Inspiring All to Excellence

Heathfields Infant & Wilnecote Junior Academy

MEDICATION AND ADMINISTRATION POLICY

Document Control

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Introduction

This policy has been created to ensure that children with medical needs receive proper care and support at school to enable regular school attendance. All reasonable adjustments will be made to enable them to participate fully and safely in school life including in Physical Education; to remain healthy and achieve their academic potential. This may extend to administering medicine and/or taking action in an emergency. This duty also extends to offsite educational visits. Medication will only be administered at school if it would be detrimental to a child's health or school attendance not to do so.

This policy has been written with regard to *supporting pupils at school with medical conditions: statutory guidance for governing bodies of maintained schools and proprietors of academies in England* (2014), the *Special Educational Needs and Disability Code of Practice* (2014) and duties placed on schools by the *Equality Act* (2010). Some children attending school may have an Education, Health and Care Plan which brings together health, social care and special educational needs.

Some children with medical conditions will require a flexible approach to ensure that their needs are met. This may mean a gradual reintegration back to school following a period of absence or part time attendance in combination with alternative provision arranged by the Local Authority. The impact of every child's medical condition will be considered and needs will be assessed on an individual basis.

Whilst full-time regular attendance is an expectation at school, children do not have to be accepted at school if it would be detrimental to their health or that of others for them to attend.

The following paragraphs explain the policy and procedure for use with children with a variety of common childhood conditions. Other conditions will be dealt with on an individual basis.

Asthma

Asthma is a widespread, serious but controllable condition affecting about 1 in every 10 children. Various trigger factors make the airways oversensitive and they become narrow and inflamed. Staff will do all that they can to ensure that the school environment is favourable to children and adults with asthma. The school does not keep any furry or feathery animals and if any animals are visiting the school as part of curriculum activities, the needs of any asthma sufferers will form part of the preparations for the visit e.g. risk assessment.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may say that their tummy hurts or that it feels like someone is sitting on their chest.

Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

However in early years settings staff may not be able to rely on younger children being able to identify or say when their symptoms are getting worse, or what medicines they should take and when. **It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens.** This should be supported by written Asthma Action Plans provided by parents, and regular training and support for staff. **Children with significant asthma should have an individual health care plan.**

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Asthma inhalers are kept in the class room for all children. Inhalers should be taken out by class teacher/adult for P.E., break and lunch time and for off-site visits. Children with asthma require immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with inhaler when stated in Asthma Action Plan, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do. For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting. **Schools are allowed to provide emergency reliever inhalers for children with asthma. The Federation of Heathfields Infant and Wilnecote Junior School has voluntarily agreed to provide these emergency inhalers and spacers e.g. if the child's own inhaler has become broken or is empty.**

To comply with the guidance staff will ensure that:

* inhalers and spacers are supplied by a reputable pharmacy

* they will be stored and disposed of in line with this policy

* there will be a register of children in the school who have been diagnosed with asthma or prescribed a reliever inhaler, a copy of which will be kept with the emergency inhaler

* written parental consent will be obtained for use of the emergency inhaler included as part of a child's Asthma Action Plan (Appendix 2)

* the emergency inhaler will only be used by children with asthma with written parental consent for its use

* appropriate support and training for staff in the use of the emergency inhaler in line with the school's wider policy on supporting pupils with medical conditions will be provided

* a record will be kept of the use of the emergency inhaler as required by *Supporting pupils* and informing parents or carers that their child has used the emergency inhaler

* There will be at least two volunteers responsible for ensuring the protocol is followed

* Parents are informed immediately that their child has used an emergency inhaler (Appendix 3) and the letter is sent home with children giving the full details

The emergency asthma kit will contain:

* a salbutamol metered dose inhaler

* at least two single-use plastic spacers compatible with the inhaler

* instructions on using the inhaler and spacer/plastic chamber

* instructions on cleaning and storing the inhaler

* manufacturer's information

* a checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded

* a note of the arrangements for replacing the inhaler and spacers

* a list of children permitted to use the emergency inhaler as detailed in their Asthma Action Plans

At least two named volunteers amongst school staff will have responsibility for ensuring that:

* on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available

* that replacement inhalers are obtained when expiry dates approach

* replacement spacers are available following use

* the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or that replacements are available if necessary.

