



## **The Edith Borthwick School**

# **POLICY FOR ADMINISTRATION OF PRESCRIBED MEDICINES AND DEALING WITH HEAD INJURY; AND GUIDELINES FOR BASIC HYGIENE PROCEDURES**

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This document supersedes the  
Guidelines on Administration of Medicines to Pupils  
and Procedures for Dealing with Certain Medical Conditions  
(dated JULY 1996)

Please destroy previous copies of this document

This Code of Practice has been revised to include additional advice on certain medical conditions e.g. 'Attention Deficit Syndrome' not contained in the previous code. Additionally, more detailed advice is provided on technique for administration, disposal of clinical waste etc.

The Learning Services Directorate would like to record its thanks to the County Health & Safety Unit for its assistance in producing this document.

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## **Introduction**

Most pupils will need medication at some time in their school life. Although this will mainly be for short periods (e.g. to finish a course of antibiotics), there are a number of pupils, with chronic conditions, who may need regular medication throughout their school life. It is often possible for parents to arrange for medication to be taken outside school hours; however, there will be circumstances when it will be necessary for children attending school to be given medication during the school day. Whilst the administration of prescribed medicines by staff in an educational establishment is a matter within the discretion of the Head of Establishment, it should be recognised that some children would be unable to attend the establishment unless medication was made available during school hours.

For certain chronic or life-threatening medical conditions, Health Authorities, through the Community Paediatricians, will provide advice, support and training for schools, to enable the pupil to participate fully in normal school life, with minimal risk to their health.

Parents are responsible for providing the school with full information about a child's medical needs, both before the child begins school and if a condition develops whilst the child is attending school. Staff should also report concerns they may have about a pupil's health to the Headteacher, so that the parent can be informed.

### **1. Confidentiality**

Schools should not disclose details about a pupil's medical condition without the consent of the parents and pupil him/herself. Where parents, or the pupil, decide not to disclose details of medical conditions they should be encouraged to indicate if there are certain aspects of school activity that should not be undertaken such as Design and Technology, Physical Education etc. Whether and how much other pupils should know about a pupil's medical condition is not a matter for the school to decide. It can be helpful, both educationally and emotionally, for other pupils to be aware of a child's medical condition, and classmates can be very supportive. However, pupils with medical conditions can be subject to teasing and bullying, and knowledge of the condition may lead to a child being singled out as different. The organisations which provide advice and support for certain medical conditions, listed in Appendix II, may provide teaching packs for classroom use.

### **2. Administration of Medication to Pupils: Duty of Care and Assessment of Risk**

If the School Policy is to administer medication, there is a legal requirement to exercise reasonable care to avoid injury. Headteachers are often concerned about the legal implications of agreeing to administer medication. However, in such circumstances they would be considered to be discharging their in 'loco parentis' duty of care (i.e. the degree of care exercised would be as great as that taken by the average careful parent in the same circumstances). Provided the administration of medication is controlled, for instance by following this Code of Practice, the risk of injury will be minimised and the member of staff administering medication may therefore be considered to have exercised reasonable care.

Some pupils may suffer from rare conditions such as Cystic Fibrosis, Diabetes, or Anaphylaxis (i.e. severe allergic reaction e.g. to certain foods such as peanuts or to

insect stings). In some cases, the pupil may require the administration of life saving medication in an emergency. Schools are often concerned about this, particularly where medication may need to be administered by injection or invasive routes. Whilst schools have a right to refuse to administer medication in such circumstances, it should be borne in mind that other arrangements would have to be made for this medication to be administered.

**Whilst there are risks when administering medication, with adequate training this should be minimal in comparison with the risk to the child if medication is not given, or is delayed in a life threatening situation.**

Liability should something go wrong will only arise where there has been negligence (i.e. a failure to exercise reasonable care). In such cases it would be the employer (County Council in Community and Voluntary Controlled Schools; Governing Body in Foundation and Voluntary Aided Schools) who would be vicariously liable for any claim arising out of the negligence of an employee. In addition, in LEA schools the County Council has agreed to meet the cost of any claims in the unlikely event of an action for negligence being taken against an individual employee.

If schools are asked to accept a child who has a rare chronic or life threatening condition, they must be provided with all necessary information on how the condition can be managed within the School. This must be provided by the Parents/Guardian and will include advice etc. from the pupil's GP and/or Community Paediatrician Consultant as relevant.

It will be necessary to develop a protocol (written statement defining the management of the pupil), with the assistance of the Community Paediatrician, parent and GP. The protocol should be child specific and detail:

- Procedures to be followed in an emergency;
- Medication (Full drug name and dosage instructions);
- Day to day and food management (where relevant);
- Precautionary measures;
- Staff training;
- Consent and agreement.

It is important that staff required to administer medication by injection (e.g. adrenaline) or invasive routes (e.g. rectal diazepam) receive adequate training and that refresher training is arranged periodically. It will be necessary for several members of staff to undergo training, to ensure cover for absences. This can normally be arranged via the School Nurse. Where administration is by an invasive route the School should try to ensure, where possible, that staff of both genders receive training or are present during administration. It is recommended that a record of training received be kept by the School.

All staff likely to come into contact with a pupil who has a condition which may require urgent medical attention should receive sufficient information and/or awareness training, to enable them to recognise symptoms of the condition and take appropriate

action in the event of an emergency. A list of organisations providing general information on the conditions referred to in this Code is available in Appendix II. It may be possible to arrange awareness training through the school doctor or nurse.

In developing emergency procedures there is a need to ensure that:

- all staff (including midday assistants) are aware of how to contact those employees trained to administer medication in an emergency;
- medication is readily accessible to staff (but out of reach of pupils);
- the member of staff responsible for calling an ambulance informs the emergency service of the condition and requests a paramedic.

### **3. When it may be Necessary to Administer Medication to School Pupils**

The following pupils may require medication whilst at school:-

- a) those who have suffered an acute medical condition but are regarded by a doctor as fit to return to school provided a prescribed medicine is taken;
- b) those who suffer certain chronic or life-threatening conditions (e.g. anaphylaxis, cystic fibrosis, asthma, diabetes, attention deficit disorder) but can satisfactorily attend school provided they are given a regular dose of medicine, or medication is available in an emergency;
- c) those pupils who suffer occasional discomfort such as tooth ache or period pain who may require analgesics (i.e. pain relievers).

It may also be necessary to administer medication to pupils whilst on school trips. The advice in this Code and Code of Practice No. 28: Educational, Adventurous and Recreational Visits will cover these circumstances. In general, pupils with medical conditions should not be excluded from school trips unless there are sound medical or health and safety reasons.

### **4. Guidelines for the Administration of Prescribed Medication**

- 4.1** Where possible parents should be encouraged to ask the GP to prescribe medication in dose frequencies which enable it to be taken outside school hours. Pharmacists should be asked to provide medication in separate containers (i.e. one for school use only) or it may be necessary for parents to request a separate prescription from the GP for medicines to be used in school. This should be communicated to parents so that their responsibilities are clear.
- 4.2** Parents (or Guardians) must inform the Headteacher in writing of any medication required to be taken by their child whilst on school premises (whether or not the School has agreed to administer the medication). See Appendix I - ADMED 2. A copy of ADMED 2 is retained with the class teacher and Sharon Clark – First Aid Co-ordinator.
- 4.3** If parents wish the School to administer the medication in loco parentis, they should give the Headteacher a written request detailing the medication to be

given along with the frequency, dosage and any other relevant information obtained from healthcare professionals (e.g. interaction with other medicines such as paracetamol). Oral information from the pupil or parent should not be acted upon. (An example of a request form is given in Appendix I)

**4.4** In complex cases the parent should be encouraged to visit the establishment during the day to administer medication in person. However, this is not always possible and can lead to the child being singled out as 'different' by his/her peers.

**4.5** The medicine should be packed and labelled professionally (with the patient information leaflet included). Where possible, not more than one week's supply should be sent at one time. The pharmacist's original container is suitable but would not necessarily refer to the timing of administration nor the expiry date. Ensure the container is clearly labelled with:

- the child's name;
- the name of the medicine;
- the method, dosage and timing of administration (e.g. Lunch – between 12:00 – 13:00);
- directions for use;
- the date of issue;
- the expiry date (if known);
- the length of treatment or stop date, where appropriate.

The medicine should have been dispensed in the last three months.

Details of possible side effects should also be given. Parents must also complete ADMED 2 of this Code of Practice.

