Saint John Fisher Catholic Voluntary Academy

'For I know the plans I have for you; plans to give you hope and a future.' Jeremiah 29:11

Everyone who works at Saint John Fisher will work together and always try their best to help me make the most of my God-given talents.

Medication in Schools Policy

The information provided in this policy is taken from government guidance published in 2005 'Managing Medicines in Schools and Early Years settings' and 'Supporting pupils at school with medical conditions' published in 2015. A copy of these documents can be accessed at: *http://www.education.gov.uk/b0013771/managing-medicines-in-schools* & *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484418/supporting-pupils-at-school-with-medical-conditions.pdf*

Please note that the term medicine may refer to prescribed medicines, inhalers, lotions or epi-pens.

There is no legal duty that requires school staff to administer medicines. Many children will need to take prescribed medicines during the day at some time during their time in school either because they are:

i) Suffering from chronic illness or allergy; or

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

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 minimises the time that they need to be absent from school. However, such medicines should only be brought to school where it would be detrimental to a child's health if it were not administered during the school day. Headteachers are advised not to allow children to bring medication into school except as covered by the guidelines in this document and the relevant codes of practice.

Prescribed Medicines

Medicines should only be brought to school when essential. St John Fisher Catholic Voluntary Academy will only accept medicine that has been prescribed by a doctor, dentist, nurse practitioner or pharmacist prescriber. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration.

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

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

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

Where occasionally this cannot be arranged, parents/guardians are encouraged to note that if the pupil needs a dose of medicine at lunchtime, the parent/guardian should come to school to administer the medicine. If this is not possible, children will self-administer the

prescribed medicine, under the supervision of an adult (see administration of medicines). Parents may provide the school with the prescribed amount of medicine ready drawn up in a medicine syringe or children can use a medicine spoon if they are able. Where medicine is provided in 'dose-quantities', the original bottle must also be provided.

St John Fisher Catholic Voluntary Academy will not accept medicines that have been taken out of the container as originally dispensed nor make changes to dosage on parental instructions.

Written Instructions
All medicines that are to be administered in school must be accompanied by written instructions from the parent and/or the GP, and parents will fill in the relevant form (Appendix 2). Each time there is a variation in the pattern of dosage, a new form should be completed.

Labelling of Medicines
All medication should be stored in original containers and must always indicate the child's name, dosage, expiry date.
It is the parents/guardian's responsibility to ensure that the medication is correctly labelled and in date.

Non-Prescribed Medicines

Except in exceptional circumstances staff will NEVER give a non-prescribed medicine to a child.

Essential and Emergency Medication

For children who suffer from ailments which result in medication being administered in school long term then the child's needs must be discussed with the Head Teacher/SENDCo and an Individual Healthcare Plan (IHP) will be drawn up. In cases where a child is suffering from a long term condition, emergency medication may need to be kept in school. In these cases, children will have an IHP. Appropriate amounts only of this medicine must be kept in secure storage but accessible, e.g. in the event of a seizure.

Access to the prescribed emergency medication must only be available to the adults named on the IHP, who will have been appropriately trained. Arrangements must be agreed with the parents/guardians to cater for trips off school premises.

Emergency medicines such as asthma inhalers, epi-pens and insulin should be readily available to children. The children will self-administer inhalers under the supervision of an adult, who will write down the time and dosage in the class inhaler log book. It is the responsibility of the parent to ensure that the child is aware of how to correctly administer the drugs. For other emergency medications, administration details will be agreed with the parents when the IHP is written.

All medication with the exception of inhalers must be handed in to our school office for safe keeping. Inhalers will be kept in the class inhaler bag. Medicine which needs refrigerating will be stored in the office fridge. Every effort will be made by staff to ensure medicine is administered at the time requested, however, should a dose be missed there is no liability on the part of school staff. It is the parents' duty to ensure that medication is collected at the end of the school day. School will dispose of any medication left in school at the end of each school term, with the exception of inhalers and epi-pens.

It is the responsibility of the parent / carer to inform school staff of any changes to medication and to ensure that the medication held in school is within its use by date.

If a child is found to be carrying any medication or lotion for which there is no paperwork completed or which does not have their name on it then school staff will confiscate it immediately. The medicine will only be returned to a parent / carer in person.

For conditions such as epilepsy, diabetes or other long term illnesses that may require use of drugs long term in school or for administering controlled drugs then arrangements will differ from those set out above and will be discussed on an individual basis with the parent / carer..

