Date established by governing body
Autumn Term 2025
Date for full implementation
Immediately
Date for review
Autumn Term 2026

Supporting Pupils with Medical Conditions

cleaswell hill school
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Contents

Introduction

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

Creating your own School policy for "Supporting Pupils with Medical Conditions"

Section 100 of the Children and Families Act 2014 places a statutory duty on governing bodies (rather than Local Authorities) to ensure that arrangements are in place to support pupils with medical conditions whilst they are at school.

Schools should treat this policy as a template and adapt it to include the specific arrangements in place at their school. It is essential that any procedures adopted from this model policy are followed in practice.

Adopting this policy will ensure that governing bodies have accurate, up-to-date information and will ensure compliance with statutory requirements. Governors can be satisfied that such measures align with their wider safeguarding duties.

Schools should publicise their own policy to parents by placing it on the school's own webpage.

What's new?

March 2023

Some minor changes to text have been made throughout the document, however, the main changes are detailed below.

'Useful Contacts'

This section has been updated and includes links to websites/training as well as contact details for key healthcare staff.

'Roles and Responsibilities'

Updated text in respect of the role of healthcare professionals such as the school nursing teams. Space for schools to record staff roles in respect of medication, asthma and anaphylaxis coordinators.

'Individual Healthcare Plan and Risk Assessments'

Amended to include additional information on the requirement to consider the need for an individual risk assessment for pupils with complex medical needs or conditions which involve daily management or use of equipment e.g diabetes, asthma.

'Anaphylaxis'

Updated section on training in respect of local arrangements for training, recommendations in national guidance and an updated section on food management in schools. *See also NCC health and safety bulletin 2-2022*

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

Form updated to reflect that in addition to medication, parental consent is needed for any procedures/testing regimes which are to be self-managed by the pupil (where it has been risk assessed by the school that the child is able to do this safely). See section above on personalised risk assessment.

Useful Documents

Document	
'Supporting pupils at school with medical conditions (DfE)	'Supporting pupils at school with medical conditions
'Guidance on the use of emergency salbutamol inhalers in school' (DoH)	'Guidance on the use of emergency salbutamol inhalers in school'
'Guidance on the use of adrenaline auto-injectors in Schools' (DoH)	Guidance on the use of adrenaline auto-injectors in Schools
'Reasonable Adjustments for Disabled Pupils' (Equality and Human Rights Commission) *(NB Applicable to all children and young people with additional needs, not just physical and health needs)*	https://www.equalityhumanrights.com/en/publication-download/reasonable-adjustments-disabled-pupils
'Data protection in Schools *(DfE)* *(in relation to retention records of medical records)*	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747620/Data_Protection_Toolkit_for_Schools_OpenBeta.pdf
'Medicines Optimisation - Guidance: Non-Prescribed Medicines in Schools'	Guidance Non Prescribed Medicines in Schools
NHS Child Health App for parents	https://apps.apple.com/gb/app/nhs-child-health/id1113584434 or via the google store
Food Management	School food standards practical guide Allergy guidance for schools'

Useful Contacts

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

Northumbria Healthcare NHS Foundation Trust
Northumberland County Council

Name	Contact Details
Public Health Nurse (School Nurse)	Child Health Centre, Wansbeck Hospital, Ashington – 01670 564048 Eddie Ferguson House, Blyth – 01670 629670 Corbridge Health Centre, Hexham – 01434 636939 Prudhoe Health Centre, Prudhoe – 01661 832512 Broomhill Health Centre, Amble- 01670 761908
Children's Community Nurse	01670 564070
Community Paediatrician Service	Morpeth/Ashington/Berwick Wansbeck Child Health Centre - 01670 564030 Blyth/Cramlington Paediatric secretaries - 01670 396467 Tynedale/Hexham Hexham General Hospital - 01434 655395
Special School Nurse	Elaine Davies, Team Lead – 07795413396 NTSpecialSchoolNursing@northumbria-healthcare.nhs.uk (this mailbox is monitored daily during school term time hours).
Specialist Epilepsy and Diabetes Nurse	Contact via switchboard at North Tyneside General Hospital Tel: 0344 811 811.
Designated Clinical Officer	Sam Barron Tel: 01670 622747 Email: Samantha.Barron@northumberland.gov.uk
Special Education Needs and Disabilities (SEND)	sen@northumberland.gov.uk
Occupational Therapist	Children's physical disability occupational therapy service Northumbria Healthcare NHS Foundation Trust Child health Woodhorn Lane Ashington NE63 9JJ Tel: 01670 564050
Physiotherapist	sylvia.tingate@northumbria-healthcare.nhs.uk
NCC Corporate Health and Safety Team	01670 623854