The School must maintain records of all medicines received and returned to parents.

**4.6** It is important that an up-to-date record of the parents home and work telephone numbers be kept so that they can be contacted at any time.

**4.7** Medicines must be kept in a safe place and at correct temperature, under lock and key, separate from the first aid box. However, bronchodilators and medication needed in an emergency should be readily accessible to staff i.e. in the classroom but out of reach of children. Where necessary, it is acceptable to store medication in a refrigerator containing food, provided it is kept in a clearly labelled, airtight container. Pupil access to refrigerators containing medication must be prevented.

**4.8** Medicines for external use must be kept separate from those for internal use.

**4.9** A daily record of each dose given must be kept to avoid overdose.

The record should be signed with:

- Name of Child;
- Name of Medication;
- Dosage Administered;



- Time the medication was given.

(An example of a record form is given in ADMED 3).

- 4.10** A duplicate key to the medicine store must be available in case of emergencies.
- 4.11** Medicines no longer required must be handed back to the parent. Where possible, parents should collect medication from the School on a daily basis.
- 4.12** Should there be any doubts over the administration or storage of particular medicines, or the treatment of specific pupils, advice should be sought from the school nurse, parent, the child's GP, a community paediatrician, local pharmacist or the local community services pharmacist. (A list of local community services pharmacists and community paediatricians are given in Appendix II).
- 4.13** Schools may wish to include a summary of this Code of Practice in information documents available to parents e.g. the school prospectus.
- 4.14** The school nurse is able to give up to date advice on the management of medical conditions. The administration of medicines log book should be made available when they visit the school, so that they can offer appropriate advice if necessary. Alternatively, advice can be sought from the community paediatrician. (A list of local community paediatricians can be found in Appendix II).

## **5. Guidelines for the Administration of Paracetamol / Analgesics**

### **Primary**

The administration of non-prescribed paracetamol to primary school pupils should only be necessary in exceptional circumstances, for instance where they suffer regularly from acute pain, such as migraine. On such occasions the parent must authorise and supply the paracetamol, with written instructions on when the medication should be administered.

### **Secondary**

Under certain conditions paracetamol can be administered to secondary aged pupils who suffer discomforts such as tooth ache or period pain. It is not reasonable in such circumstances to expect them to suffer unnecessary pain or to be sent home in the middle of the day with the resulting loss of education. There is also a risk that if paracetamol is not administered in a controlled manner, pupils may bring bottles of tablets into school and dispense them freely amongst their friends. If it is decided that paracetamol can be administered to pupils, parents should be made aware that this may happen and provision is made for those parents who would prefer medication not to be given to be contacted instead. Pupils should not be permitted to bring paracetamol into school unless this has been agreed with the School.

The following guidelines should be followed when administering paracetamol.

- 5.1 Paracetamol is the only analgesic which may be provided at school.
- 5.2 Parents should be advised that paracetamol may be administered and asked to confirm in writing that they have no objection to such treatment being given and that their child does not have a known allergy to paracetamol.  
**Paracetamol must not be given unless written permission has been obtained first.**
- 5.3 On no account should aspirins or preparations containing aspirin be given to pupils. This is particularly important where children are under the age of 12. The only exception to this will occur when the product has been prescribed by a doctor and in such cases the procedures in Section 4 will apply.
- 5.4 Standard paracetamol tablets designed for adults may be given to pupils aged 12 years and over (subject to the child's physical maturity) at the specified adult dosage and not repeated within four hours. Ensure that the child has not taken paracetamol or preparations containing paracetamol (e.g. cold remedies) within the previous twenty four hours. Advice in cases of doubt should be sought from the parent or local community services pharmacist in emergency situations. (A list of community services pharmacists can be found in Appendix II).
- 5.5 Paracetamol may not be given to any pupil known to be receiving other medication from a general practitioner without first checking with the parent, GP or a pharmacist to ensure that there are no adverse health effects from their interaction.
- 5.6 Paracetamol should only be administered to a pupil by members of staff specifically authorised to do so by the Headteacher. Authorised members of staff must keep a simple record of issue which should include the name of child, dosage, time and date given and brief reason. A check should be kept in the log to ensure that the same pupil is not regularly taking tablets. Parents should be informed, preferably in writing, that analgesics have been administered, and of the time and dose given.
- 5.7 Paracetamol must be kept secure. The keeping of paracetamol or other tablets in first aid boxes, or any place readily accessible to pupils, is expressly forbidden.
- 5.8 If a pupil is found to be frequently requesting analgesics it may be an indication of an underlying ill health problem. In such cases the School should consult the pupil's parents.
- 5.9 The risks associated with taking paracetamol are considered to be less than with other types of analgesics. However excessive dosage can lead to liver damage. Provided paracetamol is administered according to the above guidelines the risk of overdose is minimal. Schools may wish to purchase paracetamol preparations containing substances which prevent liver damage in the event of overdose (e.g. Pameton, Paradote). However such preparations should not be necessary if this guidance is adhered to.
- 5.10 Check that the foil or packaging is not broken if tablets are packaged separately.

## **Children aged 11 or 12**

A maximum of one 500mg tablet may be given no more frequently than every four hours. It may be appropriate to administer  $\frac{1}{2}$  a tablet for some younger or smaller children. No more than four tablets may be administered in any twenty-four-hour period. **Check whether the child has been given paracetamol at home within the last twenty-four hours.**

## **Children aged 13 or over**

A maximum of two 500mg tablets may be given no more frequently than every four hours. No more than eight tablets may be administered in any twenty-four-hour period. **Check whether the child has been given paracetamol at home within the last twenty-four hours.**

Immediate medical advice should be sought in the event of an overdose, even if the child feels well, because of the risk of delayed serious liver damage.

## **6. Techniques**

With all medication:

- Check logbook to ensure that medication has not already been administered.
- Wash hands before and after administration.
- Check correct medication for the child has been selected.
- Check the medication is being administered at the correct time and at the appropriate time in relation to meals.

### **6.1 Oral**

- Tablets

The number of tablets should be tipped into the lid of the container and handed to the pupil. A glass of water should be available to ease swallowing unless the instruction for the medication indicates otherwise. Record details in the log book. Wherever possible tablets should not be touched. The member of staff administering the tablets should assure themselves that the tablet(s) have been swallowed.

Follow the specific instructions for the type of tablets i.e. chew, store under tongue.

- Liquid

The medicine should be measured out using a 5ml medicine spoon or the spoon, cup or syringe provided by the parent.

## **6.2 Topical**

Disposable gloves should be worn by the member of staff administering topical medications. The instructions with the medicine should be followed e.g. spread thinly. The parent should clearly indicate the area of skin to be treated. When selecting disposable gloves for the application of topical medication, non-powdered latex gloves should be selected. If there are either staff or pupils who have known latex allergy then either vinyl or PVC gloves must be selected.

## **6.3 Eye Drops**

Reference should be made to the instructions accompanying the medication, alternatively the following guidelines should be followed.

The pupil should be seated or lying with their head tilted backwards and chin pointing upwards. The dropper must not touch the pupils eye or eyelids to prevent cross infection. The pupil should be asked to look upwards immediately before instilling the drop. The drops should be dropped into the lower eyelid which should be held away from the eye, unless the directions indicate otherwise, which can sometimes be the case. The number of drops (dosage) should be indicated by the parent and be on the packaging. The pupil should be encouraged to close their eye afterwards to distribute the drops over the eye. The parents should clearly indicate which eye is to be treated and if both eyes, which eye is to be treated first.

Ointments should also be applied to the inner part of the lower eye lid from the nasal corner outwards. A 2 cm line should be applied, unless indicated otherwise. The pupil should then close their eye, wait until any blurring of vision has cleared before allowing the pupil to return to class or play.

## **6.4 Ear Drops**

Reference should be made to the instructions accompanying the medication, alternatively the following guidelines should be followed.

If facilities exist, the pupil should lie on their side with the ear to be treated uppermost otherwise the head should be reclined at an angle so the ear to be treated is facing upwards. Warm drops to body temperature if instructions allow this. Hold the ear backwards and upwards whilst administering the drops from the dropper provided into the ear canal. The parents should clearly indicate which ear is to be treated. The pupil should stay in this position for 1 or 2 minutes after administration of the drops.

