It is important that children with diabetes are:
• Given priority in the queue at meal times.
• Allowed to have snacks as directed by the diabetes team. These can usually be taken at break times but in some circumstances may need to be eaten during class time.

Primary school children should have their snacks and meals supervised.

Physical activity

Children with diabetes should participate in all the usual activities.

Physical activity may cause the blood sugar to fall and may cause a hypo. This can be avoided by having a snack before and possibly during or after an activity, depending on the level of activity.

Each child should have an individualised care plan detailing:
• Recommended snack prior to, during and after exercise as appropriate.

Storage and labelling

All medication and the emergency pack for hypoglycaemia (see below) should be labelled with the name of the child and stored in a safe but accessible place. Care should be taken to ensure all items are 'in date.'

Common Problems Encountered

Hypoglycaemia (low blood sugar)

Hypoglycaemia ('hypo') is the commonest problem encountered and occurs when the blood sugar level falls too low (less than 4 mmo/l).

Typical symptoms and signs include: feeling faint, sweating, pallor, trembling or shakiness, lack of concentration, irrational or aggressive behaviour.

Hypo’s can result from: a missed meal or delayed meal or snack, physical activity, too much insulin

Treatment

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

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

The **child should never be left unattended** and the emergency box should be taken to taken to the child.

**Management is as follows:**

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

**Hyperglycaemia (high blood sugar)**

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

**Management is as follows:**

- Check blood sugar.
- Inform parent or carer immediately
- If not available and child unwell: call emergency services.

**Outings & trips/overnight stays**

**Day trips**

Children with diabetes should not be excluded from trips/activities which should be discussed with the parent / carer and if necessary the PDNS. It is important to take: blood testing kit, extra snacks and insulin and injection kit.

**Overnight trips/stays**

The child would need to be confident in giving their own injections if staying overnight. A member of staff would need to take responsibility for helping with blood tests and injections. The Diabetic Specialist Nurse will be able to offer advice.

**Further advice**

**Local diabetes team:**
Southern Derbyshire
Derbyshire Children’s Hospital - Tel: 01332 340131
Office hours: page Paediatric Diabetic Nurse Specialists
Out of hours: ask for Children’s Emergency Dept

North Derbyshire
Chesterfield Royal Hospital
Office hours: 01246 512113 and ask for Diabetic Liaison Nurse
Out of hours: 01246 277271 and ask for Paediatric registrar

Diabetes UK (www.diabetes.org.uk):
‘Children with diabetes at school: what all staff need to know.’
Continence Management and the Use of Clean Intermittent Catheterisation (CIBC)

Introduction

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

Learning, Emotional and Behavioural Difficulties

Bladder and bowel control are a function of physical, intellectual and social development, therefore children with learning difficulties or emotional and behavioural difficulties may be incontinent. These children will require:

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

Urinary Continence Problems with Day Time Wetting

Daytime wetting is very common in children, particularly younger children in reception and infants. This is usually due to an irritable bladder precipitated by changes in routine when children enter school or move from an early years setting. A few will have an intrinsic problem which may require long term treatment.

Most continence problems may be managed by:

1. Increase total daily fluids spread evenly throughout the day, including school (<5 years 1 litre fluid a day, 5-11 years 1 ½ litres fluid a day, >11 years 2 litres fluid a day).
2. Avoiding irritant fluids e.g. blackcurrant juice and carbonated drinks.
3. Regular toileting usually in natural breaks in the school day, but for some children easy and immediate access to toilets is essential (“holding on” is counter productive).
4. Medication e.g. oxybutynin may be required if other measures are insufficient and may need to be administered at school.

Neuropathic Bladder and Bowel

Bladder and bowel function is disrupted by abnormal development of the nerve supply and can rarely be cured by treatment. However, medication, surgery and specialist techniques can usually achieve a reasonable level of continence. To achieve social control requires very careful assessment by the continence adviser and doctors and a specific care plan implemented by children, parents and care staff. Such a care plan should be designed to achieve continence, encouraging as much independence as possible and respect for the child’s dignity and privacy.

All children will require:

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

**Types of Treatment**

**Regular Toileting**

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

**Medication**

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

**Catheterisation (CIBC)**

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

**Written Instructions**

For children with a complex problem there must be a written care plan on every child drawn up by a continence adviser/community paediatric nurse in conjunction with the consultant paediatrician or surgeon. The care plan should be reviewed at least annually. It could also include issues around mobility and dexterity which are often associated problems.

The instructions must be approved and signed by the parents/guardians and health professionals responsible.

At least two persons should be trained to perform and supervise CIBC. Training could be available from community paediatric nurse service or specialist continence adviser. Training should only be given by professionals in association with parents.

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

**Labelling**

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

**Storage and Access**

All equipment should be stored in a cupboard easily accessible to child and carer during catheterisation.
Toilet facilities must be easily accessible to the children with the advice of continence adviser and Occupational Therapist and be of sufficient size to allow procedures to take place easily but with sufficient privacy to preserve dignity and independence.

