Supporting Children with Medical Conditions

Stannington First School

Northumberland County Council

Contents

Appendices - Forms

Foreword

Northumberland County Council's Early Years Team has adapted the following guidance to ensure it supports the Early Years Foundation Stage Statutory Requirements (EYFS 2014). Childcare providers should consider their structure when this document refers to governing bodies, whether that is trustees or management committees etc.

The Corporate Health and Safety Team prepared this guidance in consultation with paediatricians from Northumbria Healthcare NHS Foundation Trust. The contents fully complement information contained in the Department for Education's (DfE's) document entitled 'Supporting pupils at school with medical conditions' which was published in April 2014. It also supersedes the document 'Policy on Supporting Children with Medical Needs' which the Council published in July 1999. Schools should dispose of all previous copies of the latter guidance.

The DfE's recently published guidance cited above fully supersedes its previous document 'Managing Medications in Schools and Early Years Settings' which was published in March 2005 and revised in 2007. Heads and governors should note that from 1 September 2014 section 100 of the Children and Families Act 2014 will place a statutory duty on governing bodies (rather than Local Authorities) to ensure that arrangements are in place to support s with medical conditions whilst they are at school. This applies to any provider regardless of management structure.

The County Council's policy (below) has taken full account of the aforementioned DfE document. Schools are recommended to treat NCC's policy as a template and adapt it as they see fit. The approach is similar to that adopted for the Model School Safety policy.

This will ensure that governing bodies have accurate, up-to-date information and guarantee that no statutory requirements to which they must adhere have been overlooked. Additionally, by implementing robust arrangements governors can be satisfied that such measures align with their wider safeguarding duties.

Roles and Responsibilities

Responsibility of Parents

In modern terminology the term 'parent' is understood to mean not just a parent but anyone who has parental responsibility for the care of a child. 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 attending a childcare provision.

It is preferable that medication be given at home whenever possible. If prescribed medications 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 childcare provision hours. Serious consideration should be given to the administration of non-prescribed medication (see section titled non-prescribed medication).

Parents have a duty to inform the childcare provider of their children's medical conditions and must make a request for medication to be administered in childcare provision. 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 childcare provision whilst still receiving a course of antibiotics or other medication.
- has needs that have changed
- is due to attend new childcare provider or school

Responsibility of Health Care Professionals

In situations where the condition requires a detailed individual healthcare plan or specific specialist training is required for practitioners, 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.

Any identified specialist training required by practitioners should be sought in partnerships with parents and the relevant healthcare professionals

Responsibility of Childcare Provision Staff

Each request for medication to be administered in the childcare provision should be considered on its merits. Decisions should be made in the best interests of the child and any implications for the childcare provision.

It is generally accepted that childcare provision nominated practitioners 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

- No medication can be administered in childcare provision without the agreement of the manager or their nominated representative.

- The management e.g. owners, committees or trustees must nominate a member of staff (usually the manager or SENCO) who will have overall responsibility for the implementation of this policy. The childcare provision's own health and safety policy and/or risk assessment should identify who has assumed this role.

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

- Practitioners should receive the appropriate guidance and training

- Parents requesting administration of medication should be given a copy of the setting's policy.

- Parents must complete the parental request form for medication (see example in appendix 1). Completion of this form safeguards the provision and practitioners by allowing medication to be administered

- Practitioners may consult with the prescriber to ascertain whether medication can be given outside of childcare provision hours.

Liability and Indemnity

Practitioners will administer medication in accordance with appropriate training or the details supplied by a Doctor and supplied by the parent, with written consent from the parent.

General Procedures

1. If medication is to be administered, parents should fill in the medical request form stating the dose to be given, the method of administration, the time and frequency of administration and the time it was last given, other treatment, any special precautions and give their signed consent.

2. The parent must bring all essential medication to childcare provision. Only the smallest practicable amount should be kept in childcare provision.

3. Prescribed medication provided must be in the original packaging (pharmacy label, child's name, dosage and date).

4. Whilst medication is in the provision it should be kept in a locked cupboard or fridge (if so required). In the event of an emergency it should be readily accessible to the named practitioner. Depending on the child's age and developing independence, different considerations may need to be given regarding self-administering medications and a risk assessment may need to

be put in place. (Consideration should be given to placing a lock on the fridge if it is accessible to children or seek alternative appropriate storage.)

5. Oral medication should be supplied with a 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 medication to the owner of that implement.