## **6.5 Injection**

There are different types of injection, dependent on the medication to be administered. There are also different injection sites. All staff who volunteer to administer injections must have received training and refresher training (consult the school nurse for advice on frequency of this training) in the specific injection type and site. In order to ensure the safety of the pupil and member of staff, the following principles apply:

- Work in a clean environment where possible;
- Talk quietly and confidently to the pupil;
- Keep all equipment needed in a clean container;
- Ensure that all packaging of sterile equipment is intact;
- Ensure sharps container is within reach for immediate and direct disposal of used needle and syringe;
- Wash hands;
- Clean injection site;
- Keep hands away from injection site;
- Never re-sheath a needle;
- Dispose of whole needle and syringe together into sharps container;
- Never try to catch a falling needle;
- Keep a record of medication administered, dosage, date and time administered, as well as site of the injection.

## **7. Disposal of Clinical Waste**

### **7.1 Clinical Waste**

Any waste which contains or is contaminated with human blood, body fluids or excreta is defined as clinical waste. Its safe disposal is necessary to protect staff and others who may come into contact with it against the risk of infection, to prevent contamination of the environment and to ensure compliance with the Environmental Protection Act. The Environmental Protection Act places a duty of care on waste producers to ensure that it is disposed of properly. The appropriate means of disposal for clinical waste will depend on the level of risk (e.g. waste contaminated with blood would be at greater risk than incontinence waste) and the amount produced.

### **7.2 Incontinence Pads and Nappies**

The risk of infection from incontinence pads and nappies will be low, although they are offensive in nature. In some establishments a large quantity is likely to be produced. In such cases they should be disposed of via a licensed contractor (either by incineration or smaller amounts can be disposed of via landfill).

### **7.3 Medical Dressings/First Aid**

If regular large quantities of medical dressings and first aid waste are produced it should be disposed of by incineration via a licensed contractor. Very small amounts of first aid waste which are produced irregularly may be double wrapped and disposed through the normal waste unless it is known to be from an individual with a higher risk of infection.

### **7.4 Syringes**

Syringes and needles may harbour infections which can be passed to the handler via puncture wounds. Generally syringes will only be used by health care professionals who would be responsible for disposal. If needles are used or found on a regular basis it is necessary to place them in a Sharp's container (complying with BS 7320) which should be sealed when three

quarters full and disposed of by incinerator via a licensed contractor. It is possible to buy Sharp's containers for small numbers of syringes where necessary. Sharp's containers must not be placed in the normal refuse.

## **7.5 Safe Disposal**

Where it is necessary to dispose of clinical waste via a licensed contractor this can be arranged through the Commercial Services Directorate. Generally clinical waste is disposed of through purpose built waste containers, provided by the contractors, or yellow clinical waste sacks (clinical waste which is suitable for landfill may be disposed of in yellow bags with black stripes). It is important that yellow or yellow/black striped bags are not placed in the normal refuse. It is also important that members of staff handling clinical waste follow hygiene precautions.

## **8. Dealing with Certain Medical Conditions**

### **8.1 Anaphylaxis**

Anaphylaxis is an acute allergic reaction to foreign substances (allergies) in various forms. They can occur following exposure by ingestion, inhalation or injection and require urgent medical attention. The most common allergens are foods, especially nuts (e.g. peanuts), eggs, cows milk and shellfish. Other triggers may include certain medicines (e.g. Penicillin) and insect stings (e.g. from bees, wasps or hornets). In its most severe form it is life threatening, however incidents of this kind are **very** rare and prompt treatment is effective.

Typical symptoms of anaphylactic shock are:

- The child complaining of feeling unwell;
- restlessness, itching or a "metallic" taste in the mouth;
- swollen lips, throat and tongue, difficulty in swallowing;
- a change in voice;
- struggling for breath;
- a change in face colour;
- generalised flushing of the skin;
- itchy red or white patches on the skin;
- sudden feeling of weakness or floppiness;
- collapse and unconsciousness.

(NB A child with a known history of the condition may have his/her own description of symptoms).

#### **8.1.1 Prediction of children 'at risk' and Preparation for response to an anaphylactic reaction**

If a child is known to have had a severe (anaphylactic) reaction to any substance(s) this should be documented in the school medical records. All staff should be made aware of 'at risk' children in school. Anaphylaxis may occur in a child not thought to be 'at risk'.

A child 'at risk' may be wearing a medical alert bracelet, disc or necklace stating the allergy from which the child suffers and possibly any relevant medication the child may require.

All members of staff should be made aware of the location of such medication and those agreeing to administer must receive prior training so that they feel confident to do so (the school nurse will be able to assist with or provide training).

### 8.1.2 Treatment

**NOTE: Adrenaline is also known as EPINEPHRINE or ANAPEN**

Treatment may include oral antihistamines or adrenaline injection. Injection in the event of an emergency can normally be administered by use of an EpiPen, which gives a pre-measured dose of adrenaline. Administration of adrenaline if the child is not suffering from anaphylactic shock will not cause any adverse reaction in the child. It is far better to administer the adrenaline than to leave administration of adrenaline to a stage where the anaphylaxis had progressed too far.

1. **NEVER** leave the child alone.
2. Try to stay calm and reassure the child all the time.

**RAPIDLY WORSENING SYMPTOMS SHOULD BE TREATED WITH INJECTED ADRENALINE** (see pupil's 'Care Plan' and individual protocol)

1. Give the injectable dose of adrenaline as described in the child's individual protocol.
2. Dial 999 ask for Ambulance Service and state that the patient is in anaphylactic shock.
3. On large sites, it may be advisable to send someone to the school entrance to direct the ambulance to the patient.
4. Check to see if the child is breathing (look for rise and fall of the chest. Listen for breathing sounds).
5. If the child stops breathing, their heart stops beating and they become unconscious, you need to start immediate resuscitation.
  - Start cardiac massage (CPR) one breath to five chest compressions.
  - If there is no improvement in the child's condition, if available a further dose of adrenaline can be given, by which time professional help should have arrived.

See ADMED 4 for a flowchart of steps to be taken in response to anaphylactic reaction.

An individual protocol document should be drawn up (preferably in liaison with the pupil's parent or guardian) so that there are clear written procedures for managing the condition (see ADMED 4). If further advice on this is required, please contact the Learning Services Directorate, Health and Safety Services Manager at County Hall (Tel. No. 01245 436896)

The Anaphylaxis Campaign, whose address is given in Appendix II, can provide further general information on the condition, including a free pack for schools.

## **8.2 Diabetes**

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high or too low because the body is unable to use it properly. People with diabetes have lost the ability to produce insulin (the hormone which controls blood glucose levels) as the cells in the pancreas, which produce it, have been destroyed. Without insulin the body cannot store glucose and so the blood glucose level rises and excess glucose leaks into the urine. Fat is also broken down to replace glucose as the body's energy source. Symptoms of undiagnosed diabetes include weight loss, thirst, tiredness and an increased need to pass urine.

Diabetes cannot be cured, but can be treated effectively with regular insulin and/or an appropriate diet. The aim is to keep blood glucose levels close to normal and so prevent hyperglycaemia (too high levels) or hypoglycaemia (too low levels). A child with diabetes is taught from an early age how to administer their own insulin injection. Usually a child will need two insulin injections a day and so will not need an injection at school: however some children may need to administer an additional injection at lunch times. The diabetic diet is based on starchy foods. Generally it will be low in sugar and fat and high in fibre. Diabetic children need to eat at regular times of the day and to have snacks between meals. Children with diabetes may also need to carry out occasional blood tests to monitor their blood glucose level. On very rare occasions a child may have an insulin pump fitted which will require detailed instructions on use from the Parent or Guardian. An insulin pump does not require the use of needles and syringes.

The greatest risk to a child with diabetes is hypoglycaemia (low blood glucose). This may be caused by a missed or delayed meal or snack, extra exercise or too much insulin. Hypoglycaemia may also occur more frequently in very hot or very cold weather. Each child's symptoms will differ, but may include:

- Hunger;
- Sweating;
- Drowsiness;
- Pallor;
- Glazed eyes;
- Shaking;
- Mood changes;
- Lack of concentration.



Treatment is by immediately giving the child fast acting sugars such as chocolate, sugary drinks, fruit juices, honey or jam, or glucose tablets or gels ( Known as Hypo - stop). When the child has recovered (which usually takes 10 to 15 minutes) he/she should be given slower acting starchy food (e.g. sandwiches, milk, biscuits). On rare occasions unconsciousness may result if the child is not given fast acting sugars promptly. If this occurs the child should be put into the recovery position and an ambulance called. Sugary materials such as jam, honey or Hypo - stop can also be rubbed into the inside of the cheek. The child will fully recover with medical assistance.