* the inhaler and spacers are kept in a safe and suitably central location in the medical room which is known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. The inhaler and spacer should not be locked away

* the inhaler is stored at the appropriate temperature (in line with manufacturer's guidelines), usually below 30C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any child's inhaler which is stored in a nearby location and the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler.

* an inhaler should be primed when first used (e.g. spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by spraying two puffs

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

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

The emergency salbutamol inhaler should only be used by children:

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

This information should be recorded in a child's individual Asthma Action Plan.

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

The signs of an asthma attack include:

- ✓ Coughing
- ✓ being short of breath
- ✓ wheezy breathing
- ✓ feeling of tight chest
- ✓ being unusually quiet
- ✓ tightened neck or chest muscles known as retractions

When a child has an attack they should be treated according to their individual health care plan or asthma action plan as previously agreed. An ambulance should be called if:

- ✓ the symptoms do not improve sufficiently in 5-10 minutes
- ✓ more than 10 puffs of the reliever inhaler has been given and there is no improvement
- ✓ the child is too breathless to speak
- ✓ the child is becoming exhausted
- ✓ the child has a blue/white tinge around the lips or is going blue
- ✓ the child has collapsed

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma Action Plan (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor/nurse.

All children with asthma should have a regular asthma review with their GP or other relevant healthcare professional. **Parents should arrange the review and make sure that a copy of their child's asthma action plan is available to the school or setting.** Children should have a reliever inhaler with them when they are in school or in a setting.

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

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

Type 1 Diabetes

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes), because the pancreas doesn't produce enough insulin to maintain a normal blood glucose level, or the body is unable to use the insulin that is produced. (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have insulin injections two or three times daily, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Children with diabetes have a health care plan. Children with Type 1 diabetes may administer their own insulin/pump with supervision from a trained adult.

At the start of each new school year, arrangements are made for the new teacher to meet with the diabetic nurse for training.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan.

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they

were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Pupils with diabetes have their lunch at the beginning of their lunchtime. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level falls low.

Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a hypoglycaemic reaction (hypo) in a child with diabetes:

- ✓ hunger
- ✓ sweating
- ✓ drowsiness
- ✓ pallor
- ✓ glazed eyes
- ✓ shaking or trembling
- ✓ lack of concentration
- ✓ irritability
- ✓ headache
- ✓ mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

* the child's recovery takes longer than 10-15 minutes

* the child becomes unconscious

Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Such information relates specifically to the child's individual health care plan.

Anaphylaxis

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention.

It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours. Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwi fruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets). The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and

vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior. If a severe allergic reaction occurs the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Epipens/Anapens are kept in clearly labelled boxes on top of the medicine box in the class room. All staff are made aware of this. For children with severe allergic reactions, a second epipen/anapen may be held with the office.

Epipens should be taken out by class teacher/adult for P.E. and for off-site visits.

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. **Children known to be at risk of severe allergic reactions have a health care plan and a training session is provided by local health services to staff.**

Epilepsy

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time.

Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition. **Seizures can take many different forms** and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. **Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy.**

If a child experiences a seizure in a school or setting, details should be recorded and communicated to parents including: any factors which might possibly have acted as a trigger to the seizure – e.g.

* visual/auditory stimulation, emotion (anxiety, upset)
* any unusual 'feelings' reported by the child prior to the seizure
* parts of the body demonstrating seizure activity e.g. limbs or facial muscles
* the timing of the seizure – when it happened and how long it lasted
* whether the child lost consciousness
* whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist. What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings.

They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure. In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

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

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flushing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. **Most children with epilepsy can use computers and watch television without any problem.**

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan. During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

* it is the child's first seizure

* the child has injured themselves badly

* they have problems breathing after a seizure

* a seizure lasts longer than the period set out in the child's health care plan

* a seizure lasts for five minutes if you do not know how long they usually last for that child

* there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

Such information should be an integral part of the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required. Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of epilepsy medication is needed and will be available from local health services. Staying with the child afterwards is important as medication may cause drowsiness.

