

ATLP Supporting Pupils with Medical Conditions Policy

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COVID-19 Update

The ATLP is reviewing this policy during a pandemic which has seen schools closed to the majority of pupils for long periods of time. The Trust recognise that students with a medical condition may be more vulnerable to infection from the virus.

Staff will be mindful of this and follow strict social distancing and personal protection guidelines when administering or observing a child administer medicine. This is particularly important to keep all ATLP staff and students safe. Where staff are unclear about such procedures, they will consult a health professional.



Statement of Intent

The Arthur Terry Learning Partnership (ATLP) will ensure that pupils with health care needs are cared for and receive appropriate support at school as in line with the latest edition of DFE Supporting Pupils at School with Medical Conditions and the latest editions of The Administration of Medicines in Schools and Settings and any Supplementary Guidance issued by Birmingham City Council, Staffordshire and Warwickshire County Councils.

Pupils with medical needs will be properly supported physically and emotionally so that they have full access to education, including school trips and physical education wherever possible and appropriate

Schools within the ATLP will establish relationships with relevant health services to help them support pupils with complex and long-term medical conditions which require ongoing support, medicines or care.

Some pupils with medical needs may have disabilities and in this case the school will need to ensure it complies with its duties under the Equality Act. For children with special needs or a disability this policy should be read and understood in conjunction with the latest edition of SEN Code of Practice and the Equality Act and Section 100 of The Children and Families Act. This act places a duty on the ATLP to make arrangements for supporting pupils at their schools with medical conditions and ensure that they are not discriminated against.

The intention of this policy is to inform the Trust's practice and ensure that all children with medical conditions within ATLP schools are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential.

Safeguarding

ATLP will ensure that policies, plans, procedures and systems are properly and effectively implemented to align with its wider safeguarding duties.

Key roles and responsibilities

- 1.1. The Trust Board has overall responsibility for ensuring the implementation of this policy.
- 1.2. The Trust Board will ensure that headteachers have arrangements in place to support pupils with medical needs whilst ensuring that such children can access and enjoy the same opportunities at school as any other child, this must be reflected in local procedures.
- 1.3. The Trust Board has overall responsibility for ensuring that this policy as written, does not discriminate on any grounds, including but not limited to: ethnicity/origin, culture, religion, gender, disability or sexual orientation.
- 1.4. The Trust Board will ensure that the procedures agreed are implemented by headteachers and give parents and pupils confidence in the school's ability to provide effective school support for medical needs in school.
- 1.5. The Trust Board has responsibility for ensuring that headteachers have designated staff that are properly trained to provide the emotional support that pupils need.
- 1.6. Headteachers are responsible for authorising staff to administer medication and as such should sign each Individual Health Care Plan / or Administration Form. If the headteacher is absent, forms can be signed by the member of staff nominated by the headteacher to undertake such responsibilities in their absence and then countersigned by the headteacher on their return.
- 1.7. Headteachers will ensure that arrangements are in place to review support for pupils by appropriate and relevant staff and in consultation with parents and pupils annually as a minimum or earlier if evidence is presented that the child's needs have changed.

Individual Healthcare Plans (IHCP) known as Care Plans can help ensure that pupils are effectively supported in school. However, not all children require one. The school, healthcare professionals and parent should agree based on evidence when a healthcare plan would be appropriate. Individual Health Care Plans will often be essential in such cases where conditions are long term and complex, fluctuate or where there is high risk that emergency intervention will be needed. Where a child has Special Educational Needs (SEN) but does not have a Statement or Education, Health and Care Plan (EHCP), their special educational needs should be mentioned in their Individual Health Care Plan. Where the child has a special educational need identified in a Statement or EHCP, the Individual Health Care Plan should be linked to or become part of that Statement or EHCP (See Appendix 3 for IHCP).

- 1.8. Headteachers have responsibility for ensuring complaints are handled appropriately and in conjunction with the ATLP Complaints Policy.
- 1.9. The Trust Board has responsibility for ensuring the correct level of insurance is in place for the administration of medication by designated staff and for those staff who watch children self-administer.

- 1.10. Headteachers will be responsible for ensuring the day-to-day implementation and management of the Supporting Pupils with Medical Needs Policy and that local procedures are followed.
- 1.11. Headteachers will ensure that sufficient staff are suitably trained so that they have confidence in their ability to support pupils, for example Epi pen, Asthma training, and first aid training. Additional guidance will be sought on a case by case basis from a health professional.
- 1.12. Headteachers will ensure that all relevant staff will be aware of a child's medical needs by ensuring a care plan, management and/or Individual Healthcare Plan is in place and that this is shared with relevant staff who need to know and are aware of a child's condition and needs.
- 1.13. Headteachers will ensure that information is available to key staff to support transitional arrangements throughout key stages and reintegration when pupils have been absent long term by meeting with key stakeholders to ensure that an Individual Healthcare Plan is in place.
- 1.14. The headteacher will ensure relevant information is made available to **cover teachers** and **where necessary in the form of written documentation including details of designated staff and information about pupils with medical needs.**
- 1.15. Headteachers are responsible for making staff aware of this policy, including teachers, support staff and volunteers, who must ensure that it will be applied fairly and consistently.
- 1.16. Parents and carers will be expected to keep the school informed about any changes to their child/children's health.
- 1.17. Parents and carers will be expected to complete a [medication administration form](#) (appendix 4). prior to bringing medication into school and where appropriate an IHCP (appendix 3).
- 1.18. Parents and carers will be expected to discuss medications with key staff and their child/children prior to requesting that a staff member administers the medication or observes a child self-administer.
- 1.19. Parents and carers are expected to supply any required medication, equipment or resources and to ensure that this is in date and replaced as and when appropriate.