Further information, including free school packs, can be obtained from the British Diabetic Association, whose address is given in Appendix II.

### **8.3 Cystic Fibrosis**

Cystic Fibrosis is an inherited condition that affects the glands which secrete body fluids, damaging many organs, including the lungs, pancreas, digestive tract and reproductive system. It causes thick, sticky mucus to be produced, which clogs the respiratory tract and also prevents the body's natural enzymes from digesting food. People with cystic fibrosis are therefore prone to chest infections and malnutrition.

In the past babies born with the condition were only likely to survive a few months. However improved diagnosis and treatment has lead to an increasing number of people with cystic fibrosis surviving to adolescence and adulthood.

Treatment includes a combination of:

- Physiotherapy to prevent the build up of mucus in the lungs. Children with the condition are encouraged to take responsibility for their own physiotherapy and breathing exercises from an early age.
- Regular exercise to maintain fitness.
- Inhaled medication and antibiotics to control chest infections.
- High energy foods and enzyme supplements to combat digestive problems.

Further information, including a guidance booklet for schools and educational videos, can be obtained from the Cystic Fibrosis Trust, whose address is given in Appendix II.

### **8.4 Attention Deficit Syndrome (ADS)**

Attention Deficit Disorder (A.D.D) (with or without hyperactivity) is a neurological condition (possibly genetic in origin). The sufferer has a very reduced ability to maintain attention without distraction; control of doing or saying something due to impulsiveness and lack of appropriate forethought. The sufferer also has the reduced ability to control the amount of physical activity appropriate to the situation (where hyperactivity is also present).

Some symptoms of A.D.D. include:

- Inattention

Many sights, sounds, memories and other stimulation's compete for a child's attention at the same time. This makes the child easily distracted, flit from one thing to another and forget instructions. Some are distant and dreamy at times, making them look spaced out. One to one supervision of the child works well, but it must be remembered that the child has a poor short-term memory.

- Impulsiveness

The child may speak or act without thinking, at times inappropriately and may have a short fuse, leading to temper tantrums.

- Over-activity

The child can be restless and fidgety, constantly tapping their foot or fiddling with their fingers.

- Insatiability

Never satisfied. The child appears to go on and on about a certain subject. Can seem as if they are interrogating and generally tries to intrude or take over conversation. This can cause enormous tension.

- Social Clumsiness

The child never seems to 'fit in' with their peer group and can act silly in a group. They can be overpowering and bossy wanting to be the centre of attention, whatever the cost.

- Poor Co-ordination

The child may be clumsy and appear awkward in their movements. They have difficulty doing two actions at the same time and will probably produce untidy written work.

- Disorganisation

Blind to mess and oblivious to organisation. The child can have problems structuring school work and find homework/projects difficult to start.

- Volatility

The child can have severe mood swings and be very volatile. They can have good and bad days with no real explanation.

- Specific Learning Difficulties

Although most children appear to have a high I.Q. most will have learning difficulties due to their poor attention span. Many however, do appear to have a combination of A.D.D. and a more specific learning difficulty, for example, Dyslexia or a language problem.

The A.D.D. child may also suffer from asthma, eczema or ear, nose and throat (ENT) problems, all of which may be exacerbated by stress.

### **Side effects of Ritalin and other medication prescribed for A.D.D.**

When these medications are first administered side effects, such as nervousness, restlessness and insomnia, are common. The performance of skilled tasks may be affected. It is suggested that staff restrict pupils' use of machinery within Design and Technology during the first week of treatment. During this period side effects should become apparent. Any effects which increase the risk of injury when using machinery should be noted and regular assessments undertaken to determine when it is safe for the pupil to use the machinery.

## **8.5 'Blood-Borne' Diseases**

Blood-borne diseases need to enter directly into the bloodstream and are normally prevented from doing so by an intact skin barrier. They enter through cuts or other skin wounds and through mucous membranes (the covering of eyes, mouth and genitalia). These infections include Hepatitis B & C and HIV (Human Immunodeficiency Virus).

The route of transmission of the infection is an important consideration in the risk assessment; if it is not present via broken skin etc., there will only be a negligible risk.

If the risk from exposure to blood and body fluids at work cannot be satisfactorily controlled by safe work practices and protective clothing, employees should be encouraged to receive Hepatitis B immunisation. NB. The cost incurred should be met from delegated budgets.

The staff most likely to require immunisation are those who:

- a) regularly work with blood and body fluids where there is a risk of contamination of eyes, skin or significant risk of sharps injury;
- b) regularly work with pupils/clients who bite or who cause other injuries where infected blood could contaminate wounds.

The following body fluids are not considered to present a risk of infection unless contaminated with blood:

- Urine
- Faeces
- Saliva
- Sweat

- Vomit

There is a risk of exposure to blood borne viruses at work if:

- a) a sharps injury or other injury takes place with a contaminated needle or other sharp object;
- b) blood or high risk body fluids contaminate an open wound, the eyes, nose or the mouth;
- c) human bites occur and blood is drawn.

The greatest risk is from a sharps injury, but only if the source person is carrying a blood borne infection. There will not be a risk in every day contact such as touching, sharing utensils or from coughs and sneezes.

### **Control Measures**

- Use good basic hygiene practices including hand washing and avoiding hand to mouth/eye etc. contact.
- Wear vinyl or latex gloves (but not thin polythene) and a disposable apron. Where staff or pupils are known or suspected of having a latex allergy, vinyl gloves must be worn. In any case latex gloves purchased must be un-powdered and low protein.
- Prevent puncture wounds, cuts, abrasions in the presence of blood and body fluids.
- Protect all breaks in exposed skin by means of waterproof dressings and impervious gloves.
- Control surface contamination by blood and bodily fluids by containment and appropriate decontamination procedures.
- Dispose of all contaminated waste safely.

Immunisation should be considered if the above control measures do not control the risks identified. It is recommended that staff who regularly (at least once a month) are exposed to biting incidents where the skin is broken receive Hepatitis B immunisation from their own GP. The School is responsible for reimbursing the cost of this from the school budget.

### **Emergency Procedures**

In the event of a sharps injury or bite involving blood or body fluids or other significant contamination, the following action should be taken without delay:

- wash with soap and running water;
- encourage bleeding if the skin has been broken;

- wash out splashes in the eye preferably using eye wash from a fresh eye wash bottle (alternatively use tap water) or nose or mouth with copious amounts of tap water;
- cover with a waterproof dressing;
- record source of contamination (name/type of injury);
- report the incident to your Supervisor or Line Manager or other person responsible for health and safety at work;
- contact your GP immediately for advice or go straight to local A & E Department, noting the time of the sharps injury or bite.

## **8.6 Asthma**

Asthma is a common cause of ill health among school children, particularly of primary school age. It is a disorder of the lungs in which the air passages become sensitive to a variety of common stimuli and become narrowed making it difficult to breathe. This may occur as a sudden acute attack, or lesser, more persistent narrowing may lead to chronic, less dramatic symptoms.

A variety of stimuli may induce an asthma attack including:

- Virus infections;
- Allergy (e.g. to dust, feathers, fur or, in rare cases certain foods);
- Exercise;
- Cold weather or strong winds;
- Excitement or prolonged laughing.

Asthmatic children vary in the extent to which they are affected and most cases are mild and easily controlled. The majority of children will be able to participate fully in the school curriculum including sports activities. It may be necessary to take specific precautions for children whose asthma is triggered by particular allergens (e.g. by keeping them away from school pets or flowering grasses).

### **8.6.1 Asthma Register**

General Practitioners (GPs) recommend that the School maintains a central asthma register for the pupils concerned.

### **8.6.2 Medication for Asthma**

Children with asthma may need to take medication during school hours. If it is not taken regularly or properly severe asthma may develop. Two types of asthma treatment may be prescribed:

- a) Treatments which give immediate relief. These are called bronchodilators. These should be readily available for the child to use whenever he/she needs to relieve asthma symptoms of coughing, wheezing or breathlessness. Examples of bronchodilators are Bricanyl and Ventolin.
- b) Preventative treatments. These are taken regularly to damp down the sensitivity of the air passages. They must be taken regularly every day to get the best results and should not be used to relieve sudden attacks of wheezing and breathlessness as they do not have an immediate effect. It is unlikely that schools would need to keep preventative inhalers in school as administration of this medication can usually take place at home.