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

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

**Administration of Procedure**

At least 2 suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave. Training should be provided by the appropriate specialist nurse through the School Health Service.

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

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

Staff training should be updated by the appropriate specialist nurse at regular intervals.

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

USEFUL CONTACTS

North Derbyshire

School Health Service
School Health Department
Poplar Court
Chesterfield Royal Hospital
Calow
Chesterfield
Derbyshire S44 5BL
Tel: 01246 516102

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

South Derbyshire

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

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

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

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

7 Epilepsy - Treatment of Prolonged Seizures

Introduction
Epilepsy is a tendency to have recurrent seizures.

Most generalized convulsive seizures last for 2-3mins after which the child normally sleeps for a few hours. Status epilepticus is when a child has a continuous convulsive seizure which lasts longer than 5mins or two seizures together without recovery between. The reason we ask staff to administer rescue medication is that the longer the seizure goes on the more difficult it is to stop.

**Types of Treatment**

Regular anti-epileptic medication to help prevent seizures:
Usually twice, very occasionally three times a day e.g. sodium valproate, carbamazepine

First Aid Treatment (Rescue medication):
Rectal diazepam & buccal midazolam (Epistatus)
Written instruction

For each child who is likely to have prolonged seizures there must be an individual treatment plan signed by the most appropriate clinician i.e. epilepsy specialist nurse, paediatrician. This plan must state when an ambulance should be called. See Appendix 1

A qualified nurse should teach staff how to use the rescue medication and provide them with an information sheet. Staff should sign a form to confirm they have been trained in the use of buccal midazolam or rectal diazepam, see below. This training should be updated annually, it is the school's/agency's responsibility to contact the trainer to provide refresher teaching. **If rectal diazepam or buccal midazolam is given an ambulance must be called.**

**Labelling and Storage**

Rectal diazepam & buccal midazolam should be labelled for the individual child and stored in a secure cupboard or drawer to enable easy access for staff but out of sight of other children.

**Administration of Medicines**

This must only be carried out by trained and authorised persons in accordance with the instructions in the individual treatment plan and the training given.
Administration/Authorisation of Rectal Diazepam

Name .......................................................... DOB ........................

Address ..............................................................................................

Typical Seizure (when diazepam needs to be given)
..............................................................................................

When should rectal diazepam be administered
..............................................................................................

Dose ............

Further action
Consider the need to dial 999 and ask for an ambulance (in line with child's plan)
..............................................................................................

Name (of clinician completing the form)
..............................................................................................

Position ........................ Signature .............................. Date ............

Parents Signature ...........................................................................

For further information please contact:
Administration/Authorisation of Buccal Midazolam (Epistatus)

Name ........................................................................... DOB ............

Address ..................................................................................................................

..............................................................................................................................

**Typical Seizure** (when epistatus needs to be given)

..............................................................................................................................

..............................................................................................................................

**When should Epistatus be administered**

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..............................................................................................................................

**Dose** ........

**Further action**

Consider the need to dial 999 and ask for an ambulance (in line with child’s plan)

..............................................................................................................................

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**Name** (of clinician completing the form)

..............................................................................................................................

**Position** ............... **Signature** ................................................. **Date** ............

**Parent’s Signature** .................................................................

For further information please contact:
# Record of Epistatus/Rectal Diazepam Training

Name of child: 

<table>
<thead>
<tr>
<th>Date of training</th>
<th>Date of refresher training recommended</th>
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Name of staff:  
Signature:  

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<tr>
<th>Name of staff</th>
<th>Signature</th>
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Name & Title of Trainer:

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FORM OF INDEMNITY

Anaphylaxis

In consideration of staff at ..............................................................School/service agreeing to administer an injection to .......................................................... (name of child) in the event of the said ..............................................(child) suffering from an anaphylactic reaction whilst at ..............................................................School/service, or on associated activities, we, .......................................................... parent(s)/guardian(s) of the said ......................................................(child) hereby indemnify the Derbyshire County Council, its servants and employees against all proceedings, costs, liabilities and damages incurred as a result of any injury or damage caused to the said ......................................................(child) by the administration of an injection of adrenalin provided always that this indemnity shall not include injury resulting from or caused by or materially attributable to the negligence of the Derbyshire County Council, its servants or employees or the failure of the Derbyshire County Council to perform its common law or statutory duties and liabilities.

Dated this .............day of ........................................ 20...

Signed ..............................................................

Parent(s)/Guardian(s)
8 Action to be taken if a medicine administration error/near miss incident is identified

The aim of all medication-related guidance is to minimise the risk of an administration error occurring. An error in medication administration is defined as any deviation from the prescribed dose. Errors fall into three different categories (plus the temporary category of unresolved at the time):

(a) Major Error - is an incident which results in major harm or death, admission to hospital for 24 hrs or more or in the service user being rendered unconscious.
   - Major errors must be reported immediately to the Manager - Head Teacher, Head of Service, Service Manager or equivalent
   - The Manager will inform the then contact Health and Safety Section.
   - A written report must be completed within 24 hours
   - The Manager and Health and Safety Officer will then compile a report
   - Section immediately, followed by this form. A copy must also be filed at the home and a copy sent to the Planning and Project Manager at Headquarters

(b) Unresolved Error - is an incident the outcome of which for the service user is unknown at the time,

(c) Minor Error - is an incident which results in no significant harm to the service user

(d) Near Miss Incident - A near miss in medication administration is defined as an incident which might have resulted in an error if it had not been noted and rectified before the error occurred. There have been no consequences for the service user.