6. Prior to administering any medication a check should be made on expiry date and when it was last administered to prevent accidental overdose.
When medication is administered a written record should be kept of the dose given, the mode of administration, the time given, who administered and who witnessed.

7. Where any change of medication or dosage occurs, clear written instructions from the parent should be provided. If a parent brings any medication to the provision, for which consent has not been given, staff should not administer it. In such circumstances the manager 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, childcare provisions should have robust procedures in place to ensure that out of date medication is not administered in error. Out of date medication should be handed back to parent.

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

10. Settings are responsible for insuring effective communications regarding administering medication during transitions.

If providers 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 a child refuses medication or practitioner forgets to administer it, the childcare provision should inform the child's parent as a matter of urgency. If necessary, the childcare provision should call for emergency medical advice in-line with your policy and procedure.

Non-prescribed Medication

In order to promote good health of children there may be circumstances where parents request you to administer non-prescribed medication e.g. sun cream, barrier creams, teething gels, etc. In all cases written permission must be sought from parents for that particular medication and be in-line with EYFS requirements as well as your policies and procedures.

Any medication must not be kept in first-aid boxes.

On no account should aspirin or preparations that contain aspirin be given to children unless prescribed by a doctor.

Individual Healthcare Plan

This section of the policy covers the role of individual healthcare plans in supporting children in provision who have long-term, severe or complex medical conditions. The new statutory guidance imposes a requirement to identify the member of staff who is responsible for the development of these plans.

The provision and management should ensure that there are robust 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 provision should ensure that it assesses and manages risks to the child's education, health and social well-being and minimises disruption.

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

A model healthcare plan is given in Appendix 2. To ensure compliance with the new statutory guidance the following points should be taken into account:

- the provider will need to review their medical administration systems and consider whether a separate policy will be needed for self-administration of medication.

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

- the child'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.

- specific support for the child 's educational, social and emotional needs – for example, how absences will be managed

- 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. Consideration should be given to the appropriate accessibility and safe storage of medication and risks should be managed appropriately

- 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 provision 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 manager to be drawn up, thus authorising a member of staff to administer medication or allowing the child to self-administer during the session

- the designated individuals to be entrusted with information about the child's condition

- 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 should be used to inform development of their individual healthcare plan.

- the separate arrangements or procedures required for trips, educational visits or other extra-curricular activities. In practice, these should be logged together with supporting information, such as personalised risk assessments.

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 provider, parent, community 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 the provision, as it is essential that parents and 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; childcare providers should contact them directly in the first instance. The child's health visitor can be contacted for advice and is able to direct inquirers to other health agencies, where necessary. An individual healthcare plan for each child with a medical need must be completed and conform to the procedures described on page 7. Information in the appendices should prove helpful.

The medical conditions in children that most commonly cause concern in provision are asthma, epilepsy, diabetes and anaphylaxis. Essential information about these conditions is given below. Further, more detailed information about them can be obtained from the following organisations:

- Asthma UK
- Epilepsy Society (formerly The National Society for Epilepsy)
- Epilepsy Action (formerly the British Epilepsy Association)
- Diabetes UK
- Anaphylaxis Campaign
- National Electronic Library for Medications (NHS)
- Resuscitation Council (UK)

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.

What causes it?

Common causes of anaphylaxis include:

- Edible triggers, such as peanuts, tree nuts, fish, shellfish, dairy products and eggs
- Other triggers, such as natural latex, the venom of stinging insects (for example wasps, bees and hornets) penicillin and any 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 a pre-loaded injection device, such as an epiPen, anapen or jext. An injection should be given as soon as a reaction is suspected.

Anaphylaxis should always be regarded as a medical emergency which requires that an ambulance be called immediately.

What arrangements are in place at our childcare provision?

Healthcare Plan

Anaphylaxis is manageable. With sound precautionary measures, the development of a suitable healthcare plan and support from members of staff, 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, anti-histamine
- knowledge of the locations where the injector is stored, preferably in an easily accessible place such as a medication box
- 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. The information should accompany the medication on trips.

Collectively, it is for the manager, the child's parents and the medical staff involved to decide how many adrenaline devices the childcare provision 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 childcare provisions 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.

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 childcare provision. When catering staff are employed by a separate organisation, it is important to ensure that they are fully aware of the child's particular requirements. A `kitchen code of practice' should be put in place.

Parents often ask for the manager 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.

