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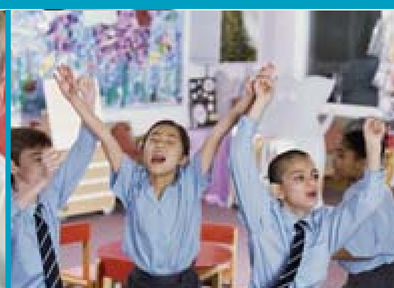
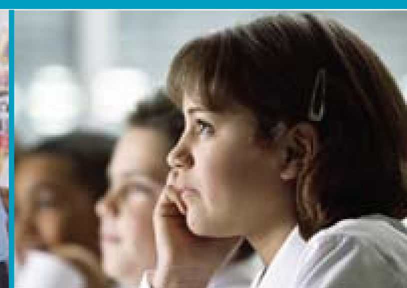
Supporting Pupils with Medication Needs





Supporting Pupils with Medication Needs

Foreword

An inclusive education policy means that children with special educational needs, disabilities or medical needs will be educated in a variety of school settings, ranging from classes and units/learning support centres in local mainstream nursery, primary and post primary schools through to special schools. This may include children with complex medical needs, where a number of specific procedures may be required in relation to their physical health.

The school's 'duty of care' to pupils requires that all staff act in 'loco parentis' to pupils entrusted to the school and any associated school related activities.

For staff who do provide support for pupils with medication needs they will be provided with appropriate training and legally indemnified in the terms outlined in Part 1.

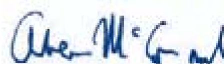
There is no legal duty that requires school staff to administer medication; this is a voluntary role and this Guidance does not intend to alter in any way the right of staff not to volunteer. It has, however, been written to help schools draw up policies on managing medication in schools and, where teachers or other staff have shown willingness to assist in the administration of medication, to help put in place effective management systems to support individual pupils with medical needs. It deals separately with protocols for pupils with short term medical needs, which may be as simple as the need to finish a course of medication and with pupils with long term medical needs. Proforma, which can be photocopied or adapted to suit local need, are provided in Part 2.

The guidance is intended for use in all schools and other educational settings, but with the increasing number of pupils included in mainstream schools, it is hoped that it will be of particular assistance in that sector.

The guidance is not a definitive interpretation of the law: interpreting the law is a matter for the Courts alone.

The Guidance has been written by the Departments of Education and Health, Social Services and Public Safety, in consultation with the Education and Library Boards, the Council for Catholic Maintained Schools, a range of education and health professionals and the Teachers' Unions.

Will Haire
Permanent Secretary
Department of Education



Dr Andrew McCormick
Permanent Secretary
Department of Health, Social Services and Public Safety

February 2008

IT IS IMPORTANT TO NOTE

There may be occasions where school staff may be asked to administer medication, but they cannot be directed to do so.

The administration of medication to children remains the responsibility of the parent or those with parental responsibility.

Medication should only be taken to school when absolutely essential and with the agreement of the Principal.

Parents should be encouraged to request, where possible, that medication be prescribed in dose frequencies which enable it to be taken outside school hours e.g. medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

Schools should be alerted to the particular risks for young persons in taking Aspirin and Ibuprofen and should not routinely administer these unless under clear medical guidance.

Contents

Page No

PART I – CONTEXTUAL ISSUES

Section

1. Introduction 1

2. General Issues 2
   - Legal Duty 2
   - Indemnity Policy 2
   - Confidentiality 3
   - Co ordinating Information 4
   - Special Educational Needs 4
   - Risk Management 4

3. Medication in Schools: Roles and Responsibilities 5
   - Parents[1] 5
   - Education Sector 6
   - Health Sector 11

4. Developing Policies and Procedures to Support Pupils with Medication Needs 13
   - Introducing a Policy 13
   - Monitoring and Evaluation 14

5. Model Policy for the Administration of Medication in School 15

6. Dealing with Medicines Safely 17
   - Safety Management 17
   - Storing Medication 18
   - Controlled Drugs 19
   - Access to Medication 20
   - Disposal of Medication 20
   - Hygiene/Infection Control 20

7. Access to Advice, Information and Training for Schools 21

8. Other Circumstances when a School may need to make Special Arrangements for Pupils with Medication Needs 25
   - Educational Trips 25
   - Sporting Activities 26
   - School Transport 27

[1] The term parent used throughout this document refers to parents or to those with parental responsibility for the child

Page No

PART II: ADMINISTRATION OF MEDICATION

1. General Issues 29
   - Delivery of Medication 29
   - Self medication 30
   - Refusing Medication 31
   - Record Keeping 31
2. Short term Medication Needs – Administration of Medication 31
   - Short term Prescribed Medication 32
   - Non prescription Medication 32
3. Medication Planning for a Pupil with Long Term Condition 33
   - Medication Planning 34
   - Proforma AM1 – AM7 to be photocopied or adapted for use by schools. 39-51
   - Sample Contact Form 53

PART III: EMERGENCY PROCEDURES

- Emergency Medication 55
- Emergency Procedures 56
- Emergency Call Form 57

PART IV: COMMON CONDITIONS

- Asthma 59
- Epilepsy 64
- Diabetes 68
- Anaphylaxis 71
- Attention Deficit Hyperactivity Disorder (ADHD) 75

PART V: CONTACTS

- Useful Contacts/Internet Resources 77

Part I: Contextual Issues

SECTION 1: INTRODUCTION

1.1.1 Most pupils will at some time have a medical condition that may affect their participation in school activities. For many this will represent a short term medical need; perhaps finishing a course of medication, as a result of an accident or recovering from illness. Some other pupils may require medication on a long term basis to keep them well, for example children with well controlled epilepsy or cystic fibrosis and, if this is not properly managed, they could be prevented from reaching their full potential. Such pupils are regarded as having medical needs. Most children with medication needs are able to attend school regularly and, with some support from the school, can take part in the majority of school activities. A positive response by the school to a pupil's medication needs will not only benefit the pupil directly, but can also positively influence the attitude of others.

1.1.2 Medication needs can be grouped into three categories:

- Pupils requiring short term prescribed medication for acute conditions, for example an ear or chest infection. Usually such children will have been off school, but may still be on medication when they return.
- Pupils with a long term condition requiring regular medication; the two biggest categories within this group would be children with asthma and those with ADHD.
- Pupils who may very rarely require medication to be given in an emergency: Two different types of medical emergency may arise within the school setting:
    - Where the pupil has not previously been known to have a medical condition and the medical emergency arises "out of the blue".
    - Where a pupil with a known medical condition and a Medication Plan experiences a medical emergency in the context of their condition, such as children with severe allergies who may need an adrenaline injection.