In addition to guidance elsewhere, all staff should:
- ensure the written prescription includes the dose, frequency of route of administration and avoids terms such as ‘as before’ or ‘as directed’.
- it should also include the maximum permissible daily dose
- seek clarification from the prescriber if there is any lack of clarity about the instructions on the prescription.

In all circumstances where there has been a failure to comply with written instructions, whether resulting in an over or under administration:
- advice as to what action should be taken should immediately be sought from the person who has prescribed the medication;
- if this person is not available, advice from another medical practitioner or pharmacist should be sought;
- where none of these are available, the local hospital accident and emergency department should be contacted;
- a full record of the incident and action taken is to be recorded and the following should be informed:
  - Child’s parents/carers
  - Health & Safety section at County Hall:  Trevor Thacker  01629 532050
  - Where the child is in care, the child’s social worker and Ian Henderson, Head of Service, Quality Assurance, Tel: 580000 Ext. 2022 to identify whether or not notification to OfSTED is required.

Finally:
- the incident should be discussed with the staff team to ensure that any lessons are learned and any changes to practice/procedure introduced to ensure there is no recurrence.
<table>
<thead>
<tr>
<th>1. Level of Error</th>
<th>✓</th>
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</thead>
<tbody>
<tr>
<td>(a) Major Error</td>
<td>(Incident resulting in major harm or death)</td>
</tr>
<tr>
<td>(b) Unresolved Error</td>
<td>(The outcome at present unknown)</td>
</tr>
<tr>
<td>(c) Minor Error</td>
<td>(No serious harm suffered)</td>
</tr>
<tr>
<td>(d) Near Miss</td>
<td>(Error was avoided)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Person completing this form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Job Title</td>
</tr>
<tr>
<td>Service name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Person in Charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Details of the medication error or near miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child/Young Person</td>
</tr>
<tr>
<td>Date and time error occurred</td>
</tr>
<tr>
<td>Date and time error discovered</td>
</tr>
<tr>
<td>Details of the error[1]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Health professionals involved with the child/young person</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
</tr>
<tr>
<td>Consultant</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>Pharmacist</td>
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<tr>
<th>5. All others staff/persons involved in the incident</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<td>Job Title</td>
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<tr>
<td>Name</td>
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<tr>
<td>Job Title</td>
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<tr>
<td>Name</td>
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<tr>
<td>Job Title</td>
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</tbody>
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<table>
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<tr>
<th>6. Who was contacted for advice?</th>
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</thead>
<tbody>
<tr>
<td>GP</td>
</tr>
<tr>
<td>Consultant</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>Pharmacist</td>
</tr>
<tr>
<td>Time of Contact</td>
</tr>
<tr>
<td>Advice received:</td>
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</tbody>
</table>

<table>
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<tr>
<th>7. Advice and Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Whom* Time</td>
</tr>
<tr>
<td>Advice given</td>
</tr>
</tbody>
</table>

\[1\] Please attach separate sheet with fuller report if necessary
\[2\] Name and contact details
### Action Taken

<table>
<thead>
<tr>
<th>By Whom</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice given</td>
<td></td>
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</tbody>
</table>

### Action Taken

<table>
<thead>
<tr>
<th>Action Taken</th>
</tr>
</thead>
</table>

### 8. Who has been informed about the incident

<table>
<thead>
<tr>
<th>Who has been informed about the incident</th>
<th>If no, give reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/young person</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Parent/Person with PR</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Other Carer</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Manager</td>
<td>Yes  No</td>
</tr>
<tr>
<td>H&amp;S Officer</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Head of Quality Assurance</td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td>Yes  If child/young person is in care</td>
</tr>
</tbody>
</table>