Administration of Medicines

Self-administration

Many pupils at school will have the capability to keep and administer their own medicine themselves. In all instances, the medicine will be taken in the school office.
The child goes to the office and takes the medicine, informing a member of staff, who will note the time on the log sheet, noting that session was supervised but clearly indicating that medication was self-administered by pupil.
In exceptional cases, administration may differ from the above, however this will be clearly stated on a child's Individual Health Plan and Individual Treatment Plan.

Individual Treatment Plan

For all pupils who may require individual specialised treatment, a clear treatment plan will be available. Treatment plans should be prepared by the doctor responsible for the management and prescription of treatment and should be shared with parents/ guardians and child's GP. The School Health Service will provide a support role in ensuring an individual treatment plan is understood and carried out in school.

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.

Signed Chair N Weightman _____ Date _____

Review date January 2017

Appendix 1

CODES OF PRACTICE

These codes of practice have been drawn up with advice from the 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:

a) Detailed guidance and sources of further information, and

b) At-a-glance “what to do” in an emergency guides where appropriate.

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

Appendix 1

CODE OF PRACTICE

FORMAT

1. Types of Treatment

2. Written Instructions

3. Labeling

4. Storage and Access

5. Administration of Medicines

6. Overdose/Misuse

7. Further Information

8. “What To Do” Guide where appropriate

Appendix 1

CODE OF PRACTICE

ASTHMA

1. Types of Treatment

2. Written Instructions

3. Labeling

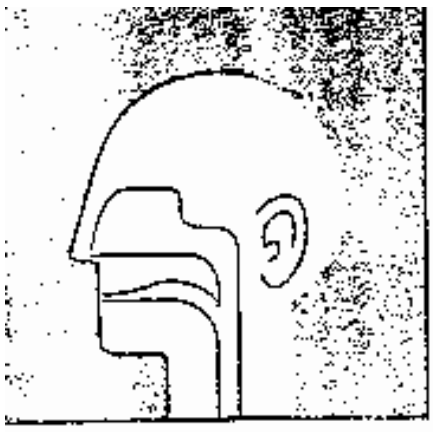
4. Storage and Access

5. Administration of Medicines

6. Overdose/Misuse

7. Further Information

8. “What To Do” Guide



Appendix 1

CODE OF PRACTICE

ASTHMA

1. TYPES OF TREATMENT

1.1 There are two types of treatment for asthma:

1. "***Relievers"***

Treatments which give **immediate relief,** called bronchodilators since they open up narrowed air passages.

2. "***Preventers"***

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

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

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

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

1.4 Young children and those with co-ordination problems may sometimes use a "spacer" device into which the aerosol is released and through which the medication is inhaled.

1.5 Some children use dry powder devices. Tablets and syrups are rarely given.

2. WRITTEN INSTRUCTIONS

2.1 Written instructions should clearly identify between "**relievers"** and "**preventers".**
In **most** situations relievers only should need to be provided in school.

2.2 Instructions can also include details of how to help a child breathe. In an attack, asthmatics tend to take quick shallow breaths and may panic.

Some children are taught to adopt a particular posture which relaxes their chest and encourages them to breathe more slowly and deeply during an attack. If they have learnt such a technique, encourage them to use it. The emphasis should always be on the rapid provision of reliever medication.

3. LABELLING

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

4. STORAGE AND ACCESS

4.1 Asthmatic children must have immediate access to "reliever" inhalers at all times.

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

4.3 Younger children should be encouraged to do so. However, some parents, after consultation with the headteacher, may request that inhalers are kept with the supervising teacher for safe-keeping and ease of access.

4.4 Inhalers should be taken to swimming lessons, sports, cross-country, team games, etc and on educational visits and used accordingly.

5. ADMINISTRATION OF MEDICINES

5.1 Self-administration is the usual practice. Staff need to be aware of possible over- useof inhalers and the headteacher should inform parents/guardians as appropriate.

5.2 In circumstances where staff assist a pupil to use an inhaler, the individual treatment plan, where one exists, should be followed. A record should be made in the School Medicine Record Form - Appendix 2.

5.3 Staff involved in helping a child during an attack should:

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

6. OVERDOSE/MISUSE

6.1 No significant danger to health results from occasional overdose/misuse of inhalers. Staff, however, should be vigilant for inhaler abuse as there is evidence nationally that children are selling use of their inhalers to friends in the mistaken belief that it will induce some sort of high.