2. Definitions

- 2.1. The ATLP defines "medication" as any drug or device prescribed by a doctor.
- 2.2. ATLP defines a designated member of staff as a member of staff who has been identified by the headteacher to administer medication.

- 2.3. ATLP defines key stakeholders as any other member of staff who may need to support the pupil(s) and ensure compliance and implementation of the IHCP, including healthcare providers, parents, and pupil.

3. Training of staff

- 3.1. Designated staff will agree to and receive any training required to ensure compliance with this policy.
- 3.2. Designated staff will receive ongoing training where necessary and as part of their development.
- 3.3. The policy will be shared widely to staff to promote whole school awareness.

4. Guidelines

- 4.1. Prior to designated staff administering any medication, the parents / carers of the child must complete and sign a medication administration form agreeing that the medication can be administered by staff or self-administered by pupils as in line with an individual IHCP or plan agreed with parents and the child. The capacity of the child to self-administer should be considered very carefully by all stakeholders. If considered appropriate the child may also be offered the option of self-administering but with a designated member of staff observing. Any key instructions as how to best support the child to do this should be relayed to the observing member of staff by the parent or health care professional where appropriate. The headteacher should also sign these agreements. If the headteacher is absent, the form will be signed by the member of staff nominated by the headteacher to undertake such responsibilities in their absence and then countersigned by the headteacher on their return.
- 4.2. ATLP schools will ensure there is a process in school to comply with all aspects of this policy. The policy should provide liability cover relating to the administration of medication and healthcare procedures.
- 4.3. No child will be given prescribed medicines without written parental consent via the Medical Administration Form
- 4.4. Schools should only accept and administer prescribed medicines if these are in date, labelled, provided in the original container as dispensed by the pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin, which must still be in date, but will generally be available to schools inside an insulin pen or a pump, rather than in its original container
- 4.5. Medicines which do not meet these criteria will not be administered.
- 4.6. A maximum of four weeks' supply of the medication may be provided to the school.
- 4.7. Medications will only be administered at school if it would be detrimental to the child not to do so and only in agreement with parents who may otherwise be required to attend school

to administer the medication, all of which must be recorded in the child's IHCP. On occasions and as stated in the IHCP, it may be appropriate for parents to come into school to administer medication.

- 4.8. Medications will be stored securely in the designated secure area.
- 4.9. Over the counter medicines will never be issued to pupils unless parental consent has been given through the completion of the Medical Administration Form (Appendix 3). Medicines should be clearly labelled, in date, in the original container and should give instructions for administration, dosage and storage.
- 4.10. Minor change to the Care Plan can be made by the school nurse who will sign and date the plan, but major change will normally mean that a new plan is required. The plan should be reviewed at least annually. However, it is the parents' responsibility to notify school of any change required to the plan. In an emergency staff, may contact an adult with parental responsibility for verbal consent.
- 4.11. A child under 16 should never be given medicine containing aspirin unless prescribed by a doctor. Medication, e.g. for pain relief, should never be administered without first checking maximum dosages and when the previous dose was taken. Parents should be informed.
- 4.12. Staff must not undertake any health care procedures without appropriate training. A first aid certificate does not constitute appropriate training in supporting children with medical conditions. Healthcare professionals will provide confirmation of the proficiency of staff in a medical procedure or in providing medication and instructions must be clearly recorded in the IHCP and agreed by designated staff and stakeholders including parents and pupil.
- 4.13. Any medications left over at the end of the course will be returned to the child's parent/carer.
- 4.14. Written records will be kept of any medication administered to children by the designated member of staff or when a designated member of staff has observed a child self-administer
- 4.15. Storage of pupil's medication will remain secure. However, pupils will never be prevented from accessing their medication if required and will be under supervision of designated staff if required and in accordance with the IHCP.
- 4.16. Pupils will be informed regarding emergency procedures and this will be included in the IHCP.
- 4.17. Parents/carers are encouraged to ask doctors to prescribe medication which can be administered outside school wherever possible and where appropriate. Pupils will be encouraged to take their own medication under the supervision of a member of staff and this will be recorded in the IHCP and in school's written records where required.
- 4.18. The ATLP cannot be held responsible for side effects which occur when medication is taken correctly but details of side effects will be included in the IHCP.

- 4.19. Staff will ensure confidentiality is maintained at all times and only relevant staff will be made party to the information required to ensure the safety and wellbeing is maintained.
- 4.20. Any member of staff may be asked to provide support for a pupil with medical needs but cannot be required to do so.
- 4.21. Although administration of medicine is not part of a teacher's main professional duties, they will take into account the needs of pupils with medical conditions that they teach.
- 4.22. School staff will receive sufficient suitable training to support these children.
- 4.23. All staff will know what to do and how to respond when a child with medical conditions needs help.
- 4.24. School will review their provision on an annual basis using the Key Questions in Appendix 10. An appropriate action plan shall be drawn up to address any concerns.