### 9. Type of incident

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong service user</td>
<td>✓</td>
</tr>
<tr>
<td>Wrong quantity given</td>
<td></td>
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<tr>
<td>Wrong strength of medicine administered</td>
<td></td>
</tr>
<tr>
<td>Wrong form of the medicine</td>
<td></td>
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<tr>
<td>Dose omitted</td>
<td></td>
</tr>
<tr>
<td>Wrong medicine given</td>
<td></td>
</tr>
<tr>
<td>Medicine out of date</td>
<td></td>
</tr>
<tr>
<td>Recording error</td>
<td></td>
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<tr>
<td>Medicine given at wrong time</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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<tr>
<td>10.</td>
<td><strong>Cause of incident</strong></td>
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<tr>
<td></td>
<td>Unclear labelling caused confusion</td>
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<td></td>
<td>Unclear instructions caused confusion</td>
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<tr>
<td></td>
<td>Wrong service user name</td>
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<tr>
<td></td>
<td>Product out of date</td>
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<tr>
<td></td>
<td>Interruptions</td>
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<td></td>
<td>Other cause</td>
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<tr>
<th>11.</th>
<th><strong>Immediate action to be taken</strong></th>
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<tbody>
<tr>
<td></td>
<td>Investigation by manager</td>
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<tr>
<td></td>
<td>Investigation by Health and Safety Officer</td>
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<tr>
<td></td>
<td>Investigation under complaints procedure</td>
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<tr>
<td></td>
<td>Investigation by external body</td>
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<table>
<thead>
<tr>
<th>12.</th>
<th><strong>Action to prevent a recurrence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Workplace procedures/systems review</td>
</tr>
<tr>
<td></td>
<td>Workplace training</td>
</tr>
<tr>
<td></td>
<td>Wider procedures/systems review</td>
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<tr>
<td></td>
<td>Wider training</td>
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<thead>
<tr>
<th>13.</th>
<th><strong>Additional Notifications – Major Incident Only</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Health &amp; Safety Officer</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Safety Executive</td>
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<tr>
<td></td>
<td>Senior Departmental Manager</td>
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<td>OFSTED</td>
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<td></td>
<td>CSCI</td>
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<tr>
<th>Name</th>
<th>Signed</th>
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<tr>
<th>Position</th>
<th>Date</th>
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</table>
9 Controlled Drugs

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. Some may be prescribed as medication for use by children, e.g. methylphenidate. Controlled drugs likely to be prescribed to children which may need to be administered in schools and other educational settings are, for example, methylphenidate and dexamfetamine for ADHD or possibly morphine/fentanyl for pain relief.

Any trained member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber’s instructions and these guidelines.

- A child who has been prescribed a controlled drug may legally have it in their possession to bring to school/setting. Once the controlled drug comes into a school or childcare setting it should be stored securely within a locked cabinet.

- Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access.
  - A record should be kept for audit and safety purposes.

- A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy).

- If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

- Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools and settings should have a policy in place for dealing with drug misuse.
10 Disposal of Medicines

All medicines should return home with the child at the end of the school day/short break or other service.

- In exceptional circumstances unused medicines will remain with staff or carers and will need to be disposed of.
- In order to provide a full audit trail of medicines, a record is required to identify the removal of a child’s medicines. This record should detail the following:
  - Date of disposal/return to pharmacy
  - Name and strength of medicine
  - Quantity removed
  - Service user for whom medication was prescribed or purchased
  - Signature of the member of staff who arranges disposal of the medicines

- This record is also necessary when medication is transferred to another service provider, for example from school to a foster home or short term break and vice versa.

- This procedure includes any transfer to an NHS hospital.
11 Clinical procedures which might be undertaken by non-health qualified staff

In supporting children with complex health needs in schools and other settings there are a number of clinical procedures which staff may be trained to undertake. In the main such training is undertaken by nursing staff, usually Children in Care nurse or school nurses or community children’s nurses who are employed by PCT’s or other NHS trusts.

The Royal College of Nursing has provided the following advisory list of procedures which may be safely taught and delegated to non-health qualified staff (agreed as of June 2005).

- Administering prescribed medicine in a pre-measured dose via nasogastric tube or gastrostomy tube.
- 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-loaded syringe.
- Intermittent catheterisation and catheter care.
- Care of a mitrofanoff.
- 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 or intra-nasal 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.3

- Re-insertion of nasogastric tube.
- Re-insertion of gastrostomy tube.
- Injections involving: assembling syringe, administering intravenously or controlled drugs.
- Programming of syringe drivers.
- Filling of oxygen cylinders.

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 required. However, it is absolutely imperative that any delegation of clinical tasks to non-health qualified staff is undertaken within a robust governance framework an integral part of which will be the arrangement for:

- Initial training and preparation of staff
- Assessment and confirmation of competence of staff
- Confirmation 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 around complex health needs.
- Training around a specific child and the procedures or care that child will require.

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3 This should be followed in most circumstances – however, where non-health qualified staff or carers are willing to receive training, their competence has been evidenced and there is adequate back-up from health professionals, an exception to this guidance may be made and recorded by the health professional in the child’s health care plan.
SAFE HANDLING & STORAGE OF MEDICAL GAS CYLINDERS

General guidance
1. All personnel handling gas cylinders and responsible for pipeline gas supplies should have received training and be competent in relation to the properties of the gas, precautions to be taken, actions in the event of an emergency and the correct operating procedures for their installations.
2. If you own your cylinders you must be aware of, and discharge your statutory obligations with regard to maintenance and testing.
3. You should ensure that when cylinders are collected the driver has been properly instructed in the method of handling cylinders and in dealing with any emergency.