Asthma and Lung UK and Beat Asthma (see resource for Schools)	Free training resources
Epilepsy Society	
Epilepsy Action	Free on-line training resources for schools
Diabetes UK	Free on-line training resources for schools
Anaphylaxis UK	Free on-line training resources for schools

Roles and Responsibilities

Responsibility of Parents

Parents have the principal responsibility for the administration of medication to their children, who have the right to be educated with their peers, regardless of any short or long-term needs for medication whilst at school. The term 'parent' is understood to include anyone who has parental responsibility for the care of a child.

Wherever possible, medication should be given at home by parents. If prescribed medicines are to be taken three or more times per day, parents should ask the prescribing doctor if the administration of the medication can occur outside normal school hours. Generally, non-prescription over the counter medication (such as cold remedies, cough medicines, hay fever eye drops etc) will not be administered in school. However, in some circumstances the school may consider administering certain medication and each request received by a parent to do so will be assessed individually. An 'Administration of Medication to Pupils - Agreement between Parents and School' form' (appendix 1) will be required in all cases before any medication can be administered. Further information can be found within the 'Non-Prescribed Medication' section.

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

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

Parents are also responsible for the timely notification to school of any changes, including the cessation, of medication administered in school. Notification should by made by phone call then followed up by an email to medication@cleaswellhill.org as soon as possible. It is not appropriate to make notification to school via Tapestry, paper diary or verbally.

Responsibility of Health Care Professionals

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

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

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

The School Nursing Service is available to provide advice and signpost all schools to appropriate services and/or professionals about any public health topic.

The Special School Nursing Service is a term time service. The service is able to provide general health advice to all special schools. The service provides assistance with healthcare plans and specialist training for Castle School, Hexham Priory, The Grove, Barndale House and Cleaswell Hill schools.

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

Responsibility of School Staff

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

It is generally accepted that school staff may administer prescribed medication whilst acting in loco parentis. However, it is important to note that this does not imply that there is a duty upon these workers to administer medication and the following should be taken into account:

No member of staff should be compelled to administer medication to a pupil

No medication can be administered in school without the agreement of the Head or his/her nominated representative

The Head and governors must nominate a member of staff to assume the role of Medication Coordinator, who will have overall responsibility for the implementation of this policy. In addition to this, if schools have an emergency asthma kit or emergency AAIs, at least two volunteers for each kit (four in total) should have the responsibility of ensuring this equipment is maintained correctly. In addition to the record below, the school's own health and safety policy should also identify who has assumed these roles.

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

If it has been agreed that medication can be administered, named volunteers should be identified to undertake this task

The volunteers should receive the appropriate guidance and training (where necessary).

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

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

The school has appointed the following staff members to carry out specific roles:

Role	**Name**	**Responsibility**
Medication Coordinator	Jordan Tolley	Overall responsibility for implementation of policy and ensuring period review/audit of arrangements. Ensuring individual healthcare plans are reviewed at least annually. Considering the need for personalised risk assessments, moving and handling risk

		assessments, emergency procedures, as appropriate.
Asthma Coordinator	Jordan Tolley	Ensuring emergency/spare inhaler and associated equipment is maintained correctly Maintain asthma register of pupils who have been prescribed an inhaler, including those permitted to use the spare inhaler.
Anaphylaxis Coordinator	Jordan Tolley	Ensuring emergency/spare AAI equipment is maintained correctly. Maintain register of pupils permitted to use the spare AAI, ensuring required paper work is provided for use of spare AAI. Maintain allergy register

Day Trips, Residential Visits and Sporting Activities

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

The needs of those attending should be considered well in advance and reasonable adjustments must be made so attendees may benefit from the experiences that are offered. To determine the reasonable adjustments required, the school should complete a personalised risk assessment. This will ensure that planned arrangements take account of any steps needed to ensure that pupils with medical needs are included. Outdoor Education Advisory Board's National guidance 3.2e 'Inclusion' and 4.4i Special Educational Needs and Disabilities provides further guidance and advice.