Treatment is usually given in the form of an inhaler. If the inhaler is used incorrectly it may spray into the surrounding air rather than into the lungs. However asthmatic children would normally have spent many hours learning to use the inhaler properly. It is important that they should have access to their medication, particularly bronchodilators. They should be kept in the classroom or, pupils considered capable by their GP or the School Nurse, should carry their own inhaler. If available a spare, unused, bronchodilator for each child should be kept in case the first one runs out during or before use.

### **8.6.3 Spacers**

A spacer is a large plastic container, which usually comes in two halves that click together. At one end is a mouthpiece containing a valve and at the other end a hole that fits the aerosol inhaler. Spacers help pupils take their asthma medication more effectively. They trap the medication and keep it in suspension until the pupil is ready to breathe in the treatment.

Spacers reduce the problems of co-ordination because pupils do not have to activate the inhaler and breathe in at the same time. They also help to get more medication into the lungs and consequently reduce the chance of side effects.

Spacers are especially useful when asthma is bad and it is more difficult to breathe in fully. Children under five are more likely to need to use a spacer with an aerosol inhaler. There are several types of spacers which are compatible with different makes of inhalers.

### **8.6.4 School Games**

The aim of total normal activity should be the goal for all but the most severely afflicted asthmatic children. Nearly all asthmatic children become wheezy during games. The following conditions in particular may induce an asthma attack:

- prolonged spells of exercise;
- exercise on cold dry days;
- exercise which uses both the arms and legs at the same time.

Teachers should consider these in deciding the most suitable form of exercise. For instance it may be possible to allow a child to play a less active position in a team game. Swimming is an excellent form of exercise for asthmatic children and seldom provokes an attack unless the water is cold or heavily chlorinated. Most exercise induced asthma can be prevented if the child takes a dose of bronchodilator beforehand. Warm up exercises before strenuous games are also helpful. Prescribed bronchodilator inhalers should be available at the site where the pupil will be playing school games.

### **8.6.5 Treatment of Asthmatic Pupils**

The following guidelines give a basis for the appropriate treatment of asthmatic pupils.

- 1 Talk to the parents to find out about the child's asthma. In particular ascertain whether it is triggered by specific allergens, what treatment the child is taking and the extent to which the child may require help when taking medication. Ask them to provide these details in writing. If the child has severe asthma it may be helpful to consult the school nurse or doctor or the child's GP.
- 2 Staff who come into contact with an asthmatic child should be made aware of the problem and any restrictions which may need to be applied to the child's activity. An entry should be made in the School's asthma register.
- 3 Allow the child to take medication when needed. It should be kept available, either by the child or in the classroom, NOT locked away. It is particularly important that bronchodilators are readily available.
- 4 Before an attack the child may show the following symptoms: Pallor, lethargy, cough and a running nose. At this stage a child should not be left unattended and should remain in full view of a teacher or another adult.
- 5 Unless there is medical advice against exercise, pupils should be encouraged to participate in sport, unless the child shows signs which may indicate an imminent attack (see 4 above), or becomes too wheezy during the games to continue.
- 6 Where necessary PE teachers should allow pupils to take a dose of bronchodilator 10 to 15 minutes before taking part in any exercise. The child should also have the bronchodilator available on the sports field.

### **8.6.6 Severe Asthma Attacks**

Severe asthma attacks are rare, however they can be life threatening so it is important that staff know what to do if a child experiences an attack. Asthmatic children often know what to do during an asthma attack as they have learned from past attacks. Staff should therefore listen to what they say or want.

- 1 Make sure that a bronchodilator is used promptly and properly. Younger children may find the use of a spacer useful to ensure that all medication reaches the lungs. See section 8.6.3 on Spacers.
- 2 Stay calm and reassure the child. Try to encourage him/her to breathe slowly and deeply and to relax.
- 3 Encourage the child to adopt a position which they find comfortable and will help them breathe. Most find it easiest to sit upright or slightly forward, resting their hands on their knees to support their chest. It is not recommended to lay the child on his/her back. If a pillow is used it should be of a synthetic material, not feather.
- 4 If the room is warm, open the window to let in some fresh air (unless it is very cold outside). It is also helpful to loosen tight clothing around the neck and to offer the child a drink of warm water.
- 5 After a mild attack the child should be able to continue with normal school activities including sports.
- 6 An ambulance should be called in the following situations:
  - If all the recommendations for treatment have been carried out correctly and things are no better 10 minutes later;
  - If the child is distressed and unable to talk;
  - If the child is getting exhausted;
  - If the child's lips turn blue;
  - If the child's pulse rate is faster than 120 beats per minute;
  - If the child loses consciousness, however brief, at any time;
  - If there are repeated attacks.

The parents should be informed immediately if it is necessary to call an ambulance.

### **8.6.7 Further Information**

The National Asthma Campaign produces information packs for schools. An asthma nurse from a local branch of the organisation may also be willing to visit schools and talk to staff on coping with asthma attacks. The address of the National Asthma Campaign can be found in Appendix II.

## **8.7 Epilepsy**

Epilepsy is a condition which results from a tendency towards brief disruptions in the normal electrical activity of the brain. This may vary from momentary inattention without loss of consciousness (Minor Epilepsy) to muscular spasm and convulsions (Major Epilepsy).



In the majority of cases the parents of an epileptic child will advise the School of the child's condition and appropriate emergency treatment. The parent should be asked to provide this information in writing. Staff who will come into contact with the child should be made aware of the condition. In the absence of specific advice the following guidelines should be followed:

### 8.7.1 Minor Epilepsy

A child suffering from minor epilepsy may appear to be day dreaming or staring ahead blankly, or they may start behaving strangely (e.g. chewing, smacking their lips, saying odd things or fiddling with their clothing). They may also suffer transient memory loss. The child should be kept calm and should be closely supervised until he/she has recovered. It is not unusual for a major fit to follow a minor one.

### 8.7.2 Major Epilepsy

Most major epileptic attacks occur unexpectedly, although sometimes a person experiences an aura beforehand, during which their normal mood may be altered. During an epileptic attack a child will suddenly lose consciousness, falling to the ground. He/she will then become rigid for a few seconds and breathing may cease, before the muscles relax and begin convulsive movements. During this stage his/her breathing may become difficult or noisy through clenched jaws and froth may appear around the mouth. Finally his/her muscles will relax and he/she will remain unconscious for a few more minutes. The fit would normally last less than 5 minutes, but the child may feel dazed and confused for several minutes to an hour afterwards.

The following action should be taken if a child has a major epileptic fit:

- 1 Clear a space around the child.
- 2 If possible loosen the child's clothing around the neck and place something soft, (e.g. a rolled up coat) under the head.
- 3 **DO NOT** move the child unless he/she is in danger. **DO NOT** restrict the child's movements. **DO NOT** give anything to drink. **DO NOT** put anything between the teeth.
- 4 After convulsions have ceased turn the child onto his/her side in the recovery position to aid breathing and general recovery (see diagram). Do not try to wake the child.
- 5 Stay with the child until you are certain recovery is complete.
- 6 **IF THE CHILD DOES NOT RECOVER CONSCIOUSNESS WITHIN 5 MINUTES SUMMON MEDICAL AID WITHOUT DELAY.**
- 7 Medical aid should also be summoned if the child has a repeat attack.

8 Inform the parents on the same day that the child has had an attack.

### 8.7.3 Rectal Diazepam

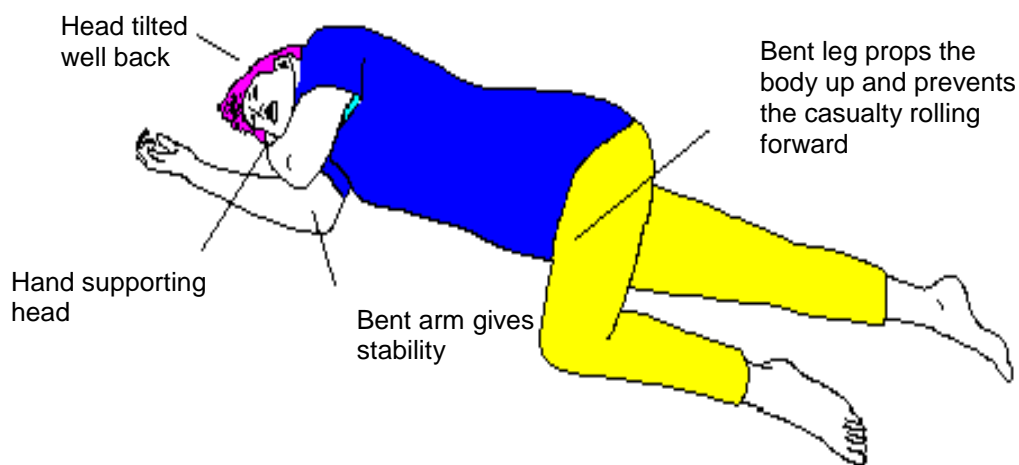
Some children and young people with learning disabilities have a type of epilepsy which is difficult to control. In some cases, it is necessary to treat breakthrough fits with rectal diazepam. Such cases are rare however.