Storage of cylinders
1. Cylinders should be stored under cover, preferably inside, kept dry and clean and not subjected to extremes of heat or cold.
2. Cylinders should not be stored near stocks of combustible materials or near sources of heat.
3. Warning notices prohibiting smoking and naked lights must be posted clearly.
4. Medical cylinders containing different gases should be segregated within the store.
5. Full and empty cylinders should be stored separately. Full cylinders should be used in strict rotation.
6. Medical cylinders should be stored separately from industrial and other non-medical cylinders.
7. Medical cylinders should be stored separately from industrial and other non-medical cylinders.
8. Cylinders must not be repainted, have any markings obscured or labels removed.
9. F size cylinders and larger should be stored vertically, E size cylinders and smaller should be stored horizontally.
10. Precautions should be taken to protect cylinders from theft.

Preparation for use
1. Cylinder valves should be opened momentarily prior to use to blow any grit or foreign matter out of the outlet.
2. Ensure that the connecting face on the yoke, manifold or regulator is clean and the sealing washer or ‘O’ ring where fitted is in good condition.
3. Cylinder valves must be opened slowly.
4. Only the appropriate regulator should be used for the particular gas concerned.
5. Pipelines for medical gases should be installed in accordance with the conditions set out in HTM 2022.
6. Cylinder valves and any associated equipment must never be lubricated and must be kept free from oil and grease.

Leaks
1. Should leaks occur this will usually be evident by a hissing noise.
2.Leaks can be found by brushing the suspected area with an approved leak test solution such as 1% *Teepol HB7 solution.
3. The gland packing around the valve spindle may become loose and can be cured by tightening the gland nut clockwise. Do not over tighten.
4. Sealing or jointing compounds must never be used to cure a leak.
5. Never use excessive force when connecting equipment to cylinders.

**Use of cylinders**
1. Cylinders should be handled with care and not knocked violently or allowed to fall.
2. Cylinders should only be moved with the appropriate size and type of trolley.
3. When in use cylinders should be firmly secured to a suitable cylinder support.
4. Cylinders containing liquefiable gas must always be used vertically with the valve uppermost.
5. Medical gases must only be used for medicinal purposes.
6. Smoking and naked lights must not be allowed within the vicinity of cylinders or pipeline outlets.
7. After use cylinder valves should be closed using moderate force only and the pressure in the regulator or tailpipe released.
8. When empty the cylinder valve must be closed.
9. Ensure the plastic valve cap is refitted to bullnose valves/outlets.
10. Immediately return empty cylinders to the empty cylinder store for return to BOC.

*Further information concerning specific problems arising from the storage and handling of gases, hazards and first aid treatment can be obtained from BOC.*

**General references**

‘Gas Safe - with Medical Gases,
‘Safe Under Pressure’ BOC Limited,
The Road Traffic (Carriage of Dangerous Substances in Packages etc) Regulations 1986, SI.1986, No 1951 and supporting Code of Practice
*Teepol is a registered trade mark of Shell International Petroleum Company Limited

### 13 NON-PRESCRIBED MEDICINES/MEDICINAL PRODUCTS

**General guidance**

“Over the counter” medicines and other products can be useful for dealing with minor self-limiting ailments, which would not normally require consultation with a doctor. They are used to help treat the symptoms of a minor ailment such as cough, cold or diarrhoea. They do not offer a cure and are not essential for good health. Therefore, it is not compulsory that a child’s carers should keep household remedies.

*They are not, however, a substitute for qualified medical attention, especially if:*
- The child has other health conditions e.g.: asthma, diabetes, epilepsy or receives anti-coagulant (Warfarin) medication

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4 This guidance is written mainly with children’s homes, foster carers and boarding schools in mind where children are cared for overnight and where medical or nursing advice may is not available and the need for such products is most likely to arise.
• The symptoms do not respond to the recommended treatment following a maximum period of 3 days

_SStaff/carers should always check the child’s medication record to confirm that they have no known allergy to any medicine - further information or advice can be obtained from local Pharmacists._

The medicines in this guide have been carefully selected on the basis that they are readily available from pharmacies. They have also been chosen on the basis that such products are commonly used in ordinary family homes. The safety record of the medicines is known to be good and there is evidence that the products help to treat the symptoms of minor ailments.

**Please remember that no medicine can be said to be wholly without side-effects.**

• Always read the information leaflet before administering the medicine.
• Children below 6 years of age should _not_ be treated with over the counter remedies
• Children aged between 6 and 11 years should take ‘paediatric’ doses.
• Children aged 12 and over may take adult doses.
• If in doubt check with a pharmacist or doctor.
• Take care to use the medicines according to the dose range stated and for _no longer than 3 days._

**Advice for children with diabetes**

Child with diabetes have special dietary needs and particular care must be taken to ensure that minor ailments and household remedies do not upset blood sugar control.

• Where appropriate, separate guidance is offered and shown _in italic text._
• Where there are practical points of relevance to the treatment of minor ailments or the use of household remedies, these are shown as separate bullet points.