The risk assessment will require consultation with parents and pupils and advice from the relevant healthcare professionals to ensure that pupils can participate safely. In certain situations, it may also be appropriate to consult the intended activity providers.

The specific arrangements for a child attending an off-site visit should be recorded with the relevant visit specific information and logged on the EVOLVE system, together with supporting information, such as the personalised risk assessment. These arrangements enable the child to participate fully in such activities.

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

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

Emergency medication, such as inhalers, AAIs etc, should be readily available, with spares being available if necessary, and not locked away. All young people at risk of anaphylaxis should carry two auto-injector devices at all times. During all off-site educational visits, there may be a requirement to purchase and administer non-prescribed, over the counter medication. In these circumstances, the advice given here should be adhered to and the parent must be contacted to gain informed consent to administer any medication. A record of all medication administered should be kept (see Appendix 5).

Liability and Indemnity

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

General Procedures

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

2. The parent (not the pupil) or transport contractor should bring all essential medication to school. It should be delivered personally to the Medication Coordinator or the reception office staff. Only the smallest practicable amount should be kept in school.

3. All prescribed medication taken in school must be kept in its original packaging with pharmacy label, which must give the owner's name, the contents and the dosage to be administered. Any non-prescribed medication given should also be kept in the original packaging and include information on dosage.

4. Whilst medication is in school it should be kept in a locked cupboard or fridge in the Medication Room. Medication is temporarily stored in a locked cupboard in the Reception Office when it is received into school. In the event of an emergency it should be readily accessible to the named volunteer or young person, when required. The exceptions to this are inhalers, adrenaline auto-injectors and insulin. These medications should be carried by the child or may be kept in the classroom, depending on the child's age and developing independence.

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

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

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

8. Renewal of medication which has passed its expiry date is the responsibility of the parent. Nevertheless, schools should have robust procedures in place to ensure that out of date medication is not administered in error. If parents are unable to collect expired

medication, then staff will take it to the local pharmacy so that it can be disposed of safely. The medication must not be disposed of in any other way.

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

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

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

Refusal or Forgetting to Take Medication

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

Northumberland CYPS have confirmed that Methylphenidate can be given within one hour of its prescribed time.

Non-prescribed Medication

The NHS North of England Commissioning Support Unit have issued guidance to Local Authorities in relation to the administration of non-prescribed medication, commonly known as over the counter medication, within schools. This is based on national guidance issued to GPs by NHS England to curb the routine prescribing of products that are for:

A self-limiting condition, which does not require any medical advice or treatment as it will clear up on its own, such as sore throats, coughs and colds

A condition that is suitable for self-care, which can be treated with items that can easily be purchased over the counter from a pharmacy, such as indigestion, mouth ulcers and warts and verrucae.

To clarify, GPs in Northumberland will no longer be routinely prescribing medication which is otherwise available over the counter in a pharmacy, although there will be exceptions to this in specific cases.

It is not anticipated that this change will have a major impact on schools, as the advice would remain that **any treatment of minor conditions where the child is still able to attend school, should, in the main be undertaken at home by the parent or carer. Schools are not expected to administer medication such as cough medicines, cold remedies, hayfever eye drops etc.** Staff should not ask parents to obtain a prescription to allow these products to be administered within school as it is extremely unlikely that the GP will provide this. The final decision on whether to administer over the counter medication lies with the Headteacher.

Where a decision is made by the Head to administer over the counter medication to a pupil, the following should be ensured:

- An 'Administration of Medication to Pupils - Agreement between Parents and School' form (appendix 1) is completed and includes any information given to the parent by the GP or Pharmacist, including dosage.

- The medication is in the original packaging from the manufacturer which includes the name of the medicine and recommended dosage range (ensure this includes the dosage range for the age of the child).
- The expiry date is checked to ensure the medication is still in date.
- The dosage on the parental agreement form matches that on the packaging/information leaflet provided with the medication and the parent is contacted if there is a discrepancy.

Non-prescription medication should be used on a time limited basis. If it appears that the child is frequently receiving this medicine, it may be appropriate to recommend that an appointment with the GP is needed to discuss the continued need for the medicine.

It is envisaged that the vast majority of medication administered within the schools will still be prescribed.