5. Unacceptable practice

Policy and Practice should be clear that it is unacceptable that:

- 5.1 Children don't have access to medication when and where necessary.
- 5.2 The assumption is made that all children with the same condition are the same.
- 5.3 The views of the child, parent or health professional are ignored.
- 5.4 Children are sent home when experiencing symptoms of their condition unless specified in their care plan.
- 5.5 Children are sent to the office/medical room unaccompanied when ill.
- 5.6 Attendance is penalised for absences related to appointments.
- 5.7 Parents are required, or made to feel obliged, to attend school to administer medication or address toileting issues unless stated in the child's Individual Healthcare Plan.
- 5.8 Personal and special student data is shared inappropriately and not in line with the current GDPR regulations.

Trips and visits.

- 6.1. The statutory guidance is very clear that children with medical conditions should be able to participate fully in school trips, off site visits, sporting activities and residential, just like any other child.
- 6.2 Schools are required to make reasonable adjustments to allow for the inclusion of pupils unless advised against by a health professional.

- 6.3 Full risk assessments will be undertaken in consultation with parents/carers, health provider and the child.
- 6.4 The Educational Visits Coordinator (EVC) should ensure that leader of trips and visits are fully aware of the policy and in particular any participant with additional needs.

APPENDICES



Appendices

- 1. List of named designated staff**
- 2. Proforma to record named, designated staff**
- 3. IHCP**
- 4. Medication Administration Form**
- 5. Good Practice Plans for Asthma**
- 6. Good practice plans for the administration of auto adrenal injections**
- 7. Good practice points for managing diabetes**
- 8. Good practice points for managing Eczema**
- 9. Good practice points for managing Epilepsy**
- 10. School Review Plan**

Appendix 1

In each ATLP school or setting the headteacher should identify and be named in the policy as well as staff responsible as listed below.

- The member of staff who has responsibility for the policy including update.
- The member of staff who has responsibility for ensuring that all staff are informed of the policy and the pupils for whom it is relevant.
- The member of staff responsible for ensuring cover/supply staff are informed.
- The member of staff responsible for maintaining and providing appropriate staff training including whole school awareness training.
- The member of staff responsible for monitoring Individual Health Care Plans.
- The member of staff responsible for ensuring that staff leading school trips/visits are fully converse with this policy.

Appendix 2

Name of School		Head teacher	
Role		Name of Designated Person	
The member of staff who has responsibility for the policy including update			
The member of staff who has responsibility for ensuring that all staff are informed of the policy and the pupils for whom it is relevant			
The member of staff responsible for ensuring cover/supply staff are informed			
The member of staff responsible for maintaining and providing appropriate staff training including whole school awareness training			
The member of staff responsible for monitoring Individual Health Care Plans			
The member of staff responsible for ensuring that staff leading school trips/visits are fully converse with this policy.			
Named designated staff who are authorised by the headteacher to administer medication			

Appendix 3

Individual Health Care Plan Template

<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> Add Photo </div>	<h2 style="margin: 0;">ATLP</h2> <h1 style="margin: 0;">Individual Health Care Plan</h1>
Pupil name:	
Address:	
Date of Birth:	
Class teacher/tutor:	Yr
TGrp	
HOS	PL
Tutor	
Medical Condition:	
Date plan drawn up:	
Review date:	
CONTACT INFORMATION <div style="display: flex; justify-content: space-between;"> <div> Family Contact 1 Phone No: </div> <div> Name: Home: Mobile: Work: Relationship: </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div> Family Contact 2 Phone No: </div> <div> Name: Home: Mobile: Work: Relationship: </div> </div>	
GP Name: Address: Phone No:	
Clinic/Hospital Contact Name: Phone No:	
Describe medical condition, its triggers, signs, symptoms and treatments:	
Resulting needs and daily care requirements and treatments including medication (dose, side effects and storage) (e.g. before sport/at lunchtime). Additional treatments, facilities,	

equipment, access to food and drink where this is used to manage the condition, dietary requirements and environmental issues such as crowded corridors, access to facilities	
Additional information on level of support: i.e. can the student administer their own medicine are they self-managing Describe what constitutes an emergency for the pupil, and the action to be taken if this occurs:	
Follow up care, including social and emotional needs/how absences will be managed, access arrangements counselling etc.	
Who is responsible in an emergency (State if different on off-site activities):	
The following staff must be notified: Please indicate	
Name	Position Head/ Deputy/Assistant Headteacher Phase Leader/ Progress Leader Class Teacher/Tutor Reception staff Office Manager SENCO Medical Admin Assistant Attendance Officer Teaching Staff First Aiders Staff Briefing Lunchtime Supervisors Any others
Signed	Date
Parent/carer	
Pupil (where appropriate) Headteacher In absence of HT, form to be signed by the member of staff nominated by HT & countersigned by the HT on their return.	