1.1.3 Within each of these categories medication may be self administered, supervised, or administered by a third party. The most challenging situations for schools are for the child on long term medication and the child requiring a drug in an emergency.

1.1.4 It is essential that policies are agreed and responsibilities understood by all parties: employers, Boards of Governors, Principals, teachers, parents, pupils, classroom assistants and other relevant staff.

SECTION 2: GENERAL ISSUES

1.2.1 This Section covers a range of issues general to all categories - legal duty; indemnity; confidentiality; special educational needs; risk assessment; and dealing with emergencies (responsibility).

Legal Duty

1.2.2 Principals, Vice Principals and teachers are not contractually required to administer medicines to pupils. This is a voluntary role, although some non teaching staff are employed on contracts, which require them to carry out certain medical procedures. Staff who provide support for pupils with medical needs, or who volunteer to administer medication, need support from the Principal and parents, access to information and training, and reassurance about their legal liability.

Indemnity Policy

1.2.3 If a member of staff administers medication to a pupil, or undertakes a medical procedure to support a pupil and, as a result, expenses, liability, loss, claim or proceedings arise, the employer will indemnify the member of staff provided all of the following conditions apply:

a. The member of staff is a direct employee.

b. The medication/procedure is administered by the member of staff in the course of, or ancillary to, their employment.

c. The member of staff follows:

- the procedures set out in this guidance;

- the school's policy;
- the procedures outlined in the individual pupil's Medication Plan, or written permission from parents and directions received through training in the appropriate procedures.

d. Except as set out in the Note below, the expenses, liability, loss, claim or proceedings are not directly or indirectly caused by and do not arise from fraud, dishonesty or a criminal offence committed by the member of staff.

Note: Condition d. does not apply in the case of a criminal offence under Health and Safety legislation.

Confidentiality

1.2.4 Each pupil should be treated as an individual. Where medication will be required during the school day, parents should provide the school with full information about their child's needs and should be encouraged to forward any GP, consultant or nursing advice to ensure the needs can be met effectively. Staff noticing deterioration in a pupil's health over time should inform the Principal who should let the parents know.

1.2.5 The Principal and school staff should treat medical information confidentially. The Principal should consult with the parent, or the pupil if appropriate, as to who else should have access to records and other information about the pupil's medical needs. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance, but otherwise in good faith.

1.2.6 The Principal should also consider how much other children in the pupil's class should know about a particular child's chronic condition. It can be helpful both educationally and emotionally for other children to be aware, for example, about diabetes or epilepsy and classmates can be very supportive if a child is known to be subject to, for example, hypoglycaemia. However, pupils with a medical condition are sometimes teased or bullied. **It is important that a school does not disclose details of a child's condition to other pupils without the consent of the parent *and* the child him/herself, if appropriate. When consent is given the situation should be handled as sensitively as possible.**

Co ordinating Information

1.2.7 If teachers volunteer to assist an individual pupil with medication needs and if the Principal agrees to this, it can be difficult to co-ordinate and share information, particularly in post primary schools. The Principal should decide which members of staff will have specific responsibility for this co-ordination role. This "identified person" can be a first contact for parents and staff, and liaise with external agencies. It would be helpful if members of staff with this role attended training on managing medicines and drawing up policies on medicines.

Special Educational Needs

1.2.8 Pupils with medical needs do not necessarily have special educational needs. But for those who do, their needs are addressed by the guidance contained within the Code of Practice for the Identification and Assessment of Special Educational Needs 1998 and the supplement to the Code published in September 2005[2]. Under the terms of the Education (Northern Ireland) Order 1996, a Health and Social Care authority must provide help to the Education and Library Board for a pupil with special educational needs, which may include medication needs, whether a child is placed in a mainstream or special school. Health and Social Care authorities have a responsibility to provide advice and training for school staff in procedures which deal with a pupil's medication needs, which in turn should support that child's access to education. Education and Library Boards, Health and Social Care authorities and schools should work together, in close partnership with parents, to ensure quality support in school for pupils with medication needs.

Risk Management

1.2.9 Dealing with medical conditions and medication needs must take into account the risks which arise from these and should aim to minimise probability of anything more serious happening to the child. Action taken should optimise opportunities to minimise risk.

[2] http://www.deni.gov.uk/index/7-special_educational_needs_pg/special_needs-codes_of_practice_pg.htm

SECTION 3: MEDICATION IN SCHOOLS: ROLES AND RESPONSIBILITIES

The voluntary nature of the role of teachers, Principals, Vice Principals should again be highlighted. However, this Section defines the roles and responsibilities of such staff who have volunteered to assist in the administration of medication to relevant pupils.

1.3.1 It is important that responsibility for pupils' health and safety is clearly defined and that each person involved with pupils who need medication is aware of what is expected of them. A partnership approach with close co operation among schools, parents, health professionals and other agencies is important in providing a supportive environment for pupils with these needs to enable them to participate fully in school activities.

Parents and Those with Parental Responsibility

1.3.2 Parents, as defined in the Education and Libraries (NI) Order 1986, as amended by the Children (NI) Order 1995, are a child's main carers. The administration of medicines is the responsibility of parents and those with parental responsibility. The dosage of many medicines can be arranged to permit medicine to be given to children before or after school - not during school - wherever possible. However, where this is not possible, pupils may be able to self administer medication. If this is a difficulty then an appropriate compromise with the parents and the prescribing doctor can be explored.[3]

1.3.3 Parents are responsible for:

- making sure that their child is well enough to attend school. A child's own doctor is the person best able to advise whether the child is fit to be in school and it is for parents to seek and obtain such advice as necessary;
- making the school aware that their child requires medication;
- reaching agreement with the Principal on the school's role in helping with their child's medication;

[3] For further information see DE Circular 1999/17 Parental Responsibility: Guidance for Schools

- providing the Principal with the original written medical evidence about their child's medical condition and treatment or special care needed at school;

- providing the Principal with written instructions and making a written agreement. Details of the dose and when the medication is to be administered, are essential;

- ensuring any changes in medication or condition are notified promptly;

- providing sufficient medication and ensuring it is correctly labelled;

- disposing of their child's unused medication; and

- giving written permission for the pupil to carry his/her own medication.