Sickle cell anaemia

Sickle cell anaemia is a serious inherited blood disorder where the red blood cells, which carry oxygen around the body, develop abnormally. Normal red blood cells are flexible and disc shaped, but in sickle cell anaemia they can become rigid and shaped like a crescent (or sickle). The sickle-shaped cells contain defective haemoglobin, the iron-rich protein that enables red blood cells to carry oxygen from your lungs to the rest of the body. The abnormal cells are also unable to move around as easily as normal shaped cells and can block blood vessels, resulting in tissue and organ damage and episodes of severe pain. Such episodes are known as a sickle cell crisis or a vaso-occlusive crisis. They can last from a few minutes to several months, although on average most last five to seven days. The abnormal blood cells also have a shorter lifespan and aren't replaced as quickly as normal blood cells. This leads to a shortage of red blood cells, known as anaemia.

Symptoms of anaemia include

* lethargy (a lack of energy)

* tiredness and breathlessness, particularly after exercise.

Sickle cell anaemia can cause a wide range of symptoms, although not everyone with the condition will experience all of the symptoms.

Sickle cell crisis

Episodes of pain during a sickle cell crisis are one of the most common and upsetting symptoms of the condition. A sickle cell crisis (also known as a vaso- occlusive episode or VOE) is triggered when the abnormal blood cells block the small blood vessels that supply the body's tissues. This damages the cells in the affected tissue, resulting in the tissue becoming swollen, which irritates nearby nerve endings. During a sickle cell crisis, younger children may develop painful swelling in their hands or feet. This is often the first noticeable symptom. As a child gets older, pain can occur in any area of the body.

Anaemia

Anaemia, where the amount of haemoglobin in the blood is lower than normal or there are less red blood cells than normal, is a common symptom of sickle cell anaemia. The abnormal cells have a shorter lifespan and aren't replaced quickly enough.

Symptoms include:

* fatigue – extreme tiredness and a general lack of energy
* shortness of breath
* palpitations (irregular heartbeat)

Children are often able to compensate for the lack of red blood cells by an increase in heartbeat, although symptoms of fatigue may persist. This can make it difficult to participate in physical activities such as sport.

When to seek urgent medical advice

Because of the risk of the potentially life-threatening complications associated with sickle cell anaemia, it is important that you are aware of any signs or symptoms that a child's health has suddenly worsened.

Signs and symptoms to look out for are:

* fever (high temperature) of 38C (100.4F) or above
* severe pain that develops during a sickle cell crisis that can't be controlled using over the-counter painkillers
* breathing difficulties
* severe abdominal pain or swelling
* severe headache, stiff neck or dizziness
* changes in mental state, such as appearing confused or drowsy
* episodes of priapism that last longer than two hours
* seizures (fits)

If a child with sickle cell anaemia develops any of the above symptoms, his/her parents should be called immediately. If they are not contactable, you should seek

advice from the child's hospital specialist and acting on their advice the child may need to be taken to hospital by ambulance. It is very important when requesting an ambulance or visiting A&E that you inform all ambulance, medical and nursing staff that the child has sickle cell anaemia. This will ensure that they are aware of the potentially serious nature of the child's condition.

There are a number of things a child can do to reduce their risk of having a sickle cell crisis (an episode of severe pain). These are described below.

Drink plenty of water

It is very important to drink plenty of water because dehydration increases the likelihood of sickle cells forming. A child with sickle cell anaemia should drink extra fluids during hot weather.

An individual child's care team will be able to give you detailed advice about their recommended fluid intake.

Exercise regularly

Children should take regular exercise but should avoid becoming too tired or seriously out of breath. Children with sickle cell anaemia usually have less stamina than their classmates. Therefore, activities that allow them to take frequent breaks, such as sprinting or cycling, are probably a better choice than long-distance running or rugby.

A child's GP or consultant will be able to advise further and recommend an appropriate level of exercise for an individual.

Eat a healthy, balanced diet

Eating a healthy diet encourages children's growth and development and strengthens their immune system, which helps reduce their risk of developing infections. A low-fat, high-fibre diet is recommended, including plenty of fresh fruit and vegetables (five portions a day) and whole grains.

Avoiding triggers

A child with Sickle Cell Anaemia should also try to avoid known triggers such as:

* **extreme temperatures** – exposure to extreme heat or cold can trigger the formation of sickle cells

* **high altitude areas** – lack of oxygen at high altitudes may trigger a crisis

* **stress** – stressful events have been shown to trigger a crisis

Hydrocephalus

Hydrocephalus is a build-up of fluid on the brain. The excess fluid puts pressure on the brain, which can damage it. Congenital hydrocephalus is present in babies when they are born and can be caused by conditions such as spina bifida, or as a result of an infection the mother develops during pregnancy, such as mumps or rubella (German measles). It is estimated that spina bifida affects one baby in every 1,000 born in Britain. Most of them will have hydrocephalus.