6.2 “INTAL” capsules are not harmful if swallowed.

Other capsules, e.g. “VENTOLIN” will have no side effects UNLESS MORE THAN 10 ARE SWALLOWED.

6.3 In all suspected cases, note the School Medicine Record and note the action taken to seek medical advice and advise parents.

7. FURTHER INFORMATION

7.1 Schools should have a copy of the National Asthma Campaign Pack issued in 1993/94. Further copies can be obtained from:
The National Asthma Campaign
Providence House Providence Place London N1 ONT
This organisation is funded by voluntary donations.

7.2 Further advice and guidance can be obtained from: (1) The Local School Health Team
(2) Community Child Health
(3) The author of an Individual Treatment Plan, if one exists, for a specific child
(4) The Child’s Family Doctor.

Appendix 1

THE ASTHMA ATTACK - WHAT TO DO

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

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

1. **Keep calm.** It's treatable.

2. **Let the pupil sit down** in the position they find most comfortable. Do not make them lie down.

3. **Let the pupil take their usual reliever treatment -** normally a blue inhaler. If the pupil has forgotten their inhaler, and you do not have prior permission to use another inhaler:

- Call the parents/guardians
- Failing that, call the family doctor
- Check the attack is not severe - see below

4. **Wait 5-10 minutes.**

5. **If the symptoms disappear,** the pupil can go back to what they were doing.

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

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

WHAT IS A SEVERE ASTHMA ATTACK?

Any of these signs mean severe:

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

HOW TO DEAL WITH A SEVERE ATTACK

Either follow your school protocol or:

1. **Call an ambulance or the family doctor** if they are likely to come immediately.

2. Get someone to **inform the parents.**

3. **Keep trying with the usual reliever inhaler every 5/10 minutes** and don't worry about the possibility of overdosing.

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

Appendix 1

CODE OF PRACTICE

ANAPHYLAXIS (Allergy Shock Syndrome)

1. Types of Treatment

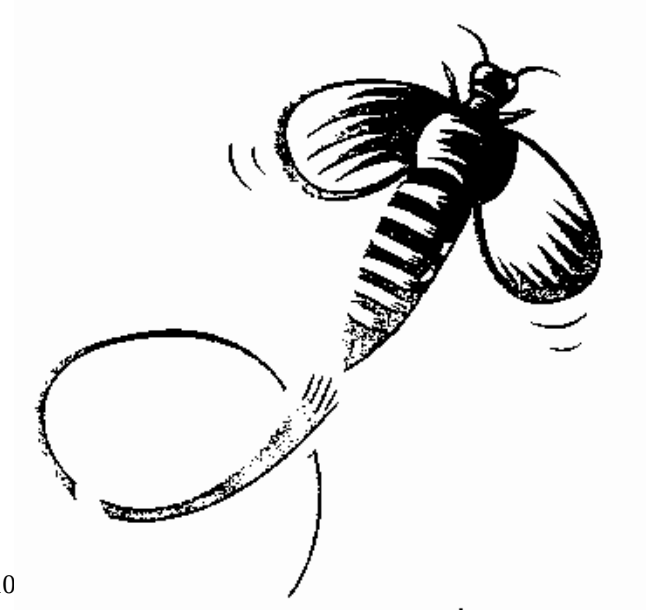
2. Written Instructions

3. Labeling

4. Storage and Access

5. Administration of Medicines

6. Overdose/Misuse



Appendix 1

CODE OF PRACTICE

ANAPHYLAXIS (ALLERGY SHOCK SYNDROME)

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

1. TYPES OF TREATMENT

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

1.1 An **anti-histamine** may be prescribed according to the severity of the reaction.

1.2 Use of an **adrenaline inhaler** may be prescribed if respiratory symptoms appear.

1.3 An **adrenalin** injection "should be immediately administered" as a life-threatening situation develops quickly.

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

2. WRITTEN INSTRUCTIONS (INDIVIDUAL TREATMENT PLANS)

2.1 An Individual Treatment Plan must be drawn up by the Consultant Paediatrician or the General Practitioner.

2.2 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 adrenalin injection where an acute allergic condition is known. (Copy attached.)

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

2.4 The parent/guardian is responsible for providing the school with names and telephone numbers of persons who can be contacted in a matter of emergency.