1.3.4 Some parents may have difficulty understanding or supporting their child's medical condition themselves. The School Health Service can often provide additional assistance in these circumstances.

The Employer

1.3.5 In Northern Ireland the employing authority for teachers and other staff in controlled schools is the relevant Education and Library Board. The employing authority for teachers in Catholic maintained schools is the Council for Catholic Maintained Schools (CCMS). The Board of Governors is the employer in voluntary grammar schools and in maintained integrated schools. In some independent schools the employer is the proprietor or the Trustees.

1.3.6 School staff who, in the course of their duties, voluntarily undertake the administration of personal or invasive medicines and follow strictly the guidelines and training given to them, will have the full support of the employer, who is legally liable for any wrongful actions committed by its employees in the course of their employment.

1.3.7 The employer is responsible for ensuring that:

- the school has a policy for supporting pupils with medication needs and managing medication;

- the school's insurance arrangements provide full cover for staff acting within the scope of their employment;

- it is made clear to staff at all levels what their legal responsibilities are (including where there is no legal responsibility on staff to administer medication in schools); the extent of insurance cover provided for staff acting within the scope of their employment; what cover is provided for staff who provide specific medication support; and where the liability is likely to lie in the event of legal action;

- correct procedures are in place;

- accurate records are kept in the school; and

- that staff who volunteer, or are recruited for the purpose of supporting pupils with medication needs, receive appropriate training to support pupils with medical needs.

The employer is also responsible, rather than the employee, in the event of legal action over an allegation of negligence.

The Board of Governors

1.3.8 The Education and Libraries (Northern Ireland) Order 2003 places a duty on the Board of Governors of a grant aided school to safeguard and promote the welfare of registered pupils at the school at all times when such pupils are:

a. on the premises of the school; or

b. in the lawful control or charge of a member of the staff of the school.

1.3.9 The Board of Governors has general responsibility for:

- ensuring their school develops its own policies to cover the needs of the school;

- ratifying all of the school's policies;

- following the health and safety policies and procedures produced by the ELBs and CCMS; and

- taking account of the views of the Principal, staff and parents in developing a policy on assisting pupils with medication needs.

The Principal

1.3.10 Day to day decisions with regard to support for pupils with medication needs will normally fall to the Principal. When parents request that medication be administered to their child at school, it is expected that Principals will deal with each case sympathetically and on its merits. If a pupil has a Statement of Special Educational Needs, the Statement should outline the procedures, support and training required as outlined in the relevant medical advices.

1.3.11 Where there is concern about whether the school can meet a pupil's medication needs, or where the parents' expectations appear unreasonable, the Principal should seek advice from the School Health Service/Designated Medical Officer. On the basis of information received the Principal will advise parents of a child with medication needs on the level of support the school will provide.

1.3.12 The Principal is responsible for:

- the operation of the policy on the administration of medication and is therefore the main person responsible for the administration of medication in school and for developing detailed administrative procedures for meeting the medication needs of pupils;

- making sure that all parents are aware of the school's policy and procedures for dealing with medication needs and the school's approach to pupils who need to take medication at school;

- dealing sympathetically with each request from parents that medication be administered to their child at school;

- ensuring that parents' cultural and religious views are always respected;

- ensuring that all staff are aware of the policy and procedures;
- designating the co ordination role to an "identified" person as outlined in Paragraph 1.2.7;
- ensuring that staff in contact with the pupil are:
  - informed about the child's condition;
  - informed about how to assist in meeting their needs in the classroom;
  - aware of the procedure for coping with an emergency associated with that medical condition; and
  - given appropriate support, advice and specialist training where necessary;
- ensuring that medicines are stored safely in a secure place, specifically designated for that purpose
- arranging cover for members of staff while medication is prepared or administered, to avoid interruption before the procedure is completed;
- ensuring that accurate records are maintained. It is recommended that monitoring arrangements are in place to ensure that guidelines are followed;
- ensuring that supply teachers or other visiting professionals know about the medication needs of individual pupils and how these are to be met;
- arranging back up cover for when the member(s) of staff, normally responsible for administering medication to a pupil, is (are) absent or unavailable;
- ensuring that, when a post primary school arranges work experience, the placement is suitable for a pupil with a particular medical condition and encouraging such pupils to share relevant medical information with employers;[4] and

[4] Guidance on organising work experience is available from each Education and Library Board, and from the Northern Ireland Council for the Curriculum, Examinations and Assessment (CCEA)

- asking the employer to provide written confirmation of the insurance cover for staff who provide specific medication support.

Teachers and Other School Staff

1.3.13 Some school staff may be naturally concerned about their ability to support a pupil with a medical condition, particularly if it is potentially life threatening. While referring to their role in pupils' welfare, teachers' conditions of employment do not include giving medication or supervising a pupil taking it, although staff **may** volunteer to do this. However, it must be emphasised again that there is no legal duty that requires school staff to administer medication. Where non teaching staff are involved, the employers should satisfy themselves that the arrangements in place for the administration of medicines in schools by such individuals is consistent with their own legal advice on this matter.

1.3.14 Teachers and other school staff, who volunteer to administer or supervise medication, are responsible for:

- understanding the nature of a pupil's medical condition and being aware of when and where the pupil may need extra attention;
- being aware of the likelihood of an emergency arising and the action to take if one occurs;
- taking part in appropriate training and being aware of the possible side effects of the medication and what to do if they occur; and
- supervising pupils who self administer medication, if this is required.

1.3.15 At different times of the school day other staff may be responsible for pupils, such as playground assistants. It is important that they are also provided with training and advice. Form AM6 provides an example of confirmation that any necessary training has been completed.

School Health Service

1.3.16 The School Health Service aims to promote the physical, emotional and mental health of all children and young people during their time at school. The services offered will help to identify health and developmental problems and enable appropriate action to be taken.

1.3.17 The School Health Service is available to all schools although not every school avails of the service. The key members of the team are the school doctor and the school nurse and as part of the health service they are in a position to liaise and work with their hospital colleagues as well as with Consultant Community Paediatricians, nurses and therapists etc from Health and Social Care (HSC) Trusts.

1.3.18 The School Health Service is responsible for providing a variety of services to schools including, health screening of pupils; immunisation; written advice to teaching staff on pupil health matters; and medical advice for special education where a child has special educational (including medical) needs; and health promotion activities.