Shunt malfunction

A shunt is a delicate piece of equipment prone to malfunction, usually through blockage or infection. It is estimated that up to four out of 10 shunts will malfunction in the first year after surgery. Sometimes a scan carried out after the operation shows that the shunt is not in the best position, and that further surgery may be needed to reposition it.

If a baby or child has a shunt fitted, the shunt may become too small as the child grows, and it will need to be replaced. As most people need to have a shunt for the rest of their life, more than one replacement may be needed.

It is estimated that most children with hydrocephalus may have an average of two procedures for shunt problems before they are 10 years old.

Occasionally, when shunt tubes are positioned, bleeding can occur. This can result in nerve problems, such as weakness down one side. There's also a small risk of seizures (fits) following any surgery on the brain.

In younger children, particularly babies, cerebrospinal fluid (CSF) can run alongside the shunt rather than down it, and it can leak through the skin wound. If this occurs, further stitches will be needed to stop the leak.

Shunt blockage

A shunt blockage can be very serious because it can lead to an excess build-up of fluid on the brain, which can cause brain damage. This will cause the symptoms of hydrocephalus, such as:

* headaches
* feeling sick
* being sick
* confusion
* drowsiness or coma

Staff should contact the child's parents immediately if a child has these symptoms. Emergency surgery would be required to replace the malfunctioning shunt.

Shunt infection

Shunt infection is also a relatively common complication. The risk of infection can be around 3- 15% and is more likely to occur during the first few months after surgery.

The symptoms of a shunt infection may include:

* redness and tenderness along the line of the shunt
* a high temperature (fever) of 38ºC (100.4ºF) or above
* headache
* being sick
* neck stiffness
* tummy pain (if the shunt drains into your tummy)

Parents should be contacted immediately if a child has these symptoms. A course of antibiotics to treat the infection and, in some cases, surgery may be required to replace the shunt.

Other Health Conditions

An individual health care plan will need to be drawn up for each child who has any significant health condition not mentioned in this document which might impact on his/her education or care. Consultation takes place with the school nurse when formulating these.

Administering Medication

No pupil should be given medication without his/her parents'/carers' written consent. Staff are required to administer medication, but do so voluntarily. Any member of staff employed by Staffordshire County Council at the Federation of Heathfields Infant and Wilnecote Junior School who follow guidelines and protocols established for the administration of medication will be indemnified by the local authority's insurance policy.

If children require the administration of emergency medication, for which training is required, the Inclusion leader will ensure that sufficient staff are trained to cover in the case of staff absence so that a child will not be prevented from attending school because a staff member is not available to administer medication.

Children who are considered competent to manage their own health needs and medication should be encouraged to do so under the supervision of appropriately trained staff. If this is the case a note will be made on his/her Individual Health Care Plan.

Medication brought into school to be administered must be recorded. The record must show:

- ✓ The name of the child for whom the medication is prescribed
- ✓ The date of receipt
- ✓ The name and strength of the medication
- ✓ The quantity received
- ✓ The dosage that should be administered
- ✓ The time the dose should be given
- ✓ The expiry date and any special precautions
- ✓ The signature of the person receiving the medication

Any member of staff giving medication to a pupil must check:

- ✓ The pupil's name
- ✓ Written instruction provided by parents or doctor
- ✓ Prescribed dose
- ✓ Expiry date

Only medication in its original container will be accepted by staff. It should be labelled with the child's name, prescribed dose and frequency of administration required. Staff will then complete and sign the record of medication administered in school each time medication is given to a pupil.

Medication will be administered if prescribed for 4 or times a day. (Parents are requested to keep children at home for the first 24 hours). Medicine will then be administered at lunchtime. This will be administered in the normal way, following completion of a parental consent form. *(See Appendix 1)*

In circumstances where a child requires non-prescribed medicine parents are encouraged to give this medication at home and if necessary are welcome to call into school during the day to administer it. Where this is not possible written details must be given by a person with parental responsibility.

Refusing Medicines

If a child refuses to take medicine, staff must not force them to do so, but should note this in the records and follow agreed procedures. Parents should be informed of the refusal as soon as possible and the refusal should be recorded on the Medication Administration Record sheet.