Paracetamol

At the discretion of the Headteacher, paracetamol can be issued, provided the practice is strictly controlled by adopting the same standards as for other medication. **Generally, this will only be agreed where it is used to manage a medical condition, and not headaches or period pains.** Once again, a formal agreement should be made between the school and the parents (Appendix 1). The Head should authorise specific members of staff to dispense the tablets. In order to monitor and prevent the danger of any individuals overdosing on the medication the nominated member of staff should keep a record of when it was issued, giving such information as the name of the pupil and the time and the dose which was administered (see Appendix 5). Before administering the medication, members of staff should always ask the child whether any side effects or allergic reactions have been experienced previously.

Paracetamol should never be administered without first checking maximum dosages and when the previous dose was taken. A record must be kept of the dose given, and the parents contacted indicating the amount and frequency of the doses administered. Overall control of the administration of such analgesics can help in preventing pupils bringing their own supplies into school.

The paracetamol must be kept securely under lock and key and dispensed with care since over-dosage is dangerous. Paracetamol must not be kept in first-aid boxes.

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

Individual School Healthcare Plan and Risk Assessment

Healthcare Plan

This section of the policy covers the role of individual healthcare plans in supporting pupils at school who have long-term, severe or complex medical conditions. Statutory guidance imposes a requirement to identify the member of staff who is responsible for the development of these plans. **The school healthcare plan in Appendix 3 must always be completed by school staff, regardless of any other health care plan or other documentation provided by a healthcare professional.**

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

- establish the need for a plan

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

Healthcare plans should be developed with the child's best interests in mind and the school should ensure that it assesses and manages risks to the child's education, health and social well-being and minimises disruption.

Personalised risk assessments (see section below), moving and handling risk assessments, emergency procedures and other such documents should be used to supplement the individual healthcare plan, as appropriate.

A healthcare plan template is given in Appendix 3, though Cleaswell Hill School uses a modified version to comply with best practice. To ensure compliance with the statutory guidance the following issues have been considered:

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

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

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

- the level of support needed, (some children will be able to take responsibility for their own health needs), including in emergencies. If a child is self-managing their medication, this should be clearly stated with appropriate arrangements for monitoring

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

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

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

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

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

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

Personalised Risk Assessments for Pupils

A risk assessment should be considered where a pupil has complex medical needs or conditions which involve daily management or use of equipment e.g diabetes, asthma. The risk assessment should record the hazards and risks (to the pupil, staff and others) which may arise in respect of the condition and what measures have been put in place to manage these.

It should also consider the competency and maturity levels of pupils when deciding on the pupil's ability to self-manage their medical condition in a safe manner. This should also consider the view of parents and medical professionals (if appropriate). For older children, self-management of their condition is more likely and is to be encouraged, however, no two young people are the same so this will need to be considered carefully on an individual basis, rather than assessed solely on age. In particular, it should be made clear to those pupils required to carry emergency equipment/medication (e.g. emergency asthma inhalers, diabetic blood testing equipment) that they are being entrusted to carry this out in a sensible safe way, in a quiet allocated place and reinforce the importance of not misusing or sharing equipment with others. Risk assessments should be periodically reviewed to ensure they remain current, and following any incidents which may bring into question their ability to continue to self-manage their condition in a safe way.

Practical Advice for Common Conditions

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

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

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

Anaphylaxis

What is Anaphylaxis?

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

What Causes it?

Common causes of anaphylaxis include:

- Edible triggers, such as peanuts, tree nuts, fish, shellfish, dairy products, wheat, sesame, soya and eggs

- Other triggers, such as latex, the venom of stinging insects (for example wasps, bees and hornets), medication such as penicillin, antibiotics, ibuprofen and other drugs or injections

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

What are the Signs of the Condition?

Common signs of anaphylaxis in children include:

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

- severe asthma

- dizziness

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

- swelling of the lips, hands and feet

- abdominal cramps, nausea and vomiting.

What is the Treatment for the Condition?

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

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

What Arrangements are in Place at our School?

Healthcare Plan

Anaphylaxis is manageable. With sound precautionary measures, the development of a suitable healthcare plan and support from members of staff, school life may continue as normal for all concerned.