If staff are willing to administer rectal diazepam, they must be given appropriate training (the school nurse will usually be able to arrange this). If the school can arrange for two adults, one the same gender as the pupil, to be present for the administration of intimate or invasive treatment, this minimises the potential for accusations of abuse. Two adults often ease practical administration of treatment too. Staff should protect the dignity of the pupil as far as possible, even in emergencies.

This treatment needs to be administered in an emergency and as quickly as possible. The issue for shared carers are that often there is only one person present, not two. This is not a health and safety issue, but one of good practice.

The Joint Epilepsy Council care plan for the administration of rectal diazepam should be used to record arrangements for deciding when to administer rectal diazepam and to record details of when it is administered. An outline care plan for the administration to individual pupils of rectal diazepam for non-medical/non-nursing staff can be found in Appendix I. Information for the Joint Epilepsy Council can be found in Appendix II.

### RECOVERY POSITION



#### **8.7.4 Further Information**

Further general information on epilepsy; including teacher's guides, videos and training packs on dealing with epilepsy and administering rectal diazepam, and teaching packs for pupils, are available from the British Epilepsy Association. The address is given in Appendix II

### **9 Youth and Adult Services**

This Code of Practice was written primarily to assist schools in supporting pupils with medical needs. However, whilst it is expected that adults and young people in the Post 16 and Lifelong Learning sector will, in the main, manage their own medication, the guidelines in this document should be followed by staff if there are occasions when self administration is not possible. Service user's who retain their own medication will be responsible for its safe custody.

#### **9.1 Consent**

Staff must have written consent from young people/adults before administering any medication or assisting with related tasks except in an emergency or unforeseen situations.

#### **9.2 Medication**

Medication, if brought into the establishment, must be administered, recorded and stored to the same standards as outlined in this document. Additional safeguards may be necessary and these should be discussed with the Line Manager in the first instance. Further advice may be required from local pharmacists. Establishments are reminded of the need to ensure that when using or sharing school accommodation, every effort must be made to prevent medication from being accessed by school pupils who may have access to the area.

## APPENDIX I

### Examples Forms To Assist With Administration Of Medication

**FORM ADMED 1:** Details of Existing Health Conditions / Permission to Administer Analgesics

**FORM ADMED 2:** Request for School to Administer Medication

**FORM ADMED 3:** Record of Medication Administered to Pupils

**FORM ADMED 4:** School Agreement Protocol

**FORM ADMED 5:** Joint Epilepsy Council Guidelines for administration of rectal diazepam in epilepsy and febrile convulsions for non-medical/non-nursing staff

These forms are **examples only**. Schools may prefer to design their own form, but disclaimers of liability for injury contravene the Unfair Contract Terms Act and will have no meaning in law in the event of a claim for negligence.

**ADMED 1**

**DETAILS OF PUPIL'S EXISTING HEALTH CONDITIONS / PERMISSION TO ADMINISTER ANALGESICS**

Dear Parent / Guardian,

It is important that the School is informed of any medical condition(s) suffered by your son/daughter which may affect the child whilst at school, or may require the administration of medication during school time.

**Where possible parents should ask GPs to prescribe medication in dose frequencies which enable it to be taken outside school hours.**

Where it is unavoidable, the School is willing, in principle, to administer prescribed medication<sup>+</sup> to pupils. Parents must complete a request form before the medication can be administered. For certain medical conditions it may be necessary for the School to seek the advice of the Community Paediatrician before agreeing to this. The School reserves the right to refuse to administer medication.

Please could you provide the following information:

**Pupils full name** \_\_\_\_\_

**Class/Form** \_\_\_\_\_

**Please delete paragraph which DOES NOT apply:**

**I confirm that, to my knowledge, the above named child does not have a medical condition which will affect his / her work whilst at school or require the administration of medication during school time**

**I confirm that the above named child has the following medical condition:**

\_\_\_\_\_  
(e.g. Allergy, asthma, epilepsy) (Please inform Headteacher if this needs to be kept confidential – see Section 1 Page 1)

**He/she MAY / WILL / WILL NOT require medication for the above medical condition whilst at school.**

(Delete as appropriate)

**Special Precautions:.**(e.g. known allergens, dietary needs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(The school should delete the following\* marked paragraph which does not apply).**

**\*Please note: The School does not administer non prescribed medication to pupils.**

**\*The School occasionally administers paracetamol+ to pupils who suffer discomfort (e.g. tooth-ache, period pain) etc. Do you give permission for the School to administer paracetamol to the above named pupil if deemed necessary YES / NO**

**Does the above named pupil have an allergy to paracetamol YES / NO**

+All medication will be administered in accordance with the County Council Code of Practice on the Administration of Medication to Pupils ( issued February 2002).

**Name of parent/guardian** \_\_\_\_\_

**Signed** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Home Tel:** \_\_\_\_\_ **Work Tel:** \_\_\_\_\_

**Mobile Tel:** \_\_\_\_\_



**The Edith Borthwick School**

**REQUEST FOR THE SCHOOL TO ADMINISTER MEDICATION**

**DETAILS OF PUPIL/STUDENT**

Surname:

Forename(s):

Address:

Male/female:

Date of Birth:

Class:

Condition or illness:

**MEDICATION**

Name/type of medication (as described on the container):

For how long will your son/daughter take this medication:

Date dispensed:

**Full directions for use:**

Dosage and method:

Timing:

Special precautions:

Side effects:

Self administration:

Procedures to take in an emergency:

Please turn over/.....

Does your child have any food allergies \*Yes/No

\*delete as appropriate

They are as follows:

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

**CONTACT DETAILS:**

Name:

Daytime telephone numbers: .....

.....

Mobile:

.....

Relationship to pupil/student: .....

Address:

.....

.....

.....

(I understand that I must deliver the medicine personally to the school office and accept that this is a service which the school is not obliged to undertake.)

Signature(s):

Relationship to pupil/student:

Date:

.....





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## **ADMED 4 SCHOOL AGREEMENT PROTOCOL**

### **BACKGROUND**

It is thought that \_\_\_\_\_ may suffer an anaphylactic reaction if he/she eats \_\_\_\_\_.

If this occurs he/she is likely to need medical attention and, in an extreme situation, maybe life threatening. However, medical advice is that attention to his/her diet, in particular the exclusion of \_\_\_\_\_ together with the availability of his/her emergency medication, are all that is necessary. In all other respects, it is recommended by his/her consultant that his/her education should carry on 'as normal'.

The arrangements set out below are intended to assist \_\_\_\_\_ parents and the School in achieving the least possible disruption to his/her education, but also to make the appropriate provision for his/her medical requirements.

### **DETAILS**

- a) The Headteacher has arranged for the teachers and other staff in the School, including supply staff, to be briefed about \_\_\_\_\_ condition and about other arrangements contained in this document.
- b) The School's staff will take all reasonable steps to ensure that \_\_\_\_\_ does not eat any food items unless they have been prepared by his/her parents.
- c) \_\_\_\_\_ parents will remind him/her regularly of the need to refuse any food items which might be offered to him/her by other pupils.
- d) In particular \_\_\_\_\_ parents will provide for him/her a suitable packed lunch.
- e) If there are any proposals which mean that \_\_\_\_\_ may leave the school site, prior discussions will be held between the School and parents in order to appropriate provision and safe handling of his/her medication.
- f) Whenever the planned curriculum involves cookery or experiments with food items, prior discussions will be held between the School and parents to agree measures and suitable alternatives.
- g) \_\_\_\_\_ medication are kept easily and to hand in the School Office. The parents accept the responsibility for maintaining appropriate up-to-date medication.

