Administration of Medicines Policy

Presented to Governors: September 2019
Review date: September 2021

This policy has been based on guidelines on the administration of medicines in educational establishments produced by the City of Plymouth in September 2008.
This document can be found at
http://www.plymouth.gov.uk/theadministrationofmedicinesineducationalestablishments_sept08.pdf

Procedures for managing prescription medicines which need to be taken during the school or setting day.

- Only prescription medicines will be allowed to be given to children.
- Parents will need to sign the permission form detailing dosage and times to be given (Appendix 1)
- Staff will double up to administer prescription medicines with one giving and one checking correct dosage is given. This will be recorded in the Record Book. These books will be stored in the relevant classroom.
- If refrigeration is necessary, the fridge in the First Aid room will be used.
- If refrigeration is not necessary medicine will be kept in classroom cupboard not locked as access needed.
- Asthma inhalers will be kept in a cupboard in the classroom.
- Staff will be trained in administering specific medicines when necessary e.g. epipens. This training will be updated annually or as necessary.
- Staff will be trained in the care of and administration of medicine for diabetic children as required.

Procedures for managing prescription medicines on trips and outings

The above requirements will apply to trips and outings also.

- The person in charge of the trip will be responsible for storing and ensuring safe administration of the medicine takes place and is checked by a colleague.

- If a child requires medicine while on an offsite activity, a copy of the 'Administration of Medicines in School' form signed by the parent with be with the risk assessment.

A Summary of Parental Responsibility

Parents have the **prime responsibility** for their child's health and should provide schools and settings with the **necessary information** about their child's medical condition. For example, parents should ensure that a copy of the health care plan provided by the child's GP or relevant professional is made available to the school or setting, and must ensure that the school or setting is informed of any change in condition, prescription or staff training need.

Parents, as defined in section 576 of the Education Act 1996, include any person who is not a parent of a child but has **parental responsibility for or care of a child**. It only requires one parent to agree or to request that medicines are administered. **Where parents disagree** over medical support, the disagreement must be resolved by the courts: the school or setting should continue to administer the medicine in line with the consent given and in accordance with the prescription, unless and until a court decides otherwise.

If a child is on regular medication it may be necessary for **two sets** of similar medicines to be kept; one at home and one at school. The child's GP or paediatrician should be willing to prescribe this, at parental request.

Close co-operation between parents, health professionals and the school is essential. However, the primary responsibility to make arrangements rests with parents, including being prepared to make alternative provision should any arrangements fail.

Further details regarding parental responsibility may be found in Chapter 2 (Roles and Responsibilities) of the DFE guidance booklet which can be found by using the link below. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/196479/Managing_Medic ines.pdf

The circumstances in which children may take any non-prescription medicines.

- *Children suffering from sore throats may take soothing sweets as long as they do not have enough with them to break any dosage guidelines. The throat sweets must be handed to the teacher and the child may request one when needed.*
- The parents of children who suffer from travel sickness will be encouraged to gain prescribed medication. If that is impossible parents can give written permission to a member of staff who is willing to carry out their instructions for administering travel sickness medication.

The school policy on assisting children with long-term or complex medical needs

- Children with long term or complex medical needs will have a health care plan drawn up in conjunction with health care professionals. (Appendix 2)

Policy on children carrying and taking their medicines themselves – i.e. older children being able to carry their own medicines

- If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

Staff training in managing medicines safely and supporting an identified individual child

- The procedures for administering prescribed medicines will form part of the induction procedures for all staff.
- Identified individual children will only be supported in their medication by adults trained to do so. A list of staff trained in specific medication is included in a file in the first aid room, a list will also be included in classroom files.

Access to the school's emergency procedures

The school's emergency procedures are stored in the red box inside the Main office.

Safe disposal of sharps

If required, **sharps boxes**, which must always be used for the disposal of needles, should be provided by parents, who may obtain boxes on prescription from the child's GP or paediatrician and should collect boxes for disposal. Schools and early years settings should be aware of the need to maintain **security of sharps boxes**, which are potential targets for theft. It is also important to remember that any individual suffering a **needle-stick injury** should go straight to Accident and Emergency

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Inspiring today's children for tomorrow's world

An Academy School

Administration of Medicines in School

Name of Pupil: _____

Address: _____

Prescribing Doctor: _____

Medicine: _____

Dose: _____ Time/s to be administered in school: _____

Parental Consent

1. I confirm that the above medicine has been prescribed by a doctor or pharmacist and that I give my permission for a staff member to administer the medicine to my child during the time they are at school.

Signed: _____

Name: _____ Date: _____
Parent/person with parental responsibility

2. I give permission for my child to carry their asthma inhaler with them whilst at school and to manage its use.

Signed: _____

Name: _____ Date: _____
Parent/person with parental responsibility

NOTES OF GUIDANCE

The member of staff will only administer medicines prescribed by a doctor or a pharmacist.

This form should be completed by the parent, or person with parental responsibility, for the pupil and be delivered personally, together with the medicine, to the school office or your child's teacher.