It is important that appropriate local procedures for the use of adrenaline auto-injectors, should include the following:

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

- awareness of the symptoms associated with anaphylactic shock

- knowledge of the type of injector to be used
- labelling of injectors for the child concerned, for example adrenaline, antihistamine
- knowledge of the locations where the injector is stored, preferably in an easily accessible place but not locked in a cupboard or office where access is restricted.
- reference the protocol for use of any spare AAIs kept in school (see following page) and the register of pupils to who the spare AAI can be given.
- the provision of appropriate instruction and training to nominated members of staff
- familiarity with the names of those trained to administer treatment
- an understanding of the need to keep records of the dates of issue
- knowledge of emergency contacts

This type of information should be suitably displayed in the areas where the medication is to be kept. This information should include the name of the child and, ideally, a photograph. Care must be given to ensure confidentiality. The information should be accessible but not publicly displayed. Most schools keep this information in the staff room and main office. The information should accompany the medication on school trips. The arrangements for swimming and other sporting activities should also be considered.

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

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

Spare Emergency AAI

As mentioned previously, schools are now able to keep spare AAI's on the premises. **It is important that school staff read the content of the DoH document Guidance on the use of adrenaline auto-injectors in Schools dated September 2017.**

Supply

Spare AAIs are available, without a prescription, from a pharmacist; a sample letter requesting these can be found in the above document, which also details the various brands and doses available, depending on the age of the child (see page 7 of the above document). The spare AAI can be administered to a pupil whose own prescribed AAI cannot be administered correctly without delay or is not available; it does not replace a child's own prescribed AAI. Staff are also able to administer this to those children who have not been prescribed an AAI, but only in cases where both written medical authorisation and written parental consent for its use has been provided. In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare AAI is appropriate.

Any school wishing to keep spare AAIs should establish a policy or protocol for their use which is in line with this policy and the above DoH document. Schools can incorporate this into existing protocols for use of AAIs or into this policy. The protocol should include:

- arrangements for the supply, storage, care, and disposal of spare AAI(s) in line with this Supporting Pupils policy.

- a register of pupils who have been prescribed an AAI(s) (or where a doctor has provided a written plan recommending AAI(s) to be used in the event of anaphylaxis).

- written consent from the pupil's parent/legal guardian for use of the spare AAI(s), as part of a pupil's individual healthcare plan.

- ensuring that any spare AAI is used only on pupils where both medical authorisation and written parental consent has been provided.

- appropriate support and training for staff in the use of the AAI in line with the schools wider policy on supporting pupils with medical conditions.

- arrangements for purchase, storage and disposal of spare AAIs.

- Details of the named individual responsible for overseeing the protocol and monitoring it's implementation and maintaining the allergy register. The names of two individuals responsible for the supply, storage, care and disposal of the AAI should also be included..

- keeping a record of use of any AAI(s), as required by Supporting Pupils policy and informing parents or carers that their pupil has been administered an AAI and whether this was the school's spare AAI or the pupil's own device.

The Emergency Anaphylaxis Kit

It is good practice for schools holding spare AAIs to store these as part of an emergency anaphylaxis kit which should include:

- 1 or more AAI(s)
- Instructions on how to use the device(s)
- Instructions on storage of the AAI device(s)
- Manufacturer's information
- A checklist of injectors, identified by their batch number and expiry date with monthly checks recorded
- A note of the arrangements for replacing the injectors
- A register of pupils to whom the AAI can be administered
- An administration record

Schools might like to keep the emergency kit together with the "emergency asthma inhaler kit" if one is kept (see section on Asthma below). Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis.

Severe anaphylaxis is an extremely time-critical situation. Delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices, including those in the Emergency kit, are kept in a safe and suitably central location to which all staff have access, such as the school office or staff room, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. They should not be located more than 5 minutes away from where they may be needed. In larger schools, it may be prudent to locate a kit near the central dining area and another near the playground; more than one kit may be needed.

Any spare AAI devices held in the Emergency Kit should be kept separate from pupil's own prescribed AAI which might be stored nearby; the spare AAI should be clearly labelled to avoid confusion.

Storage and Care of the AAI

A school's allergy/anaphylaxis policy should include staff responsibilities for maintaining the spare anaphylaxis kit. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

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

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

Disposal

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

School trips including sporting activities (see previous relevant section)

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

Food Management

Day-to-day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When catering staff are employed by a separate organisation, it is important to ensure that the Kitchen Manager is fully aware of the child's particular requirements and the child can easily be identified (such as use of photographs of children along with their dietary requirements/allergens). A `kitchen code of practice' should be put in place which should include arrangements for complying with the legal requirement to provide details of allergens in food prepared and served in the school. There is also a more recent requirement to clearly record the ingredients/allergens on any food prepared and packaged on the premises. See '**School food standards practical guide**' which includes a link to '**Allergy guidance for schools**'