2.5 The headteacher, through the employer, must ensure appropriate training is given to staff. The School Health Service, following consultation with the prescribing pediatrician, is responsible for arranging the appropriate information and training for a minimum of two responsible person who have volunteered to administer adrenalin. It may be necessary for the headteacher to arrange for the teachers and other staff in the school to be briefed about a pupil's condition and about the arrangements contained in the written instructions. If there are no volunteers to administer the medication, then an ambulance must be called should a child suffer a reaction.

2.6 The instructions may include detailed arrangements for meals and that steps are taken to ensure that the pupil does not eat any food other than items prepared/approved by the parents/guardians as far as is reasonably practicable.

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

2.8 For each child the symptoms which indicate the onset of an acute allergic reaction may be different. It is the parents'/guardians' responsibility to ensure, in conjunction with the GP, that the list of symptoms which indicate onset are notified to the school within the written instructions.

2.9 In the event of the child showing any of the physical symptoms, staff are instructed to follow the agreed emergency procedure.

2.10 The instruction must clearly indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor/guardians.

2.11 If adrenalin is administered, then the emergency services/hospital must be informed of the dose administered.

3. LABELLING

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

4. STORAGE AND ACCESS

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

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

5. ADMINISTRATION OF MEDICINES

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

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

6. OVERDOSE/MISUSE

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

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

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

Appendix 1

FORM OF INDEMNITY

In consideration of staff at

…….. School agreeing to administer an injection of adrenalin to
……(Full name of child). By means of
…….
in the event of the said child suffering from an anaphylactic reaction.
We…….the parent(s)/guardian(s) of the child (named above), hereby indemnify Derby City Council, its servants or employees against all proceedings, costs, liabilities and damages incurred as a result of any injury or damage caused to the named 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 Derby City Council, its servants or employees or the failure of the Derby City Council to perform their common law or statutory duties and liabilities.

Signed.....Parent(s)/Guardian(s) Dated ……
Address:

Telephone (Day time)……. Emergency Contact number…….

Appendix 1

CODE OF PRACTICE

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

1. Types of Treatment

2. Written Instructions

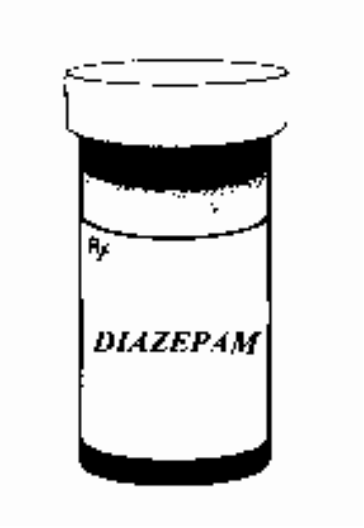
3. Labelling

4. Storage and Access

5. Administration of Medicines

6. Overdose/Misuse

7. Further Information



Appendix 1

CODE OF PRACTICE

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

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

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

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

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

1. TYPES OF TREATMENT

1.1 Administration of prescribed rescue medication

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

2. WRITTEN INSTRUCTIONS

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

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

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

3. LABELLING

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

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

4. STORAGE AND ACCESS

4.1 Appropriate amounts only must be kept in secure storage.

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

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

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

5. ADMINISTRATION

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

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

5.2.1 include aspects of storage of the drug and completion of records;

5.2.2 be updated annually;

5.2.3 eradicate all "as and when" decisions, and each case must include clear protocols for the timing of events in sequence.

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

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

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

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

6. OVERDOSE/MISUSE

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

7. FURTHER INFORMATION

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

Appendix 1

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

INSTRUCTIONS FOR THE ADMINISTRATION OF RECTAL VALIUM

Name of Child: _____

Date of Birth: _

School Attended: ____

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

Name of Consultant Paediatrician: __

Signature of Consultant: ____

Date: _

Appendix 1

CODE OF PRACTICE

DIABETES IN SCHOOLS

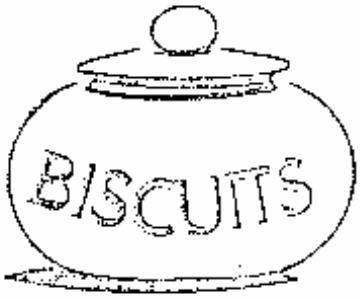
1. Types of Treatment

2. Written Instructions

3. Labelling

4. Storage and Access

5. Administration of Medicines



Appendix 1

CODE OF PRACTICE

DIABETES IN SCHOOLS

Type 1 Diabetes Management in School

Type 1 Diabetes Mellitus occurs with a lack of insulin to utilise glucose effectively. Children with Type 1 Diabetes Mellitus manage this condition with subcutaneous insulin and are at risk of high and low blood sugars which may make them unwell.