The School Doctor/Community Paediatrician

1.3.19 The school doctor/community paediatrician has specific responsibility for assessing and reporting on children with special needs or medical problems with the aim of minimising the effect these have on the child's education. Each special school and learning support centre has a named school doctor. Each Trust has a designated doctor, usually a consultant community paediatrician/ associate specialist who has responsibility for liaising with the relevant Education and Library Board, particularly regarding children who have a Statement of Special Educational Needs. As in all other medical practice a duty of confidentiality exists between the doctor and the child and/or their parents, therefore consent is required before medical information can be shared with other professionals.

1.3.20 In most areas there is not a specific school doctor for each mainstream school, however when required, schools can contact their local community paediatric department for advice. The school nurse is the key healthcare professional with responsibility for the health of school age children. The named school nurse for each school continues to work closely with community paediatricians.

1.3.21 Community paediatricians run a range of specialist clinics, including developmental assessment, assessment of autistic spectrum disorders, ADHD and community audiology. Much of this work is conducted on a multidisciplinary basis linking with a range of other professionals such as allied health professionals and community nursing.

The School Nurse

1.3.22 The School Nurse is employed by the local HSC Trust and is frequently based within a clinic or health centre. He/she has a different role from nurses directly employed by some schools to fulfil the role of 'matron', or other school based nurse. In some instances, the HSC Trusts employ nurses who are based within Special Schools. Each School Nurse provides a service to a number of schools across primary and secondary education. They are registered nurses, with a growing number also holding a BSc Degree in School Nursing. Others hold additional qualifications and expertise in a wide range of fields, e.g. health promotion or asthma management.

1.3.23 The School Nurse is often the primary point of contact between the school and health services. He/she oversees the health needs of children at school by working closely with children and young people, their families, school and health colleagues. The role of the School Nurse is diverse, ranging from the promotion of health within the school population and the health surveillance and vaccination of large groups of pupils, to the identification of the health needs of individual children. The school nurse often oversees the compilation of individual Medication Plans to identify how the health needs of the pupil can be best met within the school environment. This requires collaboration between the pupil and their family, the nurse and the school. He/she can provide information on a range of health issues, and may co ordinate training programmes.

1.3.24 Some children with long term health needs receive support from community children's nurses/specialist nurses e.g. Diabetic Nurse Specialist, Epilepsy Nurse Specialist. Such nurses provide additional nursing expertise to the child and their family. They are often the main point of contact to medical services for the child. The community children's nurse and the school nurse often work together to compile the Medication Plan, and to provide the information and support required to enable schools to meet the pupil's specific health needs. The school nurse, however, remains the primary point of contact for the school.

The General Practitioner

1.3.25 The General Practitioner is an independent medical contractor who carries out services for individual patients on their list as contracted with the Department of Health, Social Services and Public Safety. He/she has no direct relationship with schools. In some cases parents may agree for GPs to advise teachers directly about a child's condition. In others, GPs may do so by liaising with the School Health Service. GPs are not obliged to provide this information about individual pupils to schools.

1.3.26 The School Health Service, Education and Library Boards and School Boards of Governors should work in co-operation to determine need and to plan and co-ordinate effective local provision within the resources available.

The Consultant Community Paediatrician

1.3.27 The Consultant Community Paediatrician is a specialist doctor with an interest in disability, chronic illness and the impact of ill health on children. He/she may give advice to the school on individual pupils, in drawing up individual Medication Plans or on health problems generally.

SECTION 4: DEVELOPING POLICIES AND PROCEDURES FOR SUPPORTING PUPILS WITH MEDICATION NEEDS

Introducing a Policy

1.4.1 A clear policy understood and agreed by staff, parents and pupils provides a sound basis for ensuring that children with short term and long term medication needs receive appropriate care and support at school. As far as possible, policies should provide guidance that should enable regular school attendance for children with medication needs. Formal systems and procedures for carrying out the policy, drawn up in partnership with parents, education and health staff, should support the policy.

1.4.2 A policy needs to be clear to all staff, parents and pupils. The school may find it useful to include its medication policy in its prospectus or other information to parents.

1.4.3 A school policy must deal with whether the Principal accepts responsibility, in principle, for school staff giving or supervising children taking

prescribed medication during the school day and, if that responsibility is accepted must cover:

- the circumstances in which children may take non-prescription medication e.g. pain killers (analgesics);
- the school's policy on assisting pupils with long term or complex medication needs;
- the need for prior **written** agreement from parents or guardians for any medication, prescribed or non prescription, to be given to a child;
- the circumstances in which children may carry and take their medication themselves;
- action to take if a pupil refuses to take prescribed medication as agreed with the parents;
- staff training in dealing with medication needs;
- record keeping;
- safe storage of and arrangements for access to medication;
- access to the school's emergency procedures; and
- procedures for dealing with pupils with medication needs when off site.

1.4.4 The policy should make clear that parents should keep their children at home if acutely unwell. The local Consultant in Communicable Disease Control, (CCDC), can advise on the circumstances in which pupils with infectious diseases should not be in school and the action to be taken following an outbreak of an infectious disease.

Monitoring and Evaluation

1.4.5 Procedures and protocols should be put in place to ensure that all aspects of the policy are monitored and evaluated against its aims and objectives. Consideration needs to be given to the following:

- a periodic review of the policy to reflect changing circumstances and trends in drug use;

- the development of criteria for evaluating the success of the policy and its implementation; and
- the involvement of appropriate members of the school community in assessing and reviewing the effectiveness of the policy.

1.4.6 A model policy is contained in Part I Section 5.

SECTION 5: MODEL POLICY FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

1.5.1 The Board of Governors and staff of (name of school) wish to ensure that pupils with medication needs receive appropriate care and support at school. The Principal will accept responsibility in principle for members of the school staff giving or supervising pupils taking prescribed medication during the school day **where those members of staff have volunteered to do so**.

Please note that parents should keep their children at home if acutely unwell or infectious.

1.5.2 Parents are responsible for providing the Principal with comprehensive information regarding the pupil's condition and medication.

1.5.3 Prescribed medication will not be accepted in school without complete written and signed instructions from the parent.

1.5.4 Staff will not give a non prescribed medicine to a child unless there is specific prior written permission from the parents.

1.5.5 Only reasonable quantities of medication should be supplied to the school (for example, a maximum of four weeks supply at any one time).