Parents often ask for the Head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Training

National guidance stipulates that it is reasonable for ALL school staff to complete anaphylaxis awareness training which includes:

- recognising the range of signs and symptoms of an allergic reaction;
- understanding the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;

- appreciation of the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);

This training is largely generic, with good availability via e-learning. Additionally, schools should also ensure that staff are aware of:

- Who the school contact is
- the content of the school's anaphylaxis policy;
- how to check if a pupil is on the register to be able to receive the emergency AAI;
- how to access the AAI;

Suitability/Sufficiency of Training

On-line or e-learning training is sufficient for general Anaphylaxis awareness training. However, where a school has a child who has been identified as at risk of anaphylaxis, national guidance states that additional face to face training will be needed in the use of the AAI device specifically used by that child (normally either EpiPen, Jext or Emerade). This should include a practical session where staff who are likely to be dealing with an emergency situation, have the opportunity to administer an AAI training pen.

Where members of staff have volunteered to inject adrenaline in an emergency, the school will need to contact a suitable training provider, such as their existing First Aid Training provider, to arrange face-to-face practical training on the use of the AAI pen. This training usually lasts about 1 hour and involves a practical element on the use of AAIs. Some Anaphylaxis training may also be included in general first aid training undertaken by staff designated as First Aiders.

Asthma

What is Asthma?

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

What Causes it?

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

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

What are the Signs of the Condition?

The most common symptoms of an asthma attack include:

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

What is the Treatment for the Condition?

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

Relievers

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

Preventers

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

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

Spacers

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

Nebulisers

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

Training

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

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

Designated Members of Staff

Designated members of staff should be trained in:

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

ALL Members of Staff

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

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

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

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

What Arrangements are in Place at our School?

Healthcare Plan

Pupils with asthma will need to have an individual healthcare plan (and possibly a personalised risk assessment).

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action needs to be taken at that time. An Asthma Action Plan (available from Asthma UK) is a useful way to store written information about a child's asthma. The child's GP or Asthma Nurse will complete this in conjunction with the child and his/her parent. It includes details of the inhalers used, asthma triggers for the child, emergency action and contacts for the GP or Asthma Nurse. This can be attached to the healthcare plan.

In early years settings it is foreseeable that the younger children will not have the ability to convey to members of staff that their symptoms are getting worse or identify what medicines they need to take and when. It is, therefore, imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms of asthma are getting worse and what action they need to take when this happens. This should be reinforced by asthma action plans, asthma medicine cards (both provided by parents) and regular training and support for staff.

Asthma Register

A register of children who have been diagnosed with asthma or prescribed a reliever inhaler should be kept. This is particularly crucial in larger schools, where there may be many children with asthma, and it will not be feasible for individual members of staff to be aware of which children these are. In primary settings, where a teacher has responsibility for a single class each year, this will be easier to manage (so a register may not be needed).

Schools should ensure that the asthma register is easy to access, and allows for a quick check to take place to establish if a child is recorded as having asthma and that consent for an emergency inhaler to be administered has been obtained.

Carrying the Medication

Pupils with asthma need to keep their reliever inhalers with them at all times.

It is good practice to allow pupils who have asthma to carry their own medication from a relatively early age. This is especially important if the inhaler or nebuliser is needed to relieve symptoms regularly or if attacks are sporadic and particularly severe. Children with asthma learn from their past experience of attacks; they usually know just what to do and will probably carry the correct emergency treatment.

If pupils are not able to do so then inhalers should be stored safely away and members of staff should issue them when the child needs the medication. This method may be more appropriate for younger pupils with asthma who may not be able to use the inhaler without help or guidance.

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

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

Emergency Salbutamol Inhalers in Schools

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

The emergency salbutamol inhaler should only be used by children:

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

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

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

- Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital and, potentially, save the child’s life. Having a protocol that sets out how and when the inhaler should be used will also protect members of staff by ensuring they know what to do in the event of a child having an asthma attack; this should include:

- Establishing arrangements for the supply, storage, care and disposal of the inhaler and spacers. Assigning these responsibilities to at least two volunteers is recommended

- Maintaining a register of pupils who have been diagnosed with asthma or prescribed a reliever inhaler. The register should confirm that parental consent has been obtained for use of the emergency inhaler and a copy of it should be kept with the emergency inhaler

- Having written parental consent for use of the emergency inhaler included as part of a child’s individual healthcare plan. This consent can either be secured by amending the School/Parental Agreement Form (Appendix 1) to include this permission or by using the specific consent form for use of the emergency inhaler (Appendix 6) which should be updated regularly, ideally annually, to take account of changes to a child's condition.