Providers need to have regard to recent legislative changes in relation to managing allergens.

Training

Where members of staff are required to inject adrenaline in an emergency the childcare provision will need to work in partnership with the parents and any healthcare professionals to support them to identify an appropriate source of training.

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
- a whistling noise in the chest

- shortness of breath
- tight feelings in the chest
- being unusually quiet

Younger children may verbalise these symptoms by saying that their tummy hurts or that it feels like someone is sitting on their chest.

What is the treatment for the condition?

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

Relievers

Usually it is a reliever that a child will need during the day. Relievers (usually blue inhalers) are medications 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 childcare provision hours and it is rare for them to be needed during the childcare provision 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 medication to the lungs more effectively. Where prescribed, the spacer should be individually labelled and kept with the inhaler.

Nebulisers

A nebuliser is a machine that creates a mist of medication that is then breathed through a mask or mouthpiece. Should children require the use of a nebuliser, members of 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 childcare provisions 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 GPs. Although the GPs would be unable to provide training it is likely that they will provide the information that would help staff to complete the healthcare plans. Children with complex conditions may have access to a specialist nurse with expert knowledge their condition that may be able to assist.

What arrangements are in place at our childcare provision?

Healthcare Plan

Children with asthma will need to have an individual healthcare plan, details about which are given on page 5 and in appendix 2.

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. Consideration should be given to obtaining An Asthma School Card (available from Asthma UK) to support the child's symptoms. 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 medications they need to take and when. It is, therefore, imperative that provision staff, 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 written asthma plans, asthma school cards provided by parents and regular training and support for staff. Children with significant asthma should have an individual healthcare plan (see Appendix 2).

Carrying the medication

Children with asthma need to have their reliever inhalers accessible all times

It is good practice to allow children 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 children 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 children 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.

Good practice would ensure that each individual child will have spare inhaler available for them in the provision

Off-site activities

Relievers should always be available during physical activities and external visits. A spare inhaler and spacer should also be available and stored in a place where it can be readily accessed if the primary inhaler cannot be accessed.

Children with asthma should participate in all aspects of provision, including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Some children may need to take their reliever asthma medications 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.

All asthma medication should be clearly labelled with the child's name. The expiry date of the medications should be checked every six months.

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. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

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 6 may be helpful. Childcare provisions 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 childcare 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 childcare provision 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 lunch, before physical activities 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 childcare provision?

Healthcare Plan

A healthcare plan will be needed for children with diabetes. Information about these plans is given on page 7 and Appendix 2.

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. Childcare provisions may need to make special arrangements for children with diabetes if the childcare provision 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 key worker in charge of 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 medication during childcare hours.

What arrangements are in place at our childcare provision?

Healthcare Plan

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

Parents and health care professionals should provide information to the childcare provider manager 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 attending the provision, details should be recorded and communicated as soon as possible 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 childcare provision 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 activities and areas of the provision e.g. sensory rooms, water tray etc. Managers should discuss any safety issues with the child and parents as part of the healthcare plan, and these concerns should be communicated to members to staff.

Emergency Action

Information regarding emergency management is given in Appendices 7 and 8. Appendix 7 covers the procedures to be followed with regard to first aid for all seizures, whilst Appendix 8 covers procedures to be followed if the casualty is known to have epilepsy and has been prescribed buccal midazolam or 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 child 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:

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

- Buccal (oromucosal) midazolam. This is a new authorised 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). It may be considered as an alternative to rectal diazepam for this purpose.

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 midolazam 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 midolazam or diazepam should have his/her medication reviewed every year. As an additional safeguard, each child requiring buccal midolazam 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 9 below.

Buccal midolazam 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 midolazam and diazepam may cause drowsiness. Moreover, those who administer buccal midolazam 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.

Unacceptable Practice

The DfE's statutory guidance makes it very clear that governing bodies should ensure that the school's 'Policy on Supporting s with Medical Conditions' is explicit about what practice is not acceptable. Childcare provision should also have regard for this. Though most childcare provisions 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 management (owners, committees or trustees) 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 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 easily 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 childcare provision activities, including lunch, unless this is specified in their individual healthcare plans
- to not contact the parent
- penalise children for their attendance record if their absences are related to their medical condition, such as hospital appointments
- prevent children 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 childcare provision to administer medication or provide medical support to their child, including assisting with toileting and personal care. No parent should have to give up working because the childcare provision 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 childcare provision, including 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. Childcare provision should ensure the same clarity. It needs to set out how complaints concerning the support provided to children with medical conditions may be made and how they will be handled.