## ALLERGIC REACTIONS

- a) In the event of \_\_\_\_\_ showing any physical symptoms for which there is no obvious alternative explanation, his/her condition will be immediately reported to the Headteacher who will decide whether there is cause for concern and will instruct a member of staff to contact, in direct order of priority:

### 999 – EMERGENCY SERVICE – AMBULANCE

#### Message to be given – ANAPHYLACTIC REACTION

#### Parents or Carer in the following order:

NAME	RELATIONSHIP	TELEPHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## ADMINISTRATION OF MEDICATION

- a) **Whilst awaiting medical assistance a member of staff, trained for the purpose, will administer the appropriate medication in line with perceived symptoms and following the instructions given during training.**
- b) \_\_\_\_\_ will be given the \_\_\_\_\_ injection into the outer thigh, midway between the knee and hip.
- c) The administration of this medication is safe for \_\_\_\_\_, and even if it is given through misdiagnosis, it will do no harm to him/her.
- d) On the arrival of the qualified medical staff, the member of staff will appraise them of the medication given to \_\_\_\_\_. All medication will be given to the medical staff.
- e) After the incident, a debriefing session will take place with all members of staff involved.

## TRANSFER OF MEDICAL SKILLS

- a) A training session was attended by \_\_\_\_\_. \_\_\_\_\_ explained in detail symptoms of the anaphylactic reaction and the stages and procedures for the administration of medication.
- b) The County Council provides a staff indemnity for any school staff who agree to administer medication to a child in school, given the full agreement of parents and the School.

## **STAFF INDEMNITY**

The County Council fully indemnifies its staff against claims for alleged negligence, providing they are acting within the scope of their employment, have been suitably trained and are following the LEA's guidelines. For the purposes of indemnity, the administration of medicines falls within this definition and hence the staff can be assured about the protection their employer provides. The indemnity would cover the consequences that might arise where an incorrect dose is inadvertently given or where the administration is overlooked.

## **AGREEMENT AND CONCLUSION**

A copy of these notes will be held by the School and the parents. Any necessary revisions will be subject of further discussions between the School and the parents.

On a termly basis, any changes in routine will be noted and circulated.

## **AGREED AND SIGNED**

Headteacher \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**RECORD OF USE OF RECTAL DIAZEPAM**

<b>Date</b>			
<b>Recorded by</b>			
<b>Type of Seizure</b>			
<b>Length and/or number of seizures</b>			
<b>Initial dose</b>			
<b>Outcome</b>			
<b>Second dosage (if any)</b>			
<b>Outcome</b>			
<b>Observations</b>			
<b>Parent/Guardian informed</b>			
<b>Prescribing doctor informed</b>			
<b>Other Information</b>			
<b>Witness</b>			
<b>Name of Parent/Guardian re-supplying dosage</b>			
<b>Date delivered to school</b>			



## List of Contacts for Further Advice

**Local Consultant Community Paediatricians**

BASILDON AND THURROCK		Dr. Conlan } Dr. Prendergast }	Tel: 01268 533911
MID-ESSEX		Dr. Murtaza } Dr. Kugan } Dr. Bridgman }	Tel: 01376 302600 Fax: 01376 302601
NORTH ESSEX		Dr. Bhattacharyya	Tel: 01206 579411
SOUTH ESSEX	- Rochford - Westcliff	Dr. Kamalanathan } Dr. Nerminathan }	Tel: 01702 435555
WEST ESSEX	- Loughton - Harlow	Dr. Rudran } Dr Amadi }	Tel: 020 8508 6295 Tel: 01279 827178

**Local Community Services Pharmacists**

BASILDON AND THURROCK:		Miall James	Tel: 01268 592279
MID-ESSEX		Paula Wilkinson Judith Woolley Helen Kiff	Tel: 01245 513239 Pager: 07644 049534 Pager: 07644 049331 Pager: 07644 049383
NORTH EAST ESSEX		David Green	Tel: 01206 742358
SOUTH ESSEX		Jane Allan	Tel: 01702 577615
WEST ESSEX		Derek Brown	Tel: 01279 827579

Local Community Services Pharmacists are able to offer advice on safe storage and dosage etc. of medication. They can also offer health promotion talks in school, although a fee may be charged.

**Local Consultant in Communicable Disease Control**

**NORTH ESSEX HEALTH AUTHORITY**

Dr S Millership,  
 Consultant in Communicable Disease Control,  
 North Essex Health Authority,  
 Collingwood Road,  
 Witham,  
 Essex CM8 2TT.

Direct Line: 01376 302283

Dr D Irwin,  
 Consultant in Communicable Disease Control,  
 North Essex Health Authority,  
 Collingwood Road,  
 Witham,  
 Essex CM8 2TT.

Direct Line: 01376 302272

**SOUTH ESSEX HEALTH AUTHORITY**

Dr A Cummins,  
 Consultant in Communicable Disease Control,  
 South Essex Health Authority,  
 Acadia House,  
 Warley Hill Business Park,  
 The Drive,  
 Warley,  
 Brentwood,  
 Essex CM13 3BE.

Direct Line: 01277 755236

**Community Infection Control Nurses**

<b>North Essex</b>	Braintree/Witham	Rosemary Readman	Office: 01376 302281
	Colchester	Grant Crawshaw	Office: 01206 288537
	Harlow	Joanna Harris	Office: 01279 444555
<b>South Essex</b>	Basildon/Brentwood	Lisa Allen	Office: 01277 755215 Mobile: 07774218903
	Castle Point/Rochford	Sarah Brill	Office: 01268 464532 Mobile: 07771982785



**Organisations that Provide General Advice and Support for Certain Medical Conditions**

The following organisations can provide further general information on the conditions referred to in this Code, including free school information packs, teaching aids, videos etc.

**National Asthma Campaign**

Providence House  
Providence Place  
London  
N1 0NT

Tel: 020 7226 2260  
Tel: 08457 010203 (helpline)  
Fax: 020 7704 0740

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

**British Epilepsy Association**

New Anstey House  
Gateway Drive  
Yeadon  
Leeds  
LS19 7XY

Tel: 0808 800 5050 (helpline)  
Fax: 0808 800 5555

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

**Diabetes UK Central Office**

10 Queen Anne Street  
London  
W1G 9LH

Tel: 020 7323 1531  
Fax: 020 7637 3644

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

**The Anaphylaxis Campaign**

P.O. Box 149  
Fleet  
Hampshire  
GU13 9XU

Tel: 01252 542029

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

**Cystic Fibrosis Trust**

11 London Road  
Bromley  
Kent.  
BR1 1BY

Tel: 020 8464 7211

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

**OTHER SUPPORT GROUPS:**

The following organisations provide general information on other medical conditions which may be encountered at school:

Action for Sick Children	Tel: 0800 074 4519
Aid for Children with Tracheostomies	Tel: 0121 411 1348
British Allergy Foundation <a href="http://www.allergyfoundation.com">www.allergyfoundation.com</a>	Tel: 020 78303 8583 (helpline)
Cancerlink <a href="http://www.cancerlink.org">www.cancerlink.org</a>	Tel: 0808 808 0000 (helpline)
Hyperactivity Children's Support Group	Tel: 01903 725182
National Eczema Society <a href="http://www.eczema.org">www.eczema.org</a>	Tel: 0870 241 3604 (helpline)
National Society for Epilepsy <a href="http://www.epilepsyse.org.uk">www.epilepsyse.org.uk</a>	Tel: 01494 873991
The Psoriasis Association	Tel: 01604 711129
The Sickle Cell Society <a href="http://www.sicklecellsociety.org">www.sicklecellsociety.org</a>	Tel: 020 8961 7795
Terrance Higgins Trust (HIV, AIDS) <a href="http://www.tht.org.uk">www.tht.org.uk</a>	Tel: 020 7242 1010 helpline)

Members of the Joint Epilepsy Council are as follows:

British Epilepsy Association  
Epilepsy Association of Scotland  
Irish Epilepsy Association  
Mersey Region Epilepsy Association  
The David Lewis Centre  
The National Society for Epilepsy

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## THE EDITH BORTHWICK SCHOOL

### **HEAD INJURY POLICY**

Any bump or injury to the head must always be treated seriously as the young person's condition may deteriorate many hours later. It is therefore important that the following information be recorded and actions carried out by the school.

The Headteacher should be informed of the incident and a white incident form completed for school records.

Staff should try to make contact with the young person's parent/carer by telephone and provide them with details that a GP or A&E staff will need. The attached form should also be completed and sent home in the young person's home/school book with a note in the book asking parents/carers to read the enclosed head injury form.