**Storage**

• All remedies must be stored in a lockable medicine cabinet but separate from prescribed medicines
• All dosages should be recorded in line with the service’s established practice
• The provision of all medication at each establishment should be checked at least once per year and more frequently if problems are identified.
• Remedies should remain in the original containers and be accompanied by any leaflets or information supplied.
• “Use by” dates should be monitored and observed.
• They should not be thought of as ‘first-aid’.

**Bites and Stings**

Bites and stings are best treated with calamine preparations such as calamine cream or lotion. A painkilling spray, such as Wasp-Eze may be useful, especially on outings when away from home and when away from medical backup.

• Children who are known to be allergic to wasp or bee stings should make sure that they keep emergency treatment with them at all times when exposure to bee or wasp sting is possible.

**Burns and Scalds**

Apply first aid treatment only.

• Bathe or immerse in cold running water (e.g. running cold tap) for a minimum of 10 minutes.
• Do not apply creams or ointments.
• Seek medical advice if severe.
• If medical assistance is required, try wrapping the burn lightly with a damp dressing to keep it cool whilst travelling.

**Constipation**

Most children do not really need regular doses of any laxative, so the taking of laxatives on a regular basis, unless prescribed by a doctor for medical reasons, should be discouraged. Constipation may be corrected by increasing the amount of fluid and fibre taken every day. One of the easiest ways of achieving this is to include fresh fruit in the daily diet.

**Diarrhoea**

The symptom of diarrhoea is usually self-limiting and the condition generally resolves itself within a few days. The most important treatment is to give plenty of fluids to prevent dehydration. If diarrhoea persists for more than three days, further investigation is required by a doctor. Doctors may be reluctant to prescribe antibiotics for diarrhoea for fear of antibiotic resistance.

- Inappropriate use of antibiotics can cause resistance of bugs to antibiotic treatment.
- Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.

**Diabetics should:**

- also take plenty of fluids and seek advice from the doctor because diarrhoea might upset control of blood sugar levels.
- continue with insulin or oral anti-diabetic medicines and increase the frequency of blood or urine glucose monitoring.
- seek further advice if necessary

**Seek assistance from a doctor if symptoms persist**

**Cough**

This is usually a symptom of infection in the upper breathing tubes (respiratory tract) and the chest which is often minor and self-limiting. Bacteria and viruses are often responsible but the body usually successfully fights such infections without the need for antibiotics or cough medicines. Cough medicines are not particularly effective at preventing coughs and, in any case, coughing is the body’s way of helping to clear the chest.

- Doctors may be reluctant to prescribe antibiotics for a chesty cough for fear of antibiotic resistance.
- Inappropriate use of antibiotics can cause resistance of the bugs to antibiotic treatment
- Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.

If a cough is very persistent and is causing distress, then a simple linctus paediatric may be soothing and helpful.

- Dosage: One or two x 5ml spoonfuls up to three times daily and once at night.

**Diabetics should use a sugar-free product**

**Seek assistance from a doctor if symptoms persist**

**Eye Care**

Eye lotions are often sought after but are not recommended.

- Tiredness is best cured by sleep.
- If dirt or chemical substance gets in the eye, bathe the eye with plenty of tepid water.
- If the eye is red, itchy or feels gritty it is likely to have been caused by an infection.
- Consult a doctor if these symptoms persist.
Foot Care
Athlete's foot is common but also frequently mis-diagnosed. Medicated anti-fungal creams could cause dermatitis.
- Wash and dry the skin.
- Use a non-medicated cream such as zinc and castor oil or E45 cream.
- Talcum powder may be applied to the socks (not to the foot itself) to keep skin dry.
- If the condition persists, seek medical advice.

Diabetics should always seek medical attention.

Pain (such as Headache or Period Pain)
There are numerous pain remedies available from general stores and pharmacies. Most contain either aspirin or paracetamol or a combination of the two. Many branded products are more costly but greater effectiveness has not been proven.
- Aspirin is **not** recommended because of the greater possibility that it might interact with other medicines.
- Paracetamol is a good painkiller and has a better safety record compared with aspirin (at recommended doses) and is, therefore, the medicine of choice.
- The non-brand name versions of paracetamol are available from pharmacies and are inexpensive.

As with any other medication, paracetamol must be stored in a locked cabinet and staff need to be aware of its potential to cause serious harm.
- Special vigilance is required at the time of giving out medicines to children - for example, it will be necessary to guard against the possibility that a child might snatch medicines out of the hand.

Dosage:
- Children aged over 6 years of age may take paracetamol suspension (one to two 5ml spoonfuls every six hours).
- Do not exceed four doses in 24 hours.

Any persistent pain, painful movement or pain which is not controlled with paracetamol requires investigation by a doctor.

Skin
Cleansing the skin should be done by washing in soap and water. Sometimes soreness can be prevented by keeping surface of the skin (e.g. of the breast) dry. The use of talc and tissue can help prevent soreness caused when skin surfaces touch.