Appendix 4

Parental agreement for school to administer medicine

The ATLP School Medication Administration Form	
<p>The NAME OF SCHOOL will not give your child medicine unless you complete and sign this form. Any medication that has been prescribed by a GP, should be within the expiry date & include original packaging with dispensing & dosage label. Over the counter medicines must also be in date, in the original packaging and have dispensing, dosage and storage details. No medication will be administered without the completion of this form.</p>	
Name of Child:	
Date of Birth:	
Group/Class/Form:	
Medical condition/illness:	
Medicine/s:	
Name/Type of Medicine (as described on the container):	
Date dispensed:	Expiry date:
Agreed review date to be initiated by [name of member of staff]:	
Dosage, method and timing:	
Special Precautions:	
Are there any side effects that the school/setting needs to know about?	
Self-Administration: Yes/No (delete as appropriate)	
Self – administered but with designated member of staff observing :Yes/No	
Are there any key points the observing member of staff should know?	
<p>The above information is to the best of my knowledge accurate at the time of writing and I give my consent to school staff administering the medication in accordance with school policy and I understand that this is administered in good faith and on a voluntary basis and that school cannot be held responsible.</p>	
Parents Signature	
Print Name	
Date	

**Head Teacher's
signature**

In absence of HT.
form to be signed
by the member of
staff nominated by
HT &
countersigned by
the HT on their
return

Appendix 5

Good Practice Points for Asthma Care

People with asthma have airways which narrow as a reaction to various triggers. The narrowing or obstruction of the airways causes difficulty in breathing and can usually be alleviated with medication taken via an inhaler.

Schools can hold salbutamol inhalers for emergency use but if a child diagnosed with asthma may need to use the school's emergency inhaler, this possibility should be explained in their Care Plan and schools should have asked for parent's consent at the same time. For further information and guidance, please see Guidance on the use of emergency salbutamol inhalers in schools, Department for Health.

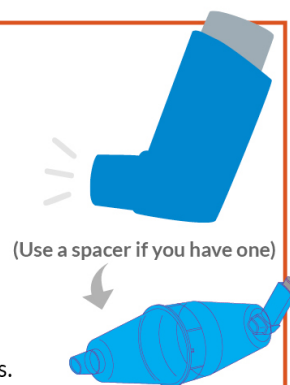
Schools should also consider:

1. Keeping a register of children in school diagnosed with asthma together with copies of their parental consent forms enabling them to take medication, i.e. inhalers.
2. Preparing Care Plans for pupils whose asthma is so severe that it may result in a medical emergency.
3. Where to keep inhalers, including during offsite visits, so that they are stored safely but are readily available for children who need them, which may mean encouraging pupils of year 5 and above to carry their own inhalers. Arrangements should be considered on a case by case basis. If the pupil is too young or immature to take responsibility for their inhaler, it should be stored in a readily accessible safe place.
4. In special school all inhalers should be kept in classrooms, but accessible immediately, and should be administered by staff who have received training.
5. Asking parents to supply schools with a spare inhaler and spacer device for pupils who carry their own inhalers to store safely at school in case the original inhaler is accidentally left at home or the pupil loses it. This inhaler should have an expiry date beyond the end of the school year and parents should be asked to replace it if it does not. Schools should dispose of out of date inhalers regularly, either by returning them to parents or to the pharmacist.
6. How they will ensure that all inhalers are labelled with the following information: -
 - Pharmacist's original label;
 - Child's name and date of birth;
 - Name and strength of medication;
 - Dose;
 - Dispensing date; and
 - Expiry date.

7. Labelling children's spacer device, which is used with an inhaler often by younger children and making arrangement with parents to ensure that it is sent home to be cleaned regularly, e.g. at the end of each term.
8. Taking appropriate disciplinary action, in line with their school's Behaviour and, if they have one, Managing Substance Related Incidents policies, if inhalers are misused by pupils or others. Inhalers are generally safe and, if a pupil took another pupil's inhaler, it is unlikely that that pupil would be adversely affected; however medical advice should be sought.
9. The arrangements for monitoring inhaler use, and how parents will be notified if their child is using the inhaler excessively.
10. How to ensure that staff running PE lessons and sports activities are aware that physical activity will benefit pupils with asthma, but that these pupils may need to use their inhaler 10 minutes before exertion. The inhaler **MUST** be available during PE and games. If pupils are unwell they should not participate.
11. How they will ensure that pupils who have a particular trigger for their asthma, such as animal fur, glue, nuts etc. can avoid those substances.

What to do if a child is having an asthma attack

- 1 Help them sit up straight and keep calm.
- 2 Help them take one puff of their reliever inhaler (usually blue) every 30-60 seconds, up to a maximum of 10 puffs.
- 3 **Call 999 for an ambulance if:**
 - their symptoms get worse while they're using their inhaler – this could be a cough, breathlessness, wheeze, tight chest or sometimes a child will say they have a 'tummy ache'
 - they don't feel better after 10 puffs
 - you're worried at any time.
- 4 You can repeat step 2 if the ambulance is taking longer than 15 minutes.



IMPORTANT! This asthma attack information is not designed for children using a SMART or MART regime. If they do not have a reliever inhaler, call an ambulance. Then speak to their GP or asthma nurse to get the correct asthma attack information for the future.