If a refusal to take medicines results in an emergency, the school's emergency procedures should be followed.

On-Going Medication e.g. Asthma, Type 1 Diabetes, Glutaric Aciduria Type 1, Cystic Fibrosis, Acute Lymphoblastic Leukaemia, ADHD.

At the start of each school year there should be an annual review of any written parental request for medication.

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/carers for disposal. Parents should be advised that the medicines are out of date and should be asked to collect them. Out of date medicines should not be sent home with pupils. Alternatively these may be taken to a pharmacy for disposal.

Provision for safe disposal of used needles requires appropriate special measures e.g. a sharps box. This is kept in a safe place and should not be accessible to pupils or unauthorised persons. The sharps box is exchanged/disposed of by a specialist contractor.

Safety, Storage and Access

Medicines can often be harmful to anyone for whom they are not prescribed and we recognise that it is our duty to ensure that the risks to the health of others are properly controlled. **No large volumes of medication will ever be stored.** Containers from home must be labelled with the name of the pupil, name and dose of drug and frequency of administration. Staff will never transfer medicines from original containers. Medicines will be stored safely, securely and will not be accessible to pupils. Pupils will know where their medicine is stored. Some medicines do need to be refrigerated.

All medications will be stored in a medical box in the classroom. ADHD medication will be stored in a locked cupboard opposite the main office. Appropriate staff will have access to the medicine.

Medicines needing refrigeration will be stored in the fridge in the staff room during the course of the school day, these are mainly antibiotics and eye drops.

These should be stored in a container to prevent contamination. All medicines should be returned at the end of the day to the adult responsible for the child. When the child has two sets of the medication for the period of treatment (one for home, one for school), medication should remain in the fridge in the staff room and be returned to the parent/carer at the end of the treatment for the disposal.

Management of Errors in administration of medicines

Every effort will be made by staff to prevent errors in the administration of medication. In the unlikely event of incorrect administration the following procedure will be followed:

- ✓ Ensure the safety of the young person. Normal first aid procedures must be followed which will include checking pulse and respiration
- ✓ Telephone for an ambulance if the child's condition is a cause for concern
- ✓ Notify the Executive Headteacher
- ✓ Contact the young person's Parents/Carers as soon as practicable
- ✓ Contact the young person's GP/Pharmacist for advice if necessary (out of hours contact NHS direct. Document any immediate adverse reactions and record the incident in the young person's file/Care Plan using the Medication Incident Report Form HSF36
- ✓ The Headteacher must complete the Medication Incident Report Form HSF 36 and, if injury results, the County Council Accident Investigation Report HSF40
- ✓ The Headteacher must commence an immediate investigation about the incident, inform the Strategic Health and Safety Team, and, where applicable inform any relevant regulatory body. Statements should be taken from both staff and young person if they are self-medicating
- ✓ The medication administration record sheet should reflect the error
- ✓ Young person's parent/carer/guardian should be informed formally in writing
- ✓ It is recognised that despite the high standards of good practice and care, mistakes may occasionally happen for various reasons. Every employee has a duty and responsibility to report any errors to his/her manager. Managers should encourage staff to report any errors or incidents in an open and honest way in order to prevent any potential harm or detriment to the young person
- ✓ Managers must handle such reporting of errors in a sensitive manner with a comprehensive assessment of the circumstances
- ✓ A thorough and careful investigation taking full account of the position of staff and circumstances should be conducted before any managerial or professional action is taken
- ✓ Any investigation must observe the conventions as set out in the County Council's Disciplinary Policy

First Aid/Head Injuries

In the event of a child failing to respond to medication or appearing to have an allergic reaction, First Aid procedures will be followed. Individual health care plans should include instructions as to how to manage a child in an emergency, and identify the role and responsibilities of staff during the emergency. Where possible staff and other children should know what to do in the event of an emergency, and all staff should know how to call the emergency services.

Staff should never take children to hospital in their own car unless accompanied by another member of staff and only then in extreme emergencies. Any child sustaining injury to the head must be brought to the medical room to be checked. The time of the incident will be recorded on the first aid book. Treatment will be given and parents/carers will be notified via text message, in more serious incidents, parent/carer will be phoned. Any head injuries require the pupil to take home an accident report slip.

Children requiring first aid should be seen by a first aider. During the learning time, this is any Teaching assistant available within the same year group. During the break time and lunch time, first aider is available on the school playground.