- Arranging for appropriate support and training for staff in the use of the emergency inhaler in line with this policy.

- Keeping a record of use of the inhaler (including when and where the attack took place, how much medication was given and by whom) and informing parents or carers that their child has used the emergency inhaler (this should be in writing so the parent can pass the information onto the child's GP – a sample letter is attached as Appendix 7)

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

Supply

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

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

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

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

The Emergency Kit

An emergency asthma inhaler kit should include:

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

Schools should consider keeping more than one emergency asthma kit, especially if they comprise several buildings, to ensure that all children within the school environment are close to such equipment. The Department of Health suggests a stock of five spacers would be adequate for a typical school.

Salbutamol

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild, temporary and not likely to cause serious harm. The child may feel a bit shaky or may tremble, or may say that they feel their heart is beating faster. The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential, therefore, that schools follow the advice previously given in relation to whom the emergency inhaler can be used by.

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

Storage and Care of the Inhaler

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

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

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

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

The two named volunteers should have responsibility for ensuring that:

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

Disposal

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

Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years. The hyperlink to enable schools to register is provided below:

https://www.gov.uk/waste-carrier-or-broker-registration

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

- If schools have an NCC recycling collection then the empty metal canister can be recycled via these bins, as the Council does permit empty aerosols to be added to its collections

- The plastic part of the inhaler should be placed into the rubbish bin, following which it will be sent with other waste to the 'energy from waste' plant

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

PE and Off-site Activities

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

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

Action During an Attack

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

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

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

Diabetes

What is Diabetes?

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

What Causes it?

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

Type 1 Diabetes

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

Type 2 Diabetes

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

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

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

What is the Treatment for the Condition?

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

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

It has become increasingly common for older children to be taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime and then insulin with breakfast, lunch and evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. The child is then responsible for administering injections and the regime to be followed would be detailed in the individual healthcare plan.

It is essential that children with diabetes make sure that their blood glucose levels remain stable. They may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs to be adjusted. The majority of older children will be able to undertake this task without assistance and will simply need a suitable place to do it. However, younger children may need adult supervision to carry out the test and/or interpret the results.

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

What Arrangements are in Place at our School?

Healthcare Plan

A healthcare plan will be needed for pupils with diabetes; a personalised risk assessment is also likely to be required due to complexities of management of the condition and the potential for pupils to be using sharps. Information on both documents is provided previously in this policy and in Appendix 3.

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. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. Members of staff need to be made aware that if a child should miss a meal or snack he/she could experience a hypoglycaemic episode (commonly known as a ‘hypo’) during which the blood glucose level falls too low. It is, therefore, important that staff should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. After strenuous activity a child may experience similar symptoms, in which case the teacher in charge of physical education or other sessions involving physical activity should be aware of the need to take appropriate action.

What are the Signs of a Hypoglycaemic Episode?

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

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

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

Emergency Action

If a child experiences a ‘hypo’, it is very important that he/she is not left alone and that a fast acting sugar, such as glucose tablets, 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

Hyperglycaemia

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

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

More immediate reasons for it include:

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

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

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

Epilepsy

What is Epilepsy?

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

What Causes it?

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

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

What are the Signs of the Condition?

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

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

Most seizures last for a few seconds or minutes, and stop of their own accord. In some cases, seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

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

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

What is the Treatment for the Condition?

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

What Arrangements are in Place at our School?

Healthcare Plan

An individual healthcare plan is needed when a pupil has epilepsy.

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

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

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

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

Emergency Action

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

An ambulance should be called during a convulsive seizure if:

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

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

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

Status Epilepticus

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

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

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

Emergency Medication

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

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

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

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

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

Administration of Buccal Midazolam and Rectal Diazepam

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

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

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

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

Dysphagia

What is Dysphagia?

Dysphagia refers to difficulties with eating, drinking and/or swallowing. Some people with dysphagia have problems swallowing certain foods or drinks, while others cannot swallow at all.