Further source of information:

Asthma UK

Tel: 0300 222 5800

Email: info@asthma.org.uk

<https://www.asthma.org.uk/>

Appendix 6

Good Practice Points for the Administration of Auto Adrenaline Injectors

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to the allergen, which may be a certain food or other substance, but may occur after a few hours. Auto adrenaline injectors should only be administered by staff who have volunteered and been trained by the appropriate health professional. Schools should have obtained parental consent and prepared a Care Plan for the child on becoming aware that the child has been prescribed this medication.

An auto adrenaline injector (AAI) is a preloaded pen device, which contains a single measured dose of adrenaline for administration in cases of anaphylaxis. It is not possible to give too large a dose from one device used correctly in accordance with the child's Care Plan, so even if it is given inadvertently it is unlikely to do any harm. However medical advice should be obtained as soon as possible after the medication is administered. Auto adrenaline injectors should only be used for the person for whom it is prescribed.

National guidance on AAI's within school was published by the DfE and this should be considered as a supplement to this guidance. The DfE Guidance can be found at: <https://www.gov.uk/government/publications/using-emergency-adrenaline-auto-injectors-in-schools>

Schools should consider:

1. Where to safely store the AAI, in the original box, at room temperature and protected from heat and light, so that it is readily available. If the Care Plan records that the pupil is competent then the AAI can be carried on their person.
2. What systems can be put in place to check, termly, the AAI expiry dates and discolouration of contents so that parents can be asked to dispose of and replace medication?
3. Ensuring that all staff know that **immediately after the AAI is administered, a 999 ambulance call must be made and parents notified**. If two adults are present, the 999 call should be made at the same time as the administration of the AAI. The used AAI must be given to the ambulance personnel.
4. The use of the AAI must be recorded on the School Record of Medication Administered, with time, date, and full signature of the person who administered it.
5. Reminding parents that, if the AAI has been administered, they must renew it before the child returns to school.
6. Ensuring that the pupil is accompanied by an adult, who has been trained to administer the AAI on off-site visits, and that the AAI is available and safely stored at all times during the visit.

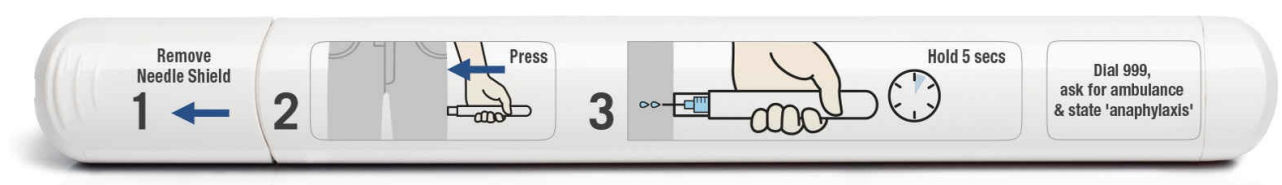
Administering EpiPen



Administering Jext



Administering emerade



Further source of information

The Anaphylaxis Campaign

Helpline: 01252 542029



Website: <https://www.anaphylaxis.org.uk>

Email: info@anaphylaxis.org.uk

Appendix 7

Good Practice Points for the Management of Diabetes

Diabetes is a condition where the person's normal hormonal mechanisms do not control their blood sugar levels because the pancreas does not make any or enough insulin, because the insulin does not work properly, or both. There are two main types of diabetes:

Type 1 Diabetes develops when the pancreas is unable to make insulin. The majority of children and young people will have Type 1 diabetes and need to replace their missing insulin either through multiple injections or an insulin pump therapy.

Type 2 Diabetes is most common in adults, but the number of children with Type 2 diabetes is increasing, largely due to lifestyle issues and an increase in childhood obesity. It develops when the pancreas can still produce insulin but there is not enough, or it does not work properly.

Treating Diabetes

Children with Type 1 diabetes manage their condition by the following: -

- Regular monitoring of their blood glucose levels
- Insulin injections or use of insulin pump
- Eating a healthy diet
- Exercise

The aim of treatment is to keep the blood glucose levels within normal limits. Blood glucose levels need to be monitored several times a day and a pupil may need to do this at least once while at school.

Insulin therapy

Children who have Type 1 diabetes may be prescribed a fixed dose of insulin; other children may need to adjust their insulin dose according to their blood glucose readings, food intake, and activity levels. Children may use a pen-like device to inject insulin several times a day; others may receive continuous insulin through a pump.

Insulin pens

The insulin pen should be kept at room temperature, but any spare insulin should be kept in the fridge. Once opened it should be dated and discarded after 1 month. Parents should ensure enough insulin is available at school and on school trips at all times.

Older pupils will probably be able to independently administer their insulin; however, younger pupils may need supervision or adult assistance. The pupil's individual Care Plan will provide details regarding their insulin requirements.

Insulin pumps

Insulin pumps are usually worn all the time but can be disconnected for periods during PE or swimming etc. The pumps can be discretely worn attached to a belt or in a pouch. They continually deliver insulin and many pumps can calculate how much insulin needs to be delivered when programmed with the pupil's blood glucose and food intake. Some pupils may be able to manage their pump independently, while others may require supervision or assistance. The child's individual Health Care Plan should provide details regarding their insulin therapy requirements.

Medication for Type 2 Diabetes

Although Type 2 Diabetes is mainly treated with lifestyle changes e.g. healthy diet, losing weight, increased exercise, tablets or insulin may be required to achieve normal blood glucose levels.