The medicine should be in date and clearly labelled with:

- Its contents
- The pupils name
- Dosage and frequency
- Name of prescribing doctor

The information overleaf is requested, in confidence, to ensure that the school is fully aware of the medical needs of your child.

While no staff member can be compelled to give medical treatment to a pupil, it is hoped that the support given through parental consent, the support of the City Council through these guidelines, and the help of the School Medical Services will encourage them to see this as part of the pastoral role.

Where such arrangements fail it is the parents' responsibility to make appropriate alternative arrangements.

Elburton Primary School - Record of Medicines Administered

Date	Medicine	Dosage	Comments	Time	Signature	Print Name

CHAPTER 5: COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

INTRODUCTION

1. The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

2. Further information, including advice specifically for schools and settings, is available from leading charities.

3. Training for first-aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

ASTHMA

What is Asthma?

4. Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK.

5. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

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

Medicine and Control

7. There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are

taken during an asthma attack. They are sometimes taken before exercise. **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

8. **Children with asthma need to have immediate access to their reliever inhalers when they need them.** Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

9. Children who have been taught the correct inhaler technique (usually by the parents) and are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

10. For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

11. The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

12. When a child has an attack they should be treated according to their individual health care 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

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

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

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

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

17. Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

18. All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

19. All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY

What is Epilepsy?

20. Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of those children attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

21. Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be

recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual "feelings" reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

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

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

24. 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.

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

Medicine and Control

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

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

28. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

29. 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 set out in the child's health care plan
- a seizure lasts for five minutes, if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

30. Such information should be an integral part of the school or setting's emergency procedures and also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

31. Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures or seizures that repeat themselves with very little break will be prescribed either Midazolam or Stesolid. Children who are prone to longer seizures may be prescribed Midazolam or Stesolid which are effective emergency treatments. The paediatrician or other appropriate health professional should provide guidance as to when to administer medicines and why.

32. Training in the administration of Midazolam or Stesolid is essential and staff must be updated annually. Currently school nurses train in schools and children's community nurses train in early years establishments. Children prescribed Midazolam **must** have a protocol provided by the paediatrician which has been agreed with the parents. This will explain the seizure types and provide instruction on when to administer the medicine. Midazolam is a liquid solution given into the mouth or nasal passages which is absorbed by the mucous membrane. Diazepam is given rectally as a suppository, again it is absorbed into the mucous membrane. Both medications cause drowsiness so it is

important to stay with the child after administration.

33. Children and young people requiring rectal Diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse (although this risk should be kept in perspective). Two adults can also ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under-8s day care require the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?

34. Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes). Type 2 is rare locally.

35. About one in 550 school-age children has diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes may be treated by diet and exercise alone but it is usually medicated.

36. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. After diagnosis, all children enter school with a health plan detailing the symptoms of a hypoglycaemic episode ("hypo") and how the family have chosen to treat it. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

37. The diabetes of the majority of children is controlled by injections of insulin each day. Younger children may be on twice daily injections which are given outside school hours; however many are changing to multiple daily injections which include one at lunch time: this reduces the risks of **hyperglycaemic** incidents or "hypers". It is increasingly likely that staff may be asked to give or assist with insulin injections for younger children. Older children may be able to manage their own injections or may only need supervision; they should be offered a suitable private place to do this. Occasionally an older child may have their insulin delivered by an insulin pump.

38. Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime, and then insulin with breakfast, lunch and the evening meal, as well as before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

39. Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Generally, older children will be able to do this for themselves and will simply need a suitable place to do so. However, younger children may need adult supervision to carry out the test and/or interpret test results.

40. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

41. Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

42. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (“hypo”) in a child with diabetes:

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

43. Each child may experience different symptoms and this should be discussed when drawing up a health care plan. The health plan should be checked annually with parents.

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

45. An ambulance should be called if:

- the child’s recovery takes longer than 10-15 minutes
- the child becomes unconscious

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

47. Such information should be an integral part of the school or setting’s emergency procedures and also relate specifically to the child’s individual health care plan.

ANAPHYLAXIS

What is anaphylaxis?

48. Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

49. Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

50. The most severe result of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically, the airways narrow, causing breathing difficulties, and the patient loses consciousness.

51. Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully; the symptoms may be heralding the start of a more serious reaction.

Medicine and Control

52. All children should be prescribed an oral antihistamine as a first line of treatment;

training indicates which symptoms may be treated in this way and which symptoms require treating with adrenaline (also known as epinephrine). The treatment for a severe allergic reaction is an injection of adrenaline. Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

53. Should a severe allergic reaction occur the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

54. Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

55. The decision has been made to always hold 2 adrenaline devices stored in the first aid cupboard in the main office. This will be agreed on an individual basis between the head, the child's parents and medical staff involved.

56. Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away, is accessible to all staff and is identifies for the particular child. In large schools or split sites it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

57. Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. The plan will need to be agreed by the child's parents, the school and the treating doctor. The doctor will usually prescribe and leave plan details to other medical staff.

58. Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

59. Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practise with trainer injection devices.