1.5.6 Where the pupil travels on school transport with an escort, parents should ensure the escort has written instructions relating to any medication sent with the pupil, including medication for administration during respite care.

1.5.7 Each item of medication must be delivered to the Principal or Authorised Person, in normal circumstances by the parent, **in a secure and**

labelled container as originally dispensed. Each item of medication must be clearly labelled with the following information:

- Pupil's Name.
- Name of medication.
- Dosage.
- Frequency of administration.
- Date of dispensing.
- Storage requirements (if important).
- Expiry date.

The school will not accept items of medication in unlabelled containers.

1.5.8 Medication will be kept in a secure place, out of the reach of pupils. Unless otherwise indicated all medication to be administered in school will be kept in a locked medicine cabinet.

1.5.9 The school will keep records, which they will have available for parents.

1.5.10 If children refuse to take medicines, staff will not force them to do so, and will inform the parents of the refusal, as a matter of urgency, on the same day. If a refusal to take medicines results in an emergency, the school's emergency procedures will be followed.

1.5.11 It is the responsibility of parents to notify the school in writing if the pupil's need for medication has ceased.

1.5.12 It is the parents' responsibility to renew the medication when supplies are running low and to ensure that the medication supplied is within its expiry date.

1.5.12 The school will not make changes to dosages on parental instructions.

1.5.13 School staff will not dispose of medicines. Medicines, which are in use and in date, should be collected by the parent at the end of each term. Date expired medicines or those no longer required for treatment will be returned immediately to the parent for transfer to a community pharmacist for safe disposal.

1.5.14 For each pupil with long term or complex medication needs, the Principal, will ensure that a Medication Plan and Protocol is drawn up, in conjunction with the appropriate health professionals.

1.5.15 Where it is appropriate to do so, pupils will be encouraged to administer their own medication, if necessary under staff supervision. Parents will be asked to confirm in writing if they wish their child to carry their medication with them in school.

1.5.16 Staff who volunteer to assist in the administration of medication will receive appropriate training/guidance through arrangements made with the School Health Service.

1.5.17 The school will make every effort to continue the administration of medication to a pupil whilst on trips away from the school premises, even if additional arrangements might be required. However, there may be occasions when it may not be possible to include a pupil on a school trip if appropriate supervision cannot be guaranteed.

1.5.18 All staff will be made aware of the procedures to be followed in the event of an emergency.

SECTION 6: DEALING WITH MEDICINES SAFELY

Safety Management

1.6.1 All medicines may be harmful to anyone for whom they are not prescribed. Where a school agrees to administer this type of medicine the employer must ensure that the risks to the health of others are properly controlled. This duty derives from the Control of Substances Hazardous to Health Regulations 2002, (COSHH).

1.6.2 The Medicines Act 1968 places restrictions on dealings with medicinal products, including their administration. In the case of prescription

only medicines anyone administering such a medicinal product by injection must be an appropriate medical practitioner, e.g. a doctor, or else must act in accordance with the practitioner's directions and authority.

1.6.3 There are exceptions for the administration of certain prescription only medicines by injection in emergencies (in order to save a life). An example of an exception is injection by a fully assembled syringe and needle delivering a set dose of adrenaline by intramuscular injection in the case of anaphylactic shock. Examples are EpiPen® and Anapen®. There are also junior versions for use in children.

Storing Medication

1.6.4 In a school where staff have volunteered to administer medication and where the Principal has agreed to this, the Principal is responsible for making sure that medicines are stored safely.

1.6.5 Schools should not store large volumes of medication. Parents should be asked to supply weekly or monthly supplies of the doses to be taken at school. Schools should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions, (paying particular note to temperature), and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration. This should be straight forward if medicines are only accepted in the original container as dispensed by a pharmacist in accordance with the prescriber's instructions.

1.6.6 Where a pupil needs two or more prescribed medicines, each should be in a separate container. Non health care staff should never transfer medicines from their original containers.

1.6.7 If the school locks away medication that a pupil might need in an emergency, **all staff should know where to quickly obtain keys to the medicine cabinet**.

1.6.8 Careful note should be taken of any requirements regarding the temperature at which the medication should be stored. Some medicines need to be refrigerated. Medicines can be kept in a refrigerator containing food, but should be in an airtight container and clearly labelled. If a school has to store

large quantities of medicines then a lockable medical refrigerator should be considered. The school should restrict access to a refrigerator holding medicines. Ideally the fridge should be fitted with a minimum and maximum thermometer.

1.6.9 Local and community services pharmacists may give advice to schools about storing medicines.

Controlled Drugs

1.6.10 The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated Regulations. Some may be prescribed as medication for use by children, e.g. methylphenidate.

1.6.11 Increasing numbers of children are taking methylphenidate, e.g. Ritalin®, Equasym®, Concerta®, for Attention Deficit Hyperactivity Disorder (ADHD). These are controlled drugs and therefore care must be taken regarding its storage.

1.6.12 Any member of staff may administer a controlled drug to the pupil for whom it has been prescribed, provided they have received appropriate training. Staff administering medicine should do so in accordance with the prescriber's instructions.

1.6.13 A pupil who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools and settings to look after a controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed.

1.6.14 Schools and settings should keep controlled drugs in a locked non portable container and only named staff should have access. A record should be kept for audit and safety purposes.

1.6.15 A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

1.6.16 Misuse of a controlled drug, such as passing it to another pupil for use, is an offence. Schools should have a policy in place for dealing with drug misuse.[5]

[5] DE Circular 1996/16: Misuse of Drugs : Guidance for Schools

Access to Medication

1.6.17 Pupils must have access to their medicine when required. They should know where their own medication is kept and who holds the key.

1.6.18 Some medicines, such as inhalers for asthma, must be readily available to pupils and should not be locked away. Many schools allow pupils to carry their own inhalers. If a pupil is likely to suffer a severe allergic reaction, the pupil may be old enough to carry his or her own medication (e.g. EpiPen®/ Anapen®) but if not, a suitable, safe, yet accessible place for storage should be found. Other medicines should generally be kept in a secure place not accessible to pupils. Further details relating to specific conditions are contained in Part V.

1.6.19 The school should make special access arrangements for emergency medication that it keeps. It is also important to make sure that medicines are only accessible to those for whom they are prescribed.