Administration of Insulin injections

If a child requires insulin injections during the day, individual guidance/training will be provided to appropriate school staff by specialist hospital paediatric diabetic nurses, as treatment is individually tailored. A Care Plan should be prepared.

Best Practice Points for Managing Hypoglycaemia (hypo or low blood sugar) in Children Who Have Diabetes

Schools should offer all staff diabetes awareness training which will be provided by the paediatric diabetic nurses, if a child in the school has diabetes. Training should include how to prevent the occurrence of hypoglycaemia which occurs when the blood-sugar level falls. Staff who volunteer can also be trained in administering treatment for hypoglycaemic episodes.

Symptoms of diabetes can vary from person to person, therefore it will always be necessary for schools to prepare a Care Plan for children who have the condition and obtain parental consent to administer treatment. Often, this will be done when the nurse attends the staff training session if the parent is also able to attend to give their views.

To prevent a hypo

1. Children must be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. Meals should not be unduly delayed due to extracurricular activities at lunchtimes, or detention sessions;
2. Offsite activities e.g. visits, overnight stays, will require additional planning and liaison with parent; and
3. Schools should ask parents to ensure that they provide the school with sufficient, in-date, quantities of the treatment that their child may require.

To treat a hypo

1. Staff should be familiar with pupil's individual symptoms of a "hypo" so that steps to treat the pupil can be taken at the earliest possible stage. Symptoms may include confrontational behaviour, inability to follow instructions, sweating, pale skin, confusion, and slurred speech.
2. If a meal or snack is missed, or after strenuous activity, or sometimes even for no apparent reason, the child may experience a "hypo". Treatment might be different for each child, and will be set out in their Care Plan, but will usually be either dextrose tablets, or sugary drink, or Glucogel/Hypostop (dextrose gel) which should be readily available, not locked away and may be carried by the pupil. Expiry dates must be checked each term by the parent/carer.
3. Glucogel/Hypostop is used by squeezing it into the side of the mouth and rubbing it into the gums, where it will be absorbed by the bloodstream.
4. Once the child has started to recover a slower acting starchy food such as biscuits and milk should be given.
5. If the child is or becomes very drowsy, unconscious, or fitting, a 999 call must be made, and the child put in the recovery position. Due to the risk of choking the caregiver should not attempt to give the child an oral treatment, i.e. a drink, tablets or food.
6. Parents should be notified that their child has experienced a hypo, informed of the treatment provided and asked to provide new stocks of medication.

Once the child has recovered the School Record of Medication Administered should be completed.

Best Practice Guidance for Blood Glucose Monitoring for Children

The Care Plan will explain how frequently the pupil needs to check their blood glucose levels and will set out the method that should be used.

It is recommended that all staff use a fully disposable Unistik 3 Comfort Lancets device if they are undertaking patient blood glucose testing on a pupil. This is a single use device and the lancet remains covered once it has been used.

If a child has an insulin pump, individual arrangements will be made with a specialist nurse and parents to ensure school staff are fully trained in the management and use of the pump.

For children who self-test the use of Unistiks is not necessary and he/she will be taught to use a finger pricker device in which a disposable lancet will be inserted. This device can be purchased at a local chemist or in some cases may be provided by the Paediatric Diabetes Specialist nurse. The disposable lancet can be ordered on prescription via the pupil's GP.

Whenever possible, staff will encourage pupils to undertake their own finger prick blood glucose testing and management of their diabetes, encouraging good hand hygiene. However, in exceptional circumstances such as a pupil having a hypoglycaemic attack, it may be necessary for a member of staff to undertake the test.

How to use the Unistik lancet:

- Prior to the test wash hands

- Encourage pupil to wash their hands wherever possible
- Ensure all equipment is together on a tray including a small sharps box
- Where possible explain the procedure to the pupil
- Apply gloves before testing
- Use a meter which has a low risk for contamination then blood is applied to the strip such as an optimum exceed or one touch ultra
- Ensure meter is coded correctly for the strips in use and that the strips are in date.
- Place the strip into the meter
- Prick the side of the finger using a Unistik comfort 3
- Apply blood to the test strip according to the manufacturer's instructions
- Once the test is completed put the used test strip and lancet directly into the sharps box
- Return the tray to a safe area/room
- Wash hands following the removal of gloves avoiding any possible contact with blood; use alcohol rub
- Record the blood glucose reading in the pupil's care plan/diary
- Parents are responsible for supplying all necessary equipment and medication
- Provision and disposal of a sharps box should be discussed individually with the Paediatric Diabetes Specialist Nurse

Further notes:

The Care Plan will document what action to take if the blood glucose result is higher or lower than expected.

Further sources of information:

Diabetes UK

Tel: 020 7424 1000

Email: info@diabetes.org.uk

Website: <https://www.diabetes.org.uk/>

Appendix 8

Good Practice Points for Managing Eczema

Eczema (also known as dermatitis) is a non-contagious dry skin condition which affects people of all ages, including one in five children in the UK. It is a highly individual condition which varies from person to person and comes in many different forms.