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

The three main diabetes regimens are:

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

Twice Daily insulin Regimen

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

Multiple Injections of Insulin (MDI) or Basal Bolus Regimen

MDI is designed to copy normal insulin production. An injection of fast acting insulin is given via a pen device before each meal (bolus) and one injection usually later in the evening is given as basal insulin. The fast acting insulin should be given within 10 minutes of eating.

The child/ Young person will require carbohydrate free snacks when applicable with school policy as discussed with their individual care plans.

Continuous Subcutaneous Insulin infusion (Pump Therapy)

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

Insulin Regimens and monitoring

Most children/young people will require some supervision when monitoring their blood glucose levels in the event of requiring any emergency treatment or advice. Some children/ young people will require supervision of the insulin dose given or depending on age and maturity they may require trained school staff to administer the injection.

All insulin regimens require the child/young person to monitor blood glucose and blood ketone levels and for staff to be aware of signs, symptoms and treatment of Hypoglycaemia (low blood sugars) and Hyperglycaemia (high) blood sugar levels as written in the individual care plans.

Hypoglycaemia (Low blood sugar levels)

Hypoglycaemia is when the blood glucose level falls below 4mmol/l

Each child is encouraged to carry their own equipment to deal with a low blood sugar however an emergency box supplied by parents to school is also advised. The emergency box should contain, glucose drinks, glucose tablets, glucogel and starchy carbohydrate snacks

Can occur regularly due to:
Not enough carbohydrate eaten with insulin
Late carbohydrate
Too much insulin
Exercise
Change in routine
Poor injection technique or lumpy injection sites

Signs and Symptoms of Hypoglycaemia are:
Hungry
Pale
Shaky
Dizzy
Confused
Difficulty concentrating
Blurred vision
Headache
Odd behaviour, Poor judgement
Slurred speech
Lack of co-ordination

Mild
Pupil requires supervision but can take instruction for necessary treatment
Glucose appropriate for weight and blood glucose level
(See individual Hypoglycaemia care plan)
Moderate
Pupil is conscious however requires intervention from a supervising adult
Glucogel gel as directed by care plan
Severe
Pupil is semi conscious or unconscious and requires emergency intervention
Glucagon Injection

Follow up treatment

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

Hyperglycaemia (High blood sugar levels)

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

Danger signs of ketoacidosis to look for:

Vomiting
Abdominal pain
Lethargy
Confusion
Fast breathing

Any signs of ketoacidosis dial 999

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

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

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

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

WRITTEN INSTRUCTIONS

Individual Care plans will be provided by the Derbyshire Children's Hospital Diabetes Team and completed by Parents. The care plans provided include:
Blood glucose testing
Injecting insulin (If applicable)
Management of Hypoglycaemia and recommended emergency supplies
Management of hyperglycaemia and blood ketone testing
Giving a correction bolus (If applicable)

LABELLING

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

STORAGE AND ACCESS

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

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

Appendix 1

ADMINISTRATION OF MEDICINES

It is advised that all schools, document any blood glucose/ketone levels and insulin given and by whom. This can be accessed through Managing Medicines in School and Early Years setting (Department of health) or Derbyshire Children's Hospital insulin administration form accessed through the diabetes nursing team.

Contacting the Paediatric Diabetes Nursing Team

(01332) 786963
Option 1- Emergency advice
Option 2- Messaging service
Option 3- Appointments
Option 4- Dieticians (alternatively- (01332) 786568)

Appendix 1

CODE OF PRACTICE

CONTINENCE MANAGEMENT
THE USE OF CLEAN INTERMITTENT CATHETERISATION (CIBC)

Introduction

1. Types of Treatment

2. Written Instructions

3. Labelling

4. Storage and Access

5. Administration Procedure

Appendix 1

CODE OF PRACTICE

CONTINENCE MANAGEMENT
THE USE OF CLAN INTERMITTENT CATHETERISATON (CIBC)

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

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

1. Full assessment by a continence adviser.

2. A toileting regime designed to accommodate the demands of the school day.

3. A positive rewarding approach.

NEUROPATHIC BLADDER AND BOWEL
The commonest cause of neuropathic bladder in children is spina bifida, but may be caused by a range of other conditions. Bladder and bowel function is disrupted by abnormal development of the nerve supply and can only rarely be cured by treatment. However, medication, surgery and specialist techniques can usually achieve a reasonable level of continence.