Should parents or children be dissatisfied with the support provided they should discuss their concerns and follow the childcare provision complaints policy. If, for whatever reason, this does not resolve the issue, they may make a formal complaint via the childcare provision's existing complaints procedure. For convenience, childcare provisions may wish to insert a hyperlink to the Complaints Policy at this point. ***Childcare provision to insert hyperlink to its own Complaints Policy***

Any complaints should be in-line with EYFS and OFSTED statutory requirements.

Administration of Medication to Children Agreement Between Parents and Childcare Provision

A parent must supply a written request in order for medication to be administered to children during childcare hours. It is only possible to administer medication that the child's doctor has prescribed. Childcare provision staff cannot administer 'over-the-counter' medication.

It is also important to keep the administration of medication to a minimum and parents are requested to consider the possibility of administering the daily doses out of childcare provision hours. If this is not possible the following consent form must be completed and returned to the childcare provision:

Note: Medications must be kept in the original container as dispensed by the pharmacy.

Part 1 – To be Completed by Parent/Carer	
To the manager: *(add name)*	**Childcare provision:**
My child *(name)* _____ Date of birth:_____ _____ has the following medical condition_____ I wish for him/her to have the following medication administered by childcare provision staff, as indicated below:	
Name of Medication:	
Dose/Amount to be given:	
Time(s) at which to be given:	
Means of administration:	
How long will the child require this medication to be administered?	
Known side effects and any special precautions (please attach details)	
Procedures to take in case of emergency (please attach details)	
Emergency Contact 1 Name:_____ Telephone *Work*: _____ *Home*: _____ *Mobile*: _____	***Emergency Contact 2*** Name:_____ Telephone *Work*: _____ *Home*: _____ *Mobile*: _____

Relationship: _____	Relationship: _____

*I undertake to deliver the medication personally to the manager/SENCO and to replace it whenever necessary. I also undertake to inform the childcare provision **immediately** of any change of treatment that the doctor or hospital has prescribed.*

Name: _____ Signature: _____

Relationship to child: _____ Date: _____

Part 2 - To be completed by manager/SENCO

Confirmation of agreement to administer medication

It is agreed that *(child)* _____ will receive (*quantity and name of medication)* _____ every day at (*time medication to be administered, for example, lunchtime or afternoon break)* _____.

(Child) _____ will be given medication or supervised whilst he/she takes it by (*name of member of staff)* _____.

This arrangement will continue until _____ *(either the end date for the course of medication or until the parents instruct otherwise).*

Name: _____ Signature: _____
Manager/SENCO

Childcare provision: _____

Parental Request for Child to Carry and Self-administer Medication

This form must be completed by a parent/carer

To: manager: *(add name)*	
Childcare provision: *(add childcare provision name)*	
Name of child:	Class:
Address:	
Name of Medication:	
Procedures to be taken in an emergency:	
Contact Information	
I would like my child to keep his/her medication on him/her for use, as necessary. Name:_____ Signature: _____ Daytime Tel no(s):_____ Date:_____ Relationship to child:_____	

If more than one medication is to be given a separate form should be completed for each one.

Appendix 3

Healthcare Plan for a Child With Medical Needs

Details of Child and Condition	
Name of child:	Add photo here
Date of birth:	
Class/Form:	
Medical Diagnosis/Condition:	
Triggers:	
Signs/Symptoms:	
Treatments:	
Has the Parental Consent Form been completed? *Yes/No* *(Medication cannot be administered without parental approval)*	
Date:	Review Date:
Medication Needs of Child	
Medication:	
Dose:	
Specify if any other treatments are required:	
Can the child self-manage his/her medication? *Yes/No* If *Yes*, specify the arrangements in place to monitor this: Indicate the level of support needed, including in emergencies: *(some children will be able to take responsibility for their own health needs)*	