It is not necessary to send children to the first aider if there is no visible injury present, unless it is a bump to the head. Before sending children to the first aider who 'do not feel very well and want to go home' staff should first assess if it is really necessary to send the child home discouraging them if possible.

In the event of a child needing to be sent home it is appropriate that children are sent straight to the office where all contact details are held, second copy of the parents/carers phone details is attached to the first aid book.

During lunchtimes, lunchtime supervisor on duty is to assess whether children need to be given first aid. All first aid administered to be logged in first aid book which is kept opposite the main office.

Emergency procedures

All staff must know who is capable of carrying out emergency aid. A current list of all qualified persons and staff trained in the use of Epipens is displayed in the office

and on the notice board in the staff room. If a child needs to be taken to hospital, an ambulance should first be called and then the parents. A member of staff should wait with the child, ensuring his/her safety and accompany him/her to hospital unless the parent has already arrived at school.

Health professionals are responsible for any decisions on medical treatment when parents are not available.

Contagious/Infectious Illness

Exclusion times for any infectious or contagious illness will be in accordance with guidelines issued by Staffordshire Health Protection Unit. Any child with sickness and/or diarrhoea should be kept at home until 48 hours after the last symptoms occurred.

Hygiene

All staff must be familiar with normal precautions for avoiding infection, and must follow basic hygiene procedures. Staff will have access to protective disposable gloves and care will be taken when dealing with spillages of blood and other body fluids and disposing of dressings and equipment. All resources and disposal bins are available in the medical room. Every classroom is equipped with an antibacterial gel.

Educational Visits

Staff will ensure what reasonable adjustments need to be made to ensure the inclusion of all children on educational visits. Evidence from a clinician such as a GP will be required to say that inclusion in a visit would not be recommended. Staff present must always be aware of any medical needs and relevant emergency procedures and take these into account when planning a visit and preparing a risk assessment. Any prescribed medication, including inhalers/EpiPens should be taken on all visits by the teacher in charge. Prior to the residential visit all parents/carers should have completed a residential medical form. These are then taken on the visit in case of an emergency.

Confidentiality

All medical information will be treated with confidentiality. **All staff including supply teachers must be aware of pupils' medical needs.** Co-ordination and

dissemination information will come directly from data stored by the administration office.

Parents are asked to keep the school up to date with any changes to medical welfare needs as and when necessary and prior to any residential visit

Health Care Plans

Where a health care plan is necessary for an individual pupil these are created by the First Aid Leader in consultation with parents and the School Nurse as well as any other relevant medical information available. The parents of any child requiring a health care plan will be asked to provide some form of medical evidence for their condition. If there is any conflict of evidence, the school nurse will be asked to ensure that the healthcare plan reflects the needs of the child appropriately. If a child has SEN but does not have a statement or Education, Health and Care Plan, their special educational needs should be mentioned in their individual health care plan. If the child does have a statement of EHC plan, the Individual health care plan should be linked to the plan.

Pupils should be aware of the content of their individual health care plans and know what will happen to manage their conditions both routinely and in an emergency. This will prepare them for any necessary procedures and help to manage any anxiety.

Parents should provide school with sufficient and up-to-date information about their child's condition. They should ensure that they carry out any action to which they have agreed as part of the plan and ensure that they or another nominated adult is contactable at all times.

Any emergency situation that can be planned for should be detailed in the Individual Health Care Plan. If an unexpected medical emergency arises, the school's general risk assessment procedure will be followed.

Individual Health Care Plans are kept in the child's file in Integris and paper copies are in the following places:

Main Office – in a green folder. All staff who administer first aid should be made aware of the individual plans and all staff who come into regular contact with the child will be required to become acquainted with the child's medical needs.

Classrooms - These plans should also be stored in the classroom first aid box with a sign to alert supply staff/other teachers and in the yellow folder found on teacher's desks.

Lunchtime – Plans are kept in the lunchtime first aid folder and all lunchtime supervisors are required to become acquainted with the child's medical needs.

Individual Health Care Plans are reviewed annually or whenever a child's condition changes and parents inform school of this change. The First Aid Leader should then ensure that the plan is updated in Integris and paper copies are re-issued to relevant staff.