Dysphagia can result in, or contribute to, crucial negative health conditions including chest infections; choking; weight loss; malnutrition; and dehydration, sometimes with serious adverse clinical events. People who have dysphagia often have a reduced quality of life, increased morbidity, and increased mortality.

What causes it?

Dysphagia is usually caused by another health condition and can happen at any age. Common causes of dysphagia include:

- Cancer, such as mouth cancer or oesophageal cancer
- Cardiovascular disorders, e.g. congenital heart disease
- Congenital syndromes, e.g. Prader-Willi, Down’s syndrome
- Craniofacial conditions, e.g. cleft palate, Pierre Robin sequence
- Conditions that affect the nervous system or brain, such as cerebral palsy,
- Gastrointestinal difficulties, e.g. gastro-oesophageal reflux, oesophagitis, oesophageal atresia
- Having a learning disability
- Heartburn and acid reflux, especially in children or people who have gastro-oesophageal reflux disease
- Infectious diseases, e.g. meningitis
- Neurological differences, e.g. traumatic brain injury, Rett syndrome
- Neuromuscular disorders, e.g. muscular dystrophy, dysarthria
- Premature birth
- Respiratory difficulties e.g. structural abnormalities of the upper respiratory tract, tracheostomy

- Some medicines, such as antipsychotics

What are the signs of the condition?

The child may present with some of the following:

- Coughing or choking when eating or drinking
- Bringing food back up, sometimes through the nose
- Complaining of a feeling that food is stuck in the throat or chest
- A gurgly, wet-sounding voice when eating or drinking
- Poor oral control, i.e. food or drink falling out of the mouth and problems chewing food
- Over time, dysphagia can also cause symptoms such as weight loss, dehydration and repeated chest infections

What is the treatment for the condition?

Speech and language therapists have a unique HCPC recognised and registered role in identifying and managing oropharyngeal dysphagia. The child needs a referral to the NHS Speech and Language Therapy Department for an assessment of eating and drinking. Treatment for dysphagia depends on the cause and severity. Treatment for children in school often include:

- Modifications to the child's food and/or fluid intake to ensure the child's safety when swallowing. This may include prescribing thickened drinks; modified diets, e.g. pureed, mashed; and behavioural strategies, such as pacing, for the child.

- Multi-disciplinary team working with parents/carers, school staff, school nurse, dietician, paediatrician, physiotherapists, and occupational therapists to optimise nutrition, hydration, positioning and independence.

- Oral motor/sensory exercises, swallow techniques and positioning, where possible.

- In some cases, children may require non-oral feeding, such as, Nasogastric (NG) tubes, or Percutaneous endoscopic gastrostomy (PEG), where nutrition can be delivered safely to the stomach, bypassing the swallow.

It is recognised that prompt intervention in the management of dysphagia can prevent costly and life-threatening complications.

What arrangements are in place at our school?

Healthcare plan

An individual healthcare plan is needed when a pupil has dysphagia.

Parents and NHS Speech and Language Therapists should provide the child's feeding care plan to the Class Lead so that it can be incorporated into the individual healthcare plan, detailing the specific food, drink, equipment, position, assistance and environment that the child needs to manage their dysphagia.

If a child experiences a choking incident whilst at school, details should be recorded and communicated to parents by the usual method. The NHS Speech and Language Therapists should also be informed.

Children with dysphagia should be included in all activities. Extra care may be needed in activities that involve food or liquids. Class and/or Phase Leads should discuss any safety issues with the child and parents as part of the Healthcare Plan, and these concerns should be communicated to members of staff.

Feeding diary

All pupils with Dysphagia and a Healthcare Plan will have a feeding diary. Staff will record all food, drink and thickening agents fed to the pupil in this diary.

Training

All school staff complete Dysphagia Awareness training annually.

All teaching staff who may be present when a pupil with Dysphagia eats/drinks completes additional Dysphagia training, as appropriate.

Unacceptable Practice

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

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

- prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary

- assume that every child with the same condition requires the same treatment

- ignore the views of the child or their parents; or ignore medical evidence or opinion (although this may be challenged)

- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans

- if the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable

- penalise children for their attendance record if their absences are related to their medical condition, such as hospital appointments

- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively

- require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including assisting with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs

- prevent children from participating, or create unnecessary barriers which would hinder their participation in any aspect of school life, including school trips by, for example, requiring parents to accompany the child

Complaints

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

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

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Appendices