To achieve social control requires very careful assessment by the continence adviser and doctors and a specific care plan implemented by children, parents and care staff. Such a care plan should be designed to achieve continence, encouraging as much independence as possible and respect for the child's dignity and privacy.

Associated problems which may affect the management of continence in schools.

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

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

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

All children will require:-

1. Regular medical and nursing supervision

2. Private and accessible toilet facilities

3. Accessible cupboard to store equipment

4. Disposal facility for soiled pads and catheters

5. Assessment of welfare support needs

6. Independence training plan

7. Access to specialist counselling as and when required

1. TYPES OF TREATMENT

1.1 *REGULAR TOILETING*

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

1.2 *MEDICATION*

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

1.3 *CATHETERISATION (CIBC)*

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

2. WRITTEN INSTRUCTIONS

2.1 There must be a written care plan on every child drawn up by a continence adviser/ community paediatric nurse in conjunction with the consultant pediatrician or surgeon. The care plan should be reviewed at least annually.

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

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

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

3. LABELLING

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

4. STORAGE AND ACCESS

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

4.2 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.

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

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

5. ADMINISTRATION OF PROCEDURE

5.1 At least two suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave. Training should be provided by a nurse either through the School Health Service or voluntary agencies (e.g. ASBAH).

5.2 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.

5.3 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.

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

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

Further Information

Useful contacts

North Derbyshire
School Health Department
School Health Services
The Health Centre
Saltergate
Chesterfield
S40 1SX
Tel: 01246 277271 ext. 4570

South Derbyshire
Mavis Blockley
Special Needs Care Programme (School Nursing)
Wilderslowe
121-123 Osmaston Road
Derby
DE1 2GA

ASBAH – Association for Spina Bifida and Hydrocephalus

National Address: ASBAH House
42 Park Road
Peterborough PE21 1UQ

Appendix 1

Tel: 01733 555988

Local Address: New Masson House
56 Derby Road
Matlock Bath
Derbyshire DE4 3PY
Tel: 01629 580297

Videos and list of useful books are available on request.

Appendix 1

PARENTAL CONSENT
ADMINISTRATION OF MEDICINES IN SCHOOL

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF- ADMINISTER.

If more than one medicine is to be given, a separate form should be completed for each

If you need help to complete this form, please contact the school. Please complete in block letters

Name of Child _____ Date of Birth _____ Year group_____

Address _____ School _____

_____ _____

_____

Doctor's Name _____

PRESCRIBED MEDICINES

The Doctor has prescribed (as follows) for my child:

1. Name of drug or medicine to be given.
2. When? (e.g. lunchtime? after food? when wheezy? before exercise?).
3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?).
4. Route, e.g. by mouth or in each ear.
5. Any special storage instructions?

1.
2.
3.
4.
5.

(Child's Name) _____

can administer his/her own medication /requires supervision to administer his/her own medicine

If your child requires assistance in administering his/her medicine, please request an appointment to complete an IHP:

_____

_____

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out-of- school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school hours:

Name_____ Name _____

Contact Address _____ Contact Address _____

_____ _____

_____ _____

Emergency Telephone Number:…….

Signed _____ Date _____

*Delete that which does not apply

THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.

Appendix 1

SCHOOL MEDICINE RECORD

Both sides of form must be completed

Child's Name	
Class/Tutor Group	
Name of Medicine	
How much to give (i.e. dose)	
When to be given	
Any other instructions *(include details of inhalers, if any)*	
Tel No of parent or adult contact	
Parent's signature obtained via parental consent form	

If more than one medicine is to be given,
a separate form should be completed for each

Additional comments & Photograph

Appendix 1

SCHOOL MEDICINE RECORD

(SA – supervised self administration / AA – adult administered)

Week beginning: ________________												
Day & date												
Time administered												
SA / AA												
Teacher Initials												

Week beginning: ________________												
Day & date												
Time administered												
SA / AA												
Teacher Initials												

Week beginning: ________________												
Day & date												
Time administered												
SA / AA												
Teacher Initials												

Week beginning: ________________												
Day & date												
Time administered												
SA / AA												
Teacher Initials												

Week beginning: ________________												
Day & date												
Time administered												
SA / AA												
Teacher Initials												

Appendix 3