The following creams and ointments are of value in the treatment of sore skin.
- Aqueous cream - a useful moisturiser for dry skin.
- CreamE45 - a non-greasy softening and soothing, unperfumed cream useful for dry or chapped skin.
- Drapolene - good for urinary rash.
- Sudocrem - contains lanolin (so beware of allergy). Useful for minor skin sores.
- Zinc and castor oil - an old favourite in the treatment of urinary rash and for pressure sores.
- Vaseline (White soft paraffin) - an invaluable barrier ointment for soothing and softening and also useful for chapped lips

Sore Throat
Sore throat often occurs with the common cold and is typically caused by both bacterial and viral infections. It is usually self-limiting and not worth treating.

In severe cases, sucking a soothing non-medicated lozenge as required such as glycerine, lemon and honey (any brand) may help.
The inappropriate use of antibiotics can cause resistance of the bugs to antibiotic treatment.
Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.
Doctors may be reluctant to prescribe antibiotics for the above reasons.
14 FIRST AID

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

First Aid Equipment

First aid boxes must be identified by a white cross on a green background and should be easily accessible and contain appropriate first aid material. When the contents are used, the box should be refilled as soon as possible with sufficient stocks of each item required. A member of staff, usually the First Aider or appointed person, should be designated to periodically check the contents of the first aid box and replace any missing contents. This check should be recorded.

There is no standard list of items to put in a first-aid box. It depends on what services assess their needs to be. However, as a guide, and where there is no special risk in the workplace, a minimum stock of items would be:

- Guidance card giving general advice on first aid e.g. HSE leaflet ‘Basic advice on first aid at work’
- 20 Plasters – assorted sizes – individually wrapped and sterile
- 2 sterile eye pads
- 4 individually wrapped triangular bandages
- 6 safety pins
- 6 medium wound dressings (sterile)
- 2 large wound dressings (sterile)
- 2 extra large wound dressings (sterile)
- Disposable gloves and aprons
- Moist cleaning wipes – not alcohol based (individually wrapped and sterile)
- Additional items, e.g. blankets where they are required should be stored nearby.

Where mains tap water is not readily available for eye irrigation, at least one litre of sterile water or sterile saline (0.9%) solution in sealed, disposable containers should be provided. These need to be checked regularly to ensure they are not used after the expiry date.

Travel Kits

Where provided these should contain:

- A leaflet giving general guidance on first aid
- 6 Individually wrapped sterile adhesive dressings (plasters)
- 1 large sterile un-medicated dressing – approximately 18cm x 18cm
- 2 triangular bandages
- 2 safety pins
- Individual wrapped moist cleansing wipes
- 1 pair of disposable gloves

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5 This guidance it to be read in conjunction with the agency/service’s Health & Safety at Work procedures
Appendix 1

Useful Forms
**Form 1 – Individual Health Care Plan**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School/Setting</td>
<td></td>
</tr>
<tr>
<td>Childs name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>Day / Month / Year</td>
</tr>
<tr>
<td>Group/Class/Form</td>
<td></td>
</tr>
<tr>
<td>Childs Address</td>
<td></td>
</tr>
<tr>
<td>Medical diagnosis or condition</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
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<tr>
<td>Review Date</td>
<td></td>
</tr>
</tbody>
</table>

**Family Contact Information – First Contact**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Phone Number (work)</td>
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<tr>
<td>(home)</td>
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<tr>
<td>(mobile)</td>
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</tbody>
</table>

**Family Contact Information – Second Contact**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
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<tr>
<td>Phone Number (work)</td>
<td></td>
</tr>
<tr>
<td>(home)</td>
<td></td>
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<tr>
<td>(mobile)</td>
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</tbody>
</table>
**Clinic/Hospital Contact**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner (G.P.)</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

Describe medical needs and give details of child's symptoms

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

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

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

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff volunteer to do this.

**Note: Medicines must be in the original container as dispensed by the pharmacy**

<table>
<thead>
<tr>
<th>Name of School/Setting</th>
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<tbody>
<tr>
<td>Date</td>
<td>Day / Month / Year</td>
</tr>
<tr>
<td>Childs name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>Day / Month / Year</td>
</tr>
<tr>
<td>Group/Class/Form</td>
<td></td>
</tr>
<tr>
<td>Medical condition or illness</td>
<td></td>
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</tbody>
</table>

**Medicine**

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

**Contact Details – First Contact**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
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<tbody>
<tr>
<td>Daytime telephone number</td>
<td></td>
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<tr>
<td>Mobile telephone number</td>
<td></td>
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<tr>
<td>Relationship to child</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
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</table>

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

**Contact Details – Second Contact**

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Daytime telephone number</td>
<td></td>
</tr>
<tr>
<td>Mobile telephone number</td>
<td></td>
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<tr>
<td>Relationship to child</td>
<td></td>
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<tr>
<td>Address</td>
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</tbody>
</table>

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

Name and phone number of G.P.

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

I accept that this is a service that the School/Setting is not obliged to undertake.