In mild cases of eczema, the skin is dry, scaly, red, and itchy but in more severe cases the child's skin may experience weeping, crusting, and bleeding which can be exacerbated by constant scratching causing the skin to split and bleed and leaving it open to infection. In severe cases, it may be helpful and reassuring for all concerned if a Care Plan is completed. . If whole body or significant creaming is required, factors that will need to be taken into account might include:

- Who will do the creaming? (Including taking into account how much the child can do for him/herself depending on age, maturity etc., Permission needed from parents)
- How often does this need to happen? (How can this be planned around curriculum time etc.?)
- Where will the creaming take place? (Considering the need to ensure both privacy and safeguarding of the pupil and the safety of staff.)
- What medication and/or equipment will the parents provide and what may school need to provide (e.g. gloves etc.)?

These details would all need to be provided on the pupil's care plan.

Atopic eczema is the most common form. It is not known exactly why atopic eczema develops in some people. Research shows a combination of factors play a part including genetics (hereditary) and the environment. Atopic eczema can flare up and then calm down for a time, but the skin tends to remain dry and itchy between flare ups. The skin is dry and reddened and may be very itchy, scaly and cracked. The itchiness of eczema can be unbearable, leading to sleep loss, frustration, poor concentration, stress, and depression.

There is currently no cure for eczema but maintaining a good skin care routine and learning what triggers a pupil's eczema can help maintain the condition successfully, although there will be times when the trigger is not clear. Keeping skin moisturised using emollients (medical moisturisers) is key to managing all types of eczema, with topical steroids commonly used to bring flare ups under control.

Appendix 9

Good practice points for epilepsy

Epilepsy is a neurological condition that causes recurrent seizures. This is caused by abnormal electrical activity in the brain. Seizures can happen anytime anywhere. 60% of people with epilepsy there is no known reason for them to have developed epilepsy. The other 40% there is an underlying cause or brain trauma. About 1 in 133 people suffer from epilepsy.

Epilepsy is diagnosed through a good medical history and an eye witness account of the seizure. When it is suspected that a child has epilepsy the child is sent for tests such as EEG's and MRI to help support the diagnosis and to look for any structural abnormalities in the brain. There is a big problem with misdiagnosis, as some things that look like epilepsy are not epilepsy such as migraine and fainting.

There are two main types of seizures: focal and generalized.

- Generalized seizure is where the whole of the brain is affected, and the electrical activity is coming from all over. These seizures are when the muscles relax and the person falls to the floor, they can become stiff and have generalized jerking of all four limbs. These are also the absence types of epilepsy.
- Focal seizures are when the electrical activity is localized to one part of the brain, these seizures can present with twitching in their face, hands, arms and legs. They can feel strong emotions, make unusual noises and have unusual behavior such as lip smacking, head turning to one side.

When you suspect a child to have a seizure, make sure you try and time the seizure, record what happened before, during and afterwards. If you have permission from parents a video is very helpful to make a diagnosis.

General first aid advice

- Managing a Tonic Clonic Seizure

If a child has a generalized tonic clonic seizure (jerking or all four limbs) it is important to stay as calm as possible. Reassure the other children in the classroom. Ensure that the child having the seizure cannot harm themselves

1. Check safety of the area
2. Move any potentially dangerous object which the child could hurt themselves on
3. Cushion head with something soft – such as a small jumper (especially if on concrete to avoid injury)
4. Stay with the child throughout the seizure
5. After the seizure is over put into recovery position until completely recovered
6. Check the child for injury and maintain privacy and dignity throughout

DO NOT

1. Restrain the child
2. Do not move the child unless they are in direct danger
3. Put anything in their mouth
4. Do not give any food or drink

When to call for an AMBULANCE

1. If the seizure is going on for longer than 5 minutes
2. If it is the child's first seizure
3. If the child is injured
4. If you are concerned at any point

REMEMBER

- Keep a record of the seizure.
- Time the seizure.
- Description of the event if possible - how it started, what happened, how it finished
- Did anything happen before the seizure? I.e. bump to the head, argument, sleepy, do they have a fever.
- What happened during? I.e. were they stiff, floppy, jerking, eyes rolled, head turned etc. - were they incontinent?
- What happened after? I.e. how long it took to recover, were they sleepy after, did they go back to normal and do they remember it?

Epilepsy can be controlled with regular medications, emergency medications, Ketogenic diet, surgery and VNS. The medications that are used to control epilepsy are strong and important to take regularly. When a child is prescribed an anti-epileptic medication, they are usually given a plan with how and when to take the medication. Usually they only take the medication twice a day however, there are some children who need a third dose in the day time. If the child was to vomit after the administration of the medication, unless it was a tablet and you can see it, it would be advised not to repeat the dose as it will not be known how much has been absorbed.

If a dose is missed, a catch-up dose may be given within 4 hours of the designated time. After the 4 hours, do not give the dose and carry on with the next dose. If a child was to miss a dose of medication, be aware that they may have more seizures as a result.

Epilepsy can have a significant impact on a child's achievement; they can experience problems with the visual/verbal learning process, reading, writing, speech language, numeracy, memory, psychosocial problems, concentration and behavior. It can be helped to improve this through group work, providing written information as a prompt, making sure that the student has not missed anything, encourage note taking, cue cards, highlighting important information, rhymes, repetition and revision.