Known side-effects of medication:
Storage requirements:
What facilities and equipment are required? *(such as changing table or hoist)*
What testing is needed? *(such as blood glucose levels):*
Is access to food and drink necessary? *(where used to manage the condition): Yes/No* Describe what food and drink needs to be accessed
Identify any dietary requirements:
Identify any environmental considerations *(such as crowded corridors, travel time between lessons):*
Action to be taken in an emergency *(If one exists, attach an emergency healthcare plan prepared by the child's lead clinician):*
Staff Providing Support
Give the names of staff members providing support *(State if different for off-site activities):*
Describe what this role entails:
Have members of staff received training? *Yes/No* (*details of training should be recorded on the Individual Staff Training Record, Appendix 4)*
Where the parent or child have raised confidentiality issues, specify the designated individuals who are to be entrusted with information about the child's condition:

Detail the contingency arrangements in the event that key members of staff are absent:
Indicate the persons (or groups of staff) in childcare provision who need to be aware of the child's condition and the support required:
Other Requirements
Detail any specific support for the child's educational, social and emotional needs *(for example, how absences will be managed; requirements for extra time to complete exams; use of rest periods; additional support in catching up with lessons or counselling sessions)*

Emergency Contacts	
Family Contact 1 Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____	***Family Contact 1*** Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____
Clinic or Hospital Contact Name:_____ Telephone: *Work*:_____	***GP*** Name:_____ Telephone: *Work*:_____
Signatures	
Signed _____ *(Keyworker worker)*	*Signed* _____ *(Manager/SENCO)*

Individual Staff Training Record – Administration of Medication

Name: _____ Job:_____
Childcare provision: _____

Type of training received	**Date completed**	**Training Provided by**	***Trainer's Signature*** *I confirm that this employee has received the training detailed and is competent to carry out any necessary treatment.*	**Staff Signature confirming receipt of training**	**Suggested review date**

Appendix 5

Record of Medication Administered in Childcare provision

Childcare provision: _____

(Please Print)

Date	**Child's Name**	**Time**	**Name of Medication**	**Dose Given**	**Previous Dose Given**	**Any Reactions**	**Name of Staff Administering** (sign & print)	**Name of Staff Witnessing** (sign & print)

Emergency Action: Asthma – First Aid

Ensure that the reliever medication is taken promptly:

A reliever inhaler (usually blue) should quickly open up narrowed air passages; try to make sure it is inhaled correctly. Preventative medication is of no use during an attack; it should be used only if the child is due to take it.

Stay calm and reassure the child:

Attacks can be frightening and it is important to stay calm and do things quietly and efficiently:

- listen carefully to what the child is saying and what he or she wants (the child has probably been through it before)
- try tactfully to take the child's mind off the attack
- do not put arms around the child's shoulder as this is restrictive

Help the child to breathe:

- encourage the child to try and breathe slowly and breathe out for longer (in an attack people tend to take quick shallow breaths)

- allow the child to take his or her favoured position. Most people find it easier to sit fairly upright or lean forwards slightly. They may want to rest their hands on their knees to support their chest. They must not lie flat on their backs.

- loosen clothing around the neck and offer the child a drink of warm water as the mouth becomes dry with rapid breathing

If any of the following apply call a doctor urgently:

- the reliever has no effect after five to ten minutes

- the child is distressed or unable to talk

- the child is getting exhausted

- there are any doubts at all about the child's condition

If a doctor is not immediately available call an ambulance

Repeat doses of reliever as required (every few minutes, if necessary, until it takes effect)

Do not be afraid of causing a fuss. Doctors prefer to be called early so that they can alter the medication.

After the attack:

- minor attacks should not interrupt a child's concentration and involvement in childcare provision activities; normal activity should be encouraged as soon as the attack is over

Emergency Action:
Epilepsy - First Aid for all Seizures

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course

- Check the time the child starts to fit

- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements

- Do not try to put anything at all between the teeth

- Do not give anything to drink

- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care

- Arrange for other children to be escorted from the area, if possible

- Call for an ambulance if:

    - a seizure shows no sign of stopping after a few minutes
    - a series of seizures take place without the individual properly regaining consciousness

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position, to aid breathing and general recovery. Wipe away saliva from around the mouth

- Be reassuring and supportive during the confused period which often follows this type of seizure. If rest is required, arrangements should be made for this purpose

- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at childcare provision if this is a regular occurrence

If a child is known to have epilepsy:

- It is not usually necessary for the child to be sent home following a seizure, but each child is different. If the key worker feels that the period of disorientation is prolonged, contact the parents. Ideally, a decision will be taken in consultation with the parents when the child's condition is first discussed, and a Healthcare Plan drawn up

- If the child is not known to have had a previous seizure medical attention should be sought