Disposal of Medicines

1.6.20 School staff should not dispose of medicines.

1.6.21 Medicines, which are in use and in date, should be collected by the parent at the end of each term.

1.6.22 Parents are responsible for disposal of date expired medicines. Date expired medicines or those no longer required for treatment should be returned to the parent immediately for transfer to a community pharmacist for safe disposal.

1.6.23 Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with local authority's environmental services.

Hygiene/Infection Control

1.6.24 All staff should be familiar with normal precautions for avoiding infection and must follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.

SECTION 7: ACCESS TO ADVICE, INFORMATION AND TRAINING FOR SCHOOLS

1.7.1 Pupils should be as safe in school as in the home. It is important that a range of training, relevant to pupils with short term and long term medication needs is made available to enable staff, who volunteer to administer medication, to develop proficiency at least equal to that of a parent. Schools should not be asked to undertake any procedure, which it is deemed unreasonable for a parent to undertake.

1.7.2 Training for the administration of medicines in schools will need to be at different levels. Depending on the identified needs of pupils, training may consist of awareness raising, advice, or training in specific procedures. As a minimum requirement schools should know who to turn to for immediate advice on medication and have access to training in the most common conditions. School staff in discussion with the School Health Service team will be able to identify the level of training required.

1.7.3 Voluntary organisations are often willing to provide awareness raising sessions related to specific conditions. Part V gives details of helpful organisations.

Children with a Short Term Need to take Medication in School

1.7.4 Pupils generally require short term prescribed medication for acute conditions, such as an ear or chest infection. There is little if any need for the School Health Service to be involved in these cases. The "training" needed would be an explanation by the parents and the manufacturers leaflet supplied with every medication. Staff should be made aware of the need for written parental consent to be obtained and to keep accurate records of each time medication is administered.

1.7.5 Where pupils are on self medication, e.g. paracetamol or cough mixture, the responsibility for medication should be with the child, if of an appropriate age and understanding. Parental consent must be secured in writing.

Children Requiring Daily Long Term Medication

1.7.6 This group includes pupils with a long term condition requiring regular medication. The two biggest categories within this group would be pupils with Asthma and those with ADHD. The School Health Service can provide pre-printed leaflets on these conditions, including advice on emergencies. In difficult cases the School Health Service would obviously be involved.

1.7.7 This category also includes pupils who, because of an existing medication condition might have an emergency episode which could put their life at risk and so would demand immediate attention. The main groups here would be those with severe epilepsy, diabetes and anaphylaxis due to food allergies. Depending on the severity of their condition these children might require a Medication Plan, which itself may reveal the need for some school staff to have further information about a medical condition or specific training in administering a particular type of medication or in dealing with emergencies. In these instances, school staff should never give medication without appropriate training from health professionals.

1.7.8 For children with significant medication needs an individual programme of training will be devised. All training should be reviewed at least annually and be child specific.

1.7.9 Training should be arranged in conjunction with the Health and Social Services Boards/Trusts, Community Paediatricians, School Nurse/Community Children's Nurse or other health professionals. Health Boards/Trusts have the discretion to make resources available for any necessary training. In many instances they will be able to provide the training themselves. A health-care professional should confirm that any training has given staff sufficient understanding, confidence and proficiency in medical procedures and communicate this to the employer. It will also be necessary to develop a programme of refresher courses to ensure that competencies remain current.

1.7.10 Training should be for named staff member(s) in the specific procedure(s) for each named child or children. The training programme undertaken must be planned and recorded in detail for the named staff member(s).

1.7.11 The training in specific procedures should include:

- information on the individual child's Medication Plan;
- the requirement to maintain the child's confidentiality;
- instruction on the procedure required by demonstration, followed by supervised practice where appropriate, and supported by a written protocol. This protocol should include the actions necessary for the trained person to implement and will become part of the pupil's Medication Plan; and
- where appropriate, child protection or intimate care issues must be addressed.

1.7.12 Ideally, the staff should be trained before the child starts attending school, but, otherwise, parents must be aware that they will need to continue being responsible for the procedures until staff are trained.

1.7.13 When nominating the staff to be trained the school must consider what action should be taken if the trained person is absent. In general it is advisable to train at least two people. If no trained person is available on a particular day, the parents should be advised of this.

1.7.14 Members of staff who have been trained should be given a Certificate of Competency from the training provider stating that he/she has completed a training programme in a specified procedure in relation to the named child. This Certificate should be kept in the school's personal file for the member of staff and a copy should be placed in the relevant pupil's personal file. This information should be updated on an annual basis or when the name of a trained individual changes. Form AM6 provides an example of such a Certificate.

1.7.15 If the pupil has a Statement of Special Educational Needs under the Education (Northern Ireland) Order 1996, as amended by the Special Educational Needs and Disability (Northern Ireland) Order 2005 the requirement for the procedures should be stated on medical, nursing or therapy advice. This advice should state that the Health and Social Services Board is willing to train staff in the procedure required.

Training in Emergency Procedures

1.7.16 All staff should know how to call the emergency services. All staff, whether they have volunteered to administer medication or not, should be given information about the most common conditions, which affect the pupils they may come into contact with during the course of a school day. This will help staff recognise symptoms and how to deal with an emergency should one arise. All staff should also know who is responsible for carrying out emergency procedures in the event of need and everyone should know how to contact these people in the event of an emergency occurring. Further guidance is contained in Part III.

1.7.17 Training in the most common conditions should include those listed below:

Allergic Reactions/Anaphylaxis

A basic understanding of the condition and the possible triggers. The recognition of the signs and symptoms of mild and severe allergic reactions, first aid procedures including the protection of airways and the recovery position, administration of medication including the use of a pre loaded adrenaline pen and emergency procedures. National minimum standards for training in allergy are currently in development and are likely to inform future practice.

Asthma

A basic understanding of the condition and the possible triggers and development of competence in the administration of medicine including the use of inhalers and spacer devices. Any training should also cover the possible side effects of medication and what to do if they occur and action to take if the pupil's condition does not improve. The type of training necessary will depend on the individual case.

Note: Normally children should not need to use a nebuliser in school. If a doctor or nurse does advise that a child needs to use a nebuliser in school, the staff involved will need training by a health professional.

Attention Deficit Hyperactivity Disorder

A full understanding of the symptoms of the condition, its treatment and management. Many sufferers will be prescribed stimulant medication, commonly methylphenidate, which is now sold under the brand names Ritalin®, Equasym®

and Concerta XL®. Methylphenidate is a class B drug and it is important that accurate records are maintained.