Every child with a diagnosis of epilepsy should have a health care plan in school with details on how to manage that child's seizure. Children with emergency medication also need an up-to-date care plan with details of when to give the medication. Most of the time the child will be prescribed Buccolam (midazolam), however if the child cannot take this, they will be prescribed a rectal emergency medication.

Guidelines for the administration of Bucolic (midazolam)

Bucolic (midazolam) is an emergency treatment for epilepsy, for prolonged convulsions and clusters of seizure activity. It is administered via the mouth in the Bucolic cavity (between the gum and the cheek).

Bucolic (midazolam) can only be administered by a member of the school staff, ideally someone who spends the most time with the student, who has been assessed and has been signed to say they have received the training and know what to do. Training of the designated staff will be provided by the school nurse and a record of the training undertaken will be kept by the headteacher for the school's records. Training must be updated annually. The training must be child specific, general Bucolic (midazolam) training can be done but each child who requires it must have their care plan reviewed and understood by the staff members who would be administering the Bucolic (midazolam).

Bucolic (midazolam) care plans should reflect the specific requirements of each case and further advice should be sought from the specialist nurse/consultant/GP.

1. Buccolam (midazolam) can only be administered in accordance with an up-to-date written care plan with medical and parental input. If the dose changes it is the responsibility of the parent to have the care plan updates. Old care plans should be filed in the pupil's records.
2. The Buccolam (midazolam) care plan should be renewed yearly. The school nurse will check with the parent/ carer that the dose remains the same.
3. The care plan must be available each time the Buccolam (midazolam) is administered: if practical to be kept with the Buccolam (midazolam).
4. Buccolam (midazolam) can only be administered by designated staff, who has received training from the school nurse. A list of appropriately training staff will be kept.
5. The consent form and care plan must always be checked before the Buccolam (midazolam) is administered.
6. It is recommended that the administration is witnessed by a second adult.
7. The child should not be left alone until fully recovered.
8. The amount of Buccolam (midazolam) that is administered must be recorded on the pupil's Buccolam (midazolam) record card. The record card must be signed with a full signature of the person who has administered the Buccolam (midazolam), timed and dated. Parents should be informed if the dose has been given in an emergency situation.
9. Each dose of Buccolam (midazolam) must be labelled with the individual pupil's name and stored in a locked cupboard, yet readily available. The keys should be readily available to all designated staff.
10. School staff must check expiry date of Buccolam (midazolam) each term. In special schools, where nurses are based on site, the school nurse may carry out this responsibility. It should be replaced by the parent/ carer at the request of the school or health staff. Please inform parents within a month of expiry to give them time to replace it.

11. All school staff designated to administer Buccolam (midazolam) should have access to a list of pupils who may require emergency Buccolam (midazolam). The list should be updated annually and amended at other times as necessary.
12. All Buccolam (midazolam) training needs to be child specific. General training can be done but each individual care plan needs to be reviewed.
13. A Buccolam authorisation form should be completed by a consultant paediatrician outlining the dosage, and administration guidance from the doctor and signed parental consent confirming the dose. Within special schools' best practice would be that parents are contacted before buccolam administration to establish if an earlier dose has been administered.

Appendix 10

Reviewing School's Provision

Key questions	School's Evidence		
	Achieved	In progress	Not achieved
• Do you ensure that parents and pupils are consulted about, and made aware of, your arrangements for supporting pupils with medical conditions in school?			
• Do you promote pupils' confidence and self-care in managing their own medical needs?			
• Do you ensure that staff receive satisfactory training on supporting pupil's medical needs in school?			
• Do governors ensure that policies, plans, procedures and systems are properly prepared and implemented?			
• Does the school have a policy for supporting children with medical conditions in school?			
• Does the school have a contingency plan to cope if staff refuse to administer medication?			
• Is the policy reviewed regularly?			
• Is the policy easily accessible by parents & staff, in particular the section which explains the school's procedures for dealing with medication in school?			
• Does a named individual have overall responsibility for implementation of the policy?			
• Are arrangements in place to ensure that the policy is implemented effectively?			
• Are Individual Healthcare Plans (IHCPs) reviewed at least annually?			
• Is there a named individual who is responsible for the development of IHCPs?			
• Is the school able to identify which staff in school need to be made aware of pupil's medical needs and are those staff aware of which children have health needs and what support is required?			
• Is written permission from parents and the Headteacher/SLT obtained to allow administration of medication by a member of staff, or self-administration by the pupil, during school hours?			
• Are arrangements identified in the policy to allow children to manage their own health needs?			
• Do IHPs contain appropriate prescription and dispensing information?			
• Are emergency contact details and contingency arrangements included within the IHCP?			
• Does the IHCP explain what arrangements or procedures should be in place during school trips or other school activities outside of the normal school timetable so that the child can participate and are these reviewed prior to each event?			
• Does practice reflect the policy?			
• Does the policy identify roles and responsibilities?			
• Are training needs regularly assessed?			

• Have sufficient staff received suitable training?			
• Is a record kept of training undertaken?			
• Are written records kept of all medicines administered to children?			
• Do all staff know what should happen in an emergency?			
• Is the appropriate level of insurance in place and does it reflect the level of risk?			
• Does the policy set out how complaints can be made?			