#### **The details required are:**

- The date and time of the incident. Try to give an accurate account of how the head Injury/bump occurred. What part of the head/body was hurt? Is there any obvious bruising areas of skin, nose bleeds or loss of fluid from the ears.
- Had the young person been unwell before the injury occurred?
- Was there any loss of consciousness at the time of injury or has the young person been sleepy since the injury.
- Has the young person been crying continuously and unable to be settled?
- Does the young person appear confused with slurred speech?
- Has the young person complained of headaches and was any medication given, and what time, to relieve this?
- Has the young person vomited?
- Is the young person any more unsteady when walking/moving?
- Has there been any complaint of blurred vision?
- Does the young person have a ventricular/peritoneal shunt or cardiac/peritoneal shunt in situ?
- Does the young person have epilepsy?

# INFORMATION FOR PARENTS/CARERS REGARDING YOUNG PERSON'S HEAD INJURY



## Head Injury Advice

Your child has sustained a head injury at school today.

You should monitor your child over the next 2-3 days for any signs or symptoms of significant injury.

Name:		Class:	
Date:	Time:	Advised to seek further medical attention.	Yes      No
How injury occurred:			
Treatment/ Action taken:			
Next of kin notified:	Yes      No	Name of next of kin:	

### Common symptoms following a head injury

These can be expected following a head injury and managed at home. If they are not improving after one week call NHS 111 or contact your GP.

- Mild Headache
- Tiredness or poor sleep
- Dizziness
- Poor concentration
- Irritability or bad temper
- Off food

### Signs and symptoms to look out for following a head injury.

If any of these occur, you should seek urgent assessment by calling 999 or visiting your local A+E department.

- Severe or increased headache.
- Vomited more than once
- Clear fluid dribbling from ears, nose or both
- Blood from one or both ears
- Difficulty in speaking or understanding what is being said
- Sleepy and cannot be woken
- Weakness to arms or legs or losing balance
- Seizures or fitting

### General Advice- Sleep

It is safe to allow your child to sleep, however, you can be reassured by the ability to wake them twice during the night.

Do not confuse normal sleep with unconsciousness. If you are unable to wake your child call **999**.

### Recovery

Most head injuries are not serious and simply result in a bump or bruise but some of the following signs and symptoms may develop:

- Altered behaviour
- Poor concentration
- Poor memory
- Excessive tiredness
- Continuing headaches

If any of these occur it is important to recognise, they may be a result of a head injury and should be discussed with a GP.

### Activities

Encourage your child to continue with their normal daily activities as soon as they are able. Note there are some activities that should be avoided for 2-3 weeks.

- Competitive contact sports
- Diving
- Climbing unsupervised above 3ft

This information has been taken from NHS Mid Essex CCG website.

**If any of these symptoms are present, particularly loss of consciousness (even for a short period of time), you should call an emergency ambulance (999 / 112) or NHS Direct on 111**

- Lasting headache that gets worse or is still present over six hours after the injury;
- Extreme difficulty in staying awake, or still being sleepy several hours after the injury. It is fine to let children go to sleep after a slight bump to the head, but you should check on them regularly and make sure you are able to wake them.
- Nausea and vomiting several hours after the injury;
- Unconsciousness or coma;
- Unequal pupil size;
- Confusion, feeling lost or dizzy, or difficulty making sense when talking;
- Pale yellow fluid or watery blood, coming from the ears or nose (this suggests a skull fracture);
- Bleeding from the scalp that cannot be quickly stopped;
- Not being able to use part of the body, such as weakness in an arm or leg;
- Difficulty seeing or double vision;
- Slurred speech; and
- Having a seizure or fit.

## THE EDITH BORTHWICK SCHOOL

### BASIC HYGIENE PROCEDURES

It is important that high standards of basic hygiene are universally maintained and practiced at all times throughout the school and that all the basic hygiene practices below are part of normal routine.

#### **HAND HYGIENE**

Hand washing is the single most effective means of reducing cross infection. Its purpose is to remove or destroy any micro-organisms which have been picked up on the hands.

Those causing disease are usually easy to remove by careful and regular hand washing.

- Warm running water, liquid dispensed soap and disposable individual towels **must** be used. It is essential that all areas of the hands are washed and dried thoroughly.
- Emollient hand cream should be applied regularly (seek advice if a particular product causes skin irritation).

#### ***Hand washing must be practiced by everyone:***

- Before meals.
- Before preparing food.
- After using the toilet.
- When attending to any body fluids or other potentially infectious material.
- When carrying out any medical procedure.

#### ***Children must be:***

- Encouraged to wash their hands after every visit to the toilet.
- Encouraged to wash their hands before eating.
- Supervised when hand washing to ensure that they wash their hands correctly.
- Encouraged to wash their hands after handling animals, soil etc.,

#### ***Food handlers must:***

- Ensure high standards of hygiene at all times.
- Wash and dry their hands thoroughly before touching food.
- Be completely well and not work if suffering from diarrhoea or open septic sores.
- They should not return to work until they have been well for 48 hours.
- Cuts and abrasions must be covered with a waterproof dressing.

#### ***Protective Clothing:***

- Disposable gloves and aprons are available for staff to use whenever required.

#### ***It is essential that disposable gloves and aprons must be worn at all times when:***

- Changing nappies/pads.
- Changing sanitary protection.
- Wiping after passing urine/bowel motion.
- Attending to a child who has vomited.
- Attending to a child who has bleeding.
- Carrying out medical procedures.



- **A new pair of gloves must** be worn after every procedure.  
Gloves and aprons **must** be disposed of immediately after use and before returning to the class area.
- Hands **must** be washed after gloves are removed.

## **DEALING WITH BLOOD AND BODYFLUIDS**

### **(Urine, faeces, saliva, vomit and blood)**

Spillages should be dealt with promptly to avoid hazards to others. The member of staff with the pupil at the time **must** take responsibility for cleaning up any spillage.

#### **Staff should:**

- Keep people away from the area.
- Wear vinyl or latex free gloves and a disposable apron.
- Soak up excess of spill with paper towels and dispose of them in clinical waste bags (yellow) in the bathroom areas.
- Wipe surface with general purpose detergent and hot water.
- Dispose of protective clothing into clinical waste bag.
- Wash hands.
- **Inform cleaning staff** so that any necessary arrangements may be made to ensure any additional cleaning required at the end of the school day.

## **MAINTENANCE OF ENVIRONMENT**

A regular programme of cleaning must be followed. Thorough cleaning with hot water and detergent using disposable cloths, followed by adequate drying, will render the environment and items of equipment free of micro-organisms likely to cause infection. Disinfectants are not necessary for general environmental cleaning.

#### **Areas which require particular attention during the school day are:**

- **Changing benches:** Which must be covered with protective sheeting for each procedure or must be cleaned between each procedure?
- **Class and lunch table surfaces:** All lunch surfaces must be cleaned prior to food being served.
- **Wheelchair tables.**
- **PE mats.**
- Toilets and washbasins must be cleaned daily by the cleaning staff and during the day by the member of staff supporting, whenever there is visible soiling.
- Potty contents must be carefully emptied down the toilet. The potty must be washed with hot water and detergent and dried thoroughly.
- Toys must be washable and need to be cleaned on a regular basis.

## **DISPOSAL OF WASTE**

The correct disposal of waste is an important part of safety practice and all staff needs to be aware that the law imposes a duty of care upon all for the safety, health and welfare of themselves and other employees. All waste should be disposed of in an approved way i.e. sacks should be not more than 2/3 full and properly secured.

Yellow plastic bags are for disposal by incineration of waste that has been contaminated with body fluids, excretions and recreations. Small amount of such waste (other than sharps) may be placed in normal waste, but large amounts should be placed in the yellow bags labelled with the words '**clinical waste**' and collection arranged through a licensed contractor.

***Sharps disposal:***

A sharp is considered to be any object actually or potentially contaminated with blood or body fluids that may pierce the skin of a person coming into direct contact, examples of such an object are hypodermic needles, blood lancets and any other similar instruments.

- Sharps should be placed directly in a sharps container.
- Sharps boxes should be carefully assembled in order to prevent leakage.
- Containers should be sealed out of reach of pupils.
- The containers should be sealed when about  $\frac{3}{4}$  full.
- All sharps boxes must be disposed of by incineration of a licensed contractor and be labelled with the name of the source establishment.