Head Lice

If a child is found to have head lice this will be dealt with in a manner which protects the dignity of the child. No member of staff is permitted to search a child's hair, however if live lice are seen the parent will be contacted to collect the child for treatment at home in order to stem the spread amongst other children. An information leaflet informing parents/carers of a case of head lice will always be issued to the whole class and not individuals. Text message asking parents to "once a week take a peak" will always be sent to the whole school.

Injuries to Staff

All injuries to staff or visitors (including contractors working in the school) will be recorded in the LA Staff/Adult/Visitor Accident Book and reported to the Local Health and Safety Coordinator on Form Riddor 3.

Medicines for a staff member's own use

An employee may need to bring medicine into school /setting for his/her own use. **All staff have a responsibility to ensure that these medicines are kept securely and that young people will not have access to them**, e.g. locked desk drawer or staff room.

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

Unacceptable Practices Staff must always use their discretion and judge each case on its merits and with reference to an Individual Health Care Plan. However there are some generally unacceptable practices which should always be avoided:

- ✓ Preventing children from accessing their medication e.g. inhalers when they need them
- ✓ Assume that every child with the same condition should be treated in the same way
- ✓ Ignore parents or medical advice, although this may be challenged
- ✓ Send children home unnecessarily or prevent them staying for lunch unless this is specified in their individual health care plan
- ✓ Sending the child to the medical room alone
- ✓ Sending the child to help themselves to the ice-pack alone
- ✓ Penalise the children for their attendance record if absence relates to a medical condition
- ✓ Prevent pupils from eating and drinking or going to the toilet in order to manage their medical condition effectively
- ✓ Require parents to attend school to administer prescribed medication or provide medical support of their child including toileting issues
- ✓ Prevent children from participating in any aspect of school life or expecting parents to accompany their child on an educational visit

Complaints

All staff at the Federation of Heathfields Infant and Wilnecote Junior School will endeavour to do their very best to ensure that children with medical needs are fully supported to have those needs met at school. However we recognise that there may be occasions on which parents have concerns about the care provided. In the first instance they should speak informally, without delay, to their child's class teacher. If they still have concerns they should follow the school's complaints procedure available at http://www.wilnecotejnrandheathfieldsinf.co.uk/policies/ or ask for a copy from the school office.

Monitoring and Evaluation

Date of next review: *Spring Term 2024*

Copies to all Teaching Staff via the Website.

Parents advised

References

http://www.nhs.uk/conditions/ (Accessed 12 March 2017)

DfE, (2015) *Supporting pupils at school with medical conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England*

DfE, (2015) *Special Educational Needs and Disability Code of Practice*

Department of Health, (2014) *Guidance on the use of emergency salbutamol inhalers in schools*

Equality Act (2010).

Appendix 1

PARENTAL REQUEST FOR THE ADMINISTRATION OF MEDICINES IN SCHOOL

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

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

Name of Child: _____ Date of Birth: _____

Address: _____

Doctor's Name: _____ School: _____

Class / Teacher: _____

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

Name of Drug or Medicine to be given and any special storage instructions	When? (e.g. lunchtime? After food? When wheezy? Before exercise?)	How much? (e.g. half a teaspoon? 1 tablet? 2 drops?)	Route? (e.g. by mouth or in each ear)

(Child's name): _____

* can administer his / her own medication *

* requires supervision to administer his / her own medicine *

* requires assistance in administering his / her medicine * * Delete that which does not apply.

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 on any such action as soon as possible.

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

Name: _____ Telephone number: _____

Contact Address: _____

Signature: _____ Date: _____

Appendix 2

CONSENT FORMS:

CONSENT FORM FOR USE OF EMERGENCY SALBUTAMOL INHALER:

1. I can confirm that my child has been diagnosed with asthma and/or has been prescribed an inhaler.

2. My child has a working in date inhaler, clearly labelled with their name, which they will bring with them to be kept in school at all times.

3. In the event of my child displaying symptoms of asthma / breathing difficulties and if their inhaler is not available or is unusable, I give consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Print Name_____Parent / Carer

Signed_____Parent / Carer Date _____

(This must be a person with parental responsibility for the named child)

_____

NO LONGER ASTHMATIC

I can confirm that my child_____class_____does not require inhaler and/or does not show the symptoms of asthma anymore. Please remove the asthma diagnosis from their file.

Print Name_____Parent / Carer

Signed_____Parent / Carer Date _____

(This must be a person with parental responsibility for the named child)