Cystic Fibrosis

A basic understanding of the disease, including its genetic origins, the maintenance treatment involved including the use of therapies, mobility and drugs for a range of reasons and the effect the disease has on the child's family and their education.

Diabetes

An understanding of the condition, the importance of diet and the symptoms of a hypoglycaemia, (low blood sugar), episode. Staff should be aware of appropriate emergency treatment for low blood sugar. For some cases, identified through the individual Medication Plan, knowledge of how to measure blood sugar levels and the appropriate action to be taken may be required.

Epilepsy

Knowledge of the nationally agreed training standards for the emergency treatment of seizures, published by the Joint Epilepsy Council. It is expected that all training will conform to these standards.

SECTION 8: OTHER CIRCUMSTANCES WHEN A SCHOOL MAY NEED TO MAKE SPECIAL ARRANGEMENTS FOR PUPILS WITH MEDICATION NEEDS

Educational Trips

1.8.1 This document does not address the issue of whether or not a child with medication needs should be permitted to go on educational visits or trips. However, it is the case that reasonable steps should be taken by schools to encourage pupils with medication needs to participate in school trips, wherever safety permits. This might include reviewing and revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medication needs. It might also include risk assessments for such children. It should be accepted, however, that there may be occasions when it may not be possible to include a pupil on a school trip if appropriate supervision cannot be guaranteed.

1.8.2 Sometimes the school may need to take additional safety measures for outside visits. Arrangements for taking any necessary medication will also need to be taken into consideration. If a child who needs medication is being taken on an overnight trip or journey (including overseas) the parent must provide detailed instructions and written consent for the administration of the medication for the period of the trip.

1.8.3 If the pupil has a Medication Plan this may be adapted through discussion with the pupil and parents, the school and health professionals, to identify the specific issues that need to be considered during the trip. Where possible the responsibilities of the pupil, parents and the school staff should be made explicit.

1.8.4 Staff supervising excursions should always be aware of any medication needs, and relevant emergency procedures. Sometimes an additional supervisor or parent might accompany a particular pupil. If staff are concerned about how they can provide for a pupil's safety, or the safety of other pupils on a trip, they should seek medical advice from the School Health Service, the child's GP or the Community Paediatrician as to what steps should be taken to ensure the medical needs are met. This advice should be sought well in advance of the proposed trip.

A copy of any Medication Plan should be taken on visits in the event of the information being needed in an emergency.

1.8.5 For further information on school trips see the DE Booklet, "Safety in Outdoor Education", issued to all schools in 1989. Further copies are obtainable from the HMSO Bookshop, 80 Chichester Street, Belfast BT1 4JY, price £3.75.

"Health and Safety of Pupils on Educational Visits: A Good Practice Guide" (DfES) can be accessed on
www.teachernet.gov.uk/wholeschool/healthandsafety/visits/

Sporting Activities

1.8.6 Most pupils with medical conditions can participate in extra curricular sport or in the PE curriculum, which is sufficiently flexible for all pupils to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well being. Any

restrictions on a pupil's ability to participate in PE should be included in their individual Medication Plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

1.8.7 Some activities, however, may need to be modified or precautionary measures may need to be taken, before or during exercise and pupils should be allowed immediate access to their medication if necessary. For example, children with asthma may need to take their reliever inhaler before exercise. Staff supervising sporting activities should consider whether risk assessments are necessary for some children and be aware of relevant medical conditions and emergency procedures. More details about specific health conditions can be found in Part IV.

School Transport

1.8.8 Education and Library Boards arrange home to school transport where legally required to do so. They **must** make sure that pupils are safe during the journey. Most pupils with medication needs do not require supervision on school transport, but Education and Library Boards should provide appropriately trained supervisors if they consider them necessary. Guidance should be sought from the child's GP or paediatrician.[6]

1.8.9 Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but where it is agreed that a driver or escort will administer medicines, i.e. in an emergency, they **must** receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles, responsibilities and liabilities.

1.8.10 Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. Individual transport health care plans will need input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training. Additionally trained escorts may be required to support some pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

6 'Home to school travel for pupils requiring special arrangements' (DfES, 2004) NI reference

1.8.11 Some pupils are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first-aid training and should be trained in the use of a pre loaded adrenaline pen for emergencies where appropriate.

Part II: Administration of Medication

SECTION 1: GENERAL ISSUES

2.1.1 This Part is divided into Sections relating to Short Term Medical Needs, Long Term Medical Needs and Emergency Medication. Pro-Forma are provided for completion by the parents, in conjunction with the school.

2.1.2 Medication includes both prescription and non prescription medications and includes those taken by mouth, taken by inhaler, which are injectable, applied as drops to the eye or nose, or applied to the skin.

Delivery of Medication

2.1.3 All items of medication should be delivered directly to the school by parents or escorts employed by the Education and Library Board by written instruction from parents.

2.1.4 Each item of medication must be delivered to the Principal or Authorised Person **in a secure and labelled container as originally dispensed**. It may be appropriate for the GP to prescribe a separate amount of medication for school use, where appropriate and practicable, one for home and one for use in the school, avoiding the need for repackaging or relabelling of medicines by the parent.

2.1.5 Each container must be clearly labelled with the following:

- Name of medication.
- Pupil's name.
- Dosage.
- Dosage of dispensing.
- Date of dispensing.
- Storage requirements (if important).
- Expiry date.

Items of medication in unlabelled containers will be returned to the parent.

2.1.6 It is the parents' responsibility to renew the medication when supplies are running low. Any changes in the dosage or other arrangements must be notified by parents, in writing, to the Principal.

Self Medication

2.1.7 It is good practice to allow pupils who are competent to do so to manage their own medication from a relatively early age and schools should encourage this with the written consent of the pupil's parents. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility. In cases where a child is managing his/her own medication he/she will not normally be expected to hand over their medication for storage. In these cases, however, a risk assessment will be made following discussion with the parents about the potential risks to others arising from this arrangement.

2.1.8 It is recognised that older pupils may wish to carry their own medication with them, but they should be encouraged to bring only the amount needed for the day, and should be made aware of the need for vigilance over access and use of such medication. Generally speaking pupils should be discouraged from carrying medication with them, unless absolutely essential.