I understand that I must notify the School/Setting of any changes in writing

Date  __________________________  Signature  __________________________

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

For School/Setting Use

<table>
<thead>
<tr>
<th>Reviewed by</th>
<th>Date</th>
<th>Signature</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
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To be reviewed annually or if dose changes
Form 3 - Head teacher/Head of Setting Agreement to Administer Medicine

Name of School/Setting

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

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

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

Date __________________

Signed _______________________________
(The Head teacher/Head of Setting/named member of staff)
# Form 4 - Record of medicine administered to an individual child

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Name of School/Setting</td>
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<tr>
<td>Child's name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>Day / Month / Year</td>
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<tr>
<td>Group/Class/Form</td>
<td></td>
</tr>
<tr>
<td>Date medicine provided by parent</td>
<td></td>
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<tr>
<td>Quantity received</td>
<td></td>
</tr>
<tr>
<td>Name and strength of medicine</td>
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<tr>
<td>Expiry date</td>
<td>Day / Month / Year</td>
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<tr>
<td>Quantity returned</td>
<td></td>
</tr>
<tr>
<td>Dose and frequency of medicine</td>
<td></td>
</tr>
<tr>
<td>Staff signature</td>
<td></td>
</tr>
<tr>
<td>Signature of parent</td>
<td></td>
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<tr>
<td>Date</td>
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<tr>
<td>Time given</td>
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<tr>
<td>Dose given</td>
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<tr>
<td>Name of member of staff</td>
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<td>Staff initials</td>
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<td>Time given</td>
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<td>Time given</td>
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<tr>
<td>Time given</td>
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</tbody>
</table>
# Form 5 - Record of Medicines Administered to all Children

(This form is optional if form 4 is used)

<table>
<thead>
<tr>
<th>Name of School/Setting</th>
<th>Date</th>
<th>Childs name</th>
<th>Time</th>
<th>Name of medicine</th>
<th>Dose given</th>
<th>Any reaction</th>
<th>Signature of staff</th>
<th>Print Name</th>
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**Form 6 - Request for child to carry his/her own medicine**

This form must be completed by parents/guardian/pupil over 16 (delete as appropriate)

**If staff have any concerns discuss this request with healthcare professionals**

<table>
<thead>
<tr>
<th>Name of School/Setting</th>
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<tbody>
<tr>
<td>Childs name</td>
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<tr>
<td>Date of birth</td>
<td>Day / Month / Year</td>
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<tr>
<td>Group/Class/Form</td>
<td></td>
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<tr>
<td>Address</td>
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<tr>
<td>Name of medicines</td>
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<tr>
<td>Procedures to be taken in an emergency</td>
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**Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Daytime phone number</td>
<td></td>
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<tr>
<td>Mobile Number</td>
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<tr>
<td>Relationship to child</td>
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</table>

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

Signed  
______________________________________________________

Date  
______________________________________________________

If more than one medicine is to be given a separate form should be completed for each one.
Form 7 - Staff training record – Administration of Medicines

<table>
<thead>
<tr>
<th>Name of School/Setting</th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Types of training received</td>
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<td>Date of training completed</td>
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<tr>
<td>Training provided by</td>
<td></td>
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<tr>
<td>Profession and title</td>
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</table>

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

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

Trainers signature ______________________________

Date ______________________________

I confirm that I have received the training detailed above.

Staff signature ______________________________

Date ______________________________

Suggested review date ______________________________
ADMINISTRATION OF MEDICINES IN SCHOOLS/SETTING FLOWCHART

This flow chart should be used in conjunction with the accompanying text in the guidance document which gives more information on each section.

PRESCRIBED MEDICINES
Medical practitioner to prescribe where possible medication to be given out of school hours.

DECLARATION
The Headteacher to ensure that all medication is checked and no medication to be allowed unless accompanied by a completed parental consent form.

STORAGE
The Headteacher to ensure that suitable storage facilities are provided by the school where necessary, ie, where pupil is not keeping and administering his/her own medicine or where special pharmaceutical conditions need to be met for storage of the medicines.

SELF ADMINISTRATION
Many pupils will have the ability to self administer their own medication. This will principally be most secondary school age pupils and may include some primary age pupils, although this will depend more on the child’s capability than age. If a child is to keep and administer their own medication, be it prescription or non-prescription, then the school must be alerted to this fact on the parental consent form. With the exception of Asthma inhalers, the child should not bring in any more than one day’s requirement in an original labelled container.

SUPERVISION
The Headteacher must ensure that where staff supervise pupils administering their own medication, the following conditions must be met.

a) There is/are available staff who have volunteered to undertake this duty and have received the necessary training.
b) An appropriate medicine record form (Appendix 2) is available and used.
c) The medication is properly labelled and accompanied by a parental consent form.
d) An individual treatment plan is available where appropriate and this and any other specific conditions (eg storage) are met.

ADMINISTRATION
Where staff actually administer the medication to pupils.
This should occur only if a pupil is unable to self administer the medication and conditions a), b), c) and d) in the supervision section are met.

SCHOOL MEDICINE RECORD FORM (APPENDIX 2)
Must be filled in after each administration/supervision.