- If the child is known to have diabetes this seizure may be due to low blood sugar (a hypoglycaemic attack) in which case an ambulance should be summoned immediately

Emergency Action: Epilepsy
First Aid for Children Known to Have Epilepsy and Prescribed Rectal Diazepam

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course.
- Check the time the child starts to fit
- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements
- Do not try to put anything at all between the teeth
- Do not give anything to drink
- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care
- Arrange for other children to be escorted from the area, if possible
- Rectal diazepam must only be given to a child with a prescription that a Consultant Paediatrician has endorsed and updated annually
- Rectal diazepam must only be administered in an emergency by an appropriately trained member of staff in the presence of at least one other member of staff
- Rectal diazepam must only be administered if a trained First Aider is on site
- If the child has been convulsing for five minutes and there is no suggestion of the convulsion abating, the first dose of rectal diazepam should be given. The medication should indicate the name of child, the date of birth, date of expiry, contents and the dosage to be administered
- If after a further five minutes

  (a) a seizure shows no sign of stopping or
  (b) a series of seizures takes place without the individual properly regaining consciousness, then call an ambulance

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position to aid breathing and general recovery. Wipe away saliva from around the mouth
- Be reassuring and supportive during the confused period which often follows this type of seizure. Many children sleep afterwards and if rest is required, arrangements could be made for this purpose
- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at childcare provision if this is a regular occurrence
- A child should be taken home after a fit if he/she feels ill

Appendix 9

Individual Care Plan for the Administration of Rectal Diazepam

This care plan should be completed by or in consultation with the medical practitioner

(Please use language appropriate to the lay person)

Details of Child and Condition	
Name:	Class:
Date of birth:	
Identify the seizure classification and/or description of seizures which may require rectal diazepam *(Record all details of seizures, for example goes stiff, falls, convulses down both sides of body, convulsions last 3 minutes etc. Include information re: triggers, recovery time etc. If in status epileptics, note whether it is convulsive, partial or absence)*	
Usual duration of seizure?	
Other useful information:	
Diazepam Treatment Plan	
When should rectal diazepam be administered? *(Note here should include whether it is after a certain length of time or number of seizures)*	

Initial dosage: how much rectal diazepam is given initially? *(Note recommended number of milligrams for this person*)

What are the usual reactions to rectal diazepam?

What action should be taken if there are difficulties in the administration of rectal diazepam *such as constipation/diarrhoea?*

Can a second dose of rectal diazepam be given? *Yes/No*

If ***Yes***, after how long can a second dose of rectal diazepam be given? (*state the time to have elapsed before re-administration takes place)*

How much rectal diazepam is given as a second dose? *(state the number of milligrams to be given and how many times this can be done after how long)*

When should the person's usual doctor be consulted?

When should 999 be dialled for emergency help?

- if the full prescribed dose of rectal diazepam fails to control the seizure *Yes/No*
- Other (Please give details)

Who Should:

- administer the rectal diazepam? *(ideally someone should be trained in at least 'Emergency Aid,' preferably 'First Aid at Work'):*
- witness the administration of rectal diazepam?

Who/where needs to be informed?

Parent_____ Tel: _____ Prescribing Doctor:_____ Tel: _____ Other:_____ Tel: _____	
Precautions: under what circumstances should rectal diazepam not be used? *(for example, Oral Diazepam already administered within the last……..minutes)*	

All occasions when rectal diazepam is administered must be recorded on the "Record of Use of Rectal Diazepam" log sheet (Appendix 10)

This plan has been agreed by the following:

Prescribing Doctor

Name_____Signature_____Date_____

Authorised person(s) trained to administer rectal diazepam

Name_____Signature_____Date_____

Name_____Signature_____Date_____

Parent

Name_____Signature_____Date_____

Key worker/SENCO

Name_____Signature_____Date_____

Good practice would state to share this form be available at every medical review of the patient and copies held by the GP and the childcare provision. (seek parental permission)

Expiry date of this form:_____

Copy holders to be notified of any changes by: _____

Record of Use of Rectal Diazepam

Name of Child:_____ **Class:**_____

Date:					
Recorded by:					
Type of seizure:					
Length and/or number of seizures:					
Initial dosage:					
Outcome:					
Second dosage (if any):					
Outcome:					
Observations:					
Parent informed:					
Prescribing doctor informed:					
Other information:					
Witness:					
Name of Parent re-supplying dosage:					
Date delivered to childcare provision:					