2.1.9 Older children with a long term illness should, whenever possible, assume complete responsibility for their own medicines under the supervision of their parent. Children develop at different rates and so the ability to take this responsibility will vary. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self manage. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

2.1.10 If pupils can take their medicine themselves, staff may only need to supervise. An example would be inhalers for pupils with Asthma. Some pupils with diabetes may require to inject insulin during the school day. Appropriate facilities should be provided to allow the pupil to do this in private. The school policy should say whether pupils may carry and administer (where appropriate) their own medication, bearing in mind the safety of other pupils and medical advice from the prescriber in respect of the individual child. Schools need to be

kept informed if a child is to self administer and a parental consent form, Form AM3 is provided for this purpose.

2.1.11 Where children have been prescribed controlled drugs staff need to be aware that these should be kept in safe custody. However children could access them for self medication if it is agreed that it is appropriate.

Refusing Medication

2.1.12 If children refuse to take medicines, staff should not force them to do so, but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in an individual child's Medication Plan. Parents should be informed of the refusal as a matter of urgency on the same day. If a refusal to take medicines results in an emergency, the school's emergency procedures should be followed.

Record Keeping

2.1.13 It is good practice for schools to keep records of medicines given to pupils, including time/date and route of administration. Records offer protection to staff and proof that they have followed agreed procedures. It is recommended that schools should keep a Medical Needs Register for this. Staff involved should complete and sign a record card each time they give medication to a pupil. Form AM4 can be used for this purpose. When the form is fully completed, a copy should be put in the pupil's main school file. If the pupil transfers before the form is fully completed a copy should be placed in the pupil's main school file for transmission to the next school.

SECTION 2: SHORT TERM MEDICATION NEEDS

2.2.1 Short term medication needs may be managed as the administration of medication by others or as self administration of medication, but both categories will require the completion of consent forms. No pupil should be given short term medication by school staff without his or her parent's written consent.

2.2.2 Forms AM2 to AM6, which may be photocopied or adapted for use by schools, are included at the end of Part II.

Pupils requiring short term prescribed medication for acute conditions, such as an ear or chest infection.

2.2.3 Many pupils will need to take medication (or be given it) at school at some time in their school life. Mostly this will be for a short period only, e.g. to finish a course of antibiotics or apply a lotion. This may also be the case if a pupil suffers regularly from acute pain, such as migraine. To allow pupils to take medication in school will minimise the time they need to be off school but medicines should only be taken to school or settings when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school day. The appropriate consent forms must be completed.

2.2.4 Any member of staff giving medicine to a pupil should check:

- the pupil's name and date of birth;
- written instructions provided by parents or doctor;
- that the child has not already received medication;
- the prescribed dose;
- the expiry date; and
- route of administration.

2.2.5 If in doubt about any of the procedures the member of staff should check with the parents or a health professional before taking further action.

2.2.6 It is good practice, where possible, to have the dosage and administration witnessed by a second adult.

Pupils requesting non prescription medication

2.2.7 Pupils sometimes ask for painkillers (analgesics) at school such as paracetamol. Some schools have a consent form, which should be completed by the parent on an annual basis, which will allow the routine administration of these short term medications. School staff should **never** give non prescribed medication to pupils unless there is specific prior written permission from the parents.

2.2.8 In some instances pupils may be permitted to self administer from a personally held supply as governed by school policy.

2.2.9 Over the counter medicine e.g. cough mixture or hay fever remedies, should only be accepted in exceptional circumstances, and be treated in the same way as prescribed medication. Parents must clearly label the original container with the child's name, date of birth, dose and time to be taken and complete the relevant consent form.

SECTION 3: MEDICATION PLANNING FOR A PUPIL WITH A LONG TERM CONDITION

2.3.1 Long term medication needs may be managed as the supervised administration of medication or as the administration of medication by others, but both categories will require the completion of a Medication Plan.

2.3.2 It is important for the school to have sufficient information about the medical condition of any pupil with long term medical needs and a procedure drawn up for this. If a pupil's medical needs are inadequately supported this can have a significant impact on a pupil's academic attainments and/or lead to emotional and behavioural problems. The school therefore needs to know about any medical needs before a child starts school, or when a pupil develops a condition. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. Some pupils may have serious medical conditions, such as diabetes, epilepsy, severe allergies or asthma and may very rarely require a drug to be given in an emergency: e.g. epilepsy (rectal diazepam), anaphylaxis (adrenaline), acute asthma (inhaler). These drugs may be lifesaving. Other pupils may need regular prescribed medication, for example Ritalin®. In these cases, there needs to be agreement with teachers as to who will administer them. An individual Medication Plan should be drawn up, involving the parents and relevant health professionals and the child should he/she have sufficient understanding.

Forms AM1 to AM6, which may be photocopied or adapted for use by schools, are included at the end of Part II and can be used to constitute a full Medication Plan.

Medication Planning

2.3.3 Young people vary in their ability to cope with poor health or a particular medical condition and this involves schools responding to individual health care needs. However, the school's medication policy must be applied uniformly but not inflexibly or insensitively. Staff should not make value judgements about the type of medication prescribed by a registered medical or dental practitioner.

2.3.4 Not all pupils who have medical needs will require a Medication Plan. A short written agreement with parents may be all that is necessary such as Forms AM2 or AM3.

2.3.5 For those who do require a Plan the purpose is to ensure that school staff have sufficient information to understand and support a pupil with long term medical needs. It should be overseen by the school nurse or doctor and should be drawn up in conjunction with the parents and, where appropriate, the child and the child's medical carers. It should set out in detail the measures needed to support a pupil in school, including preparing for an emergency situation.

2.3.6 Drawing up a Medication Plan should not be onerous, although each Plan will contain different levels of detail, according to the needs of the individual pupil.

2.3.7 Each Plan will identify the pupil's medical condition, its impact in relation to the school and the assistance the pupil will require during the school day.

2.3.8 **The need for a Medication Plan and the medical detail of such a plan should only be assessed by a health professional**. It is not anticipated that detailed plans will be required for short term needs where a child for example is taking a course of antibiotics. In such cases it would be sufficient to record details of the medication, time of administration and any possible side effects. More detailed plans will be required for those with long term needs. Those who will need to contribute to a detailed Medication Plan are:

- the School Health Service, the school nurse, the child's GP or other health care professionals (depending on the level of support the child needs);

- the Principal;
- the parent;
- the child (if sufficiently mature and capable of understanding);
- the class teacher (primary schools)/Head of Year/form teacher (post primary schools);
- the Special Educational Needs Co-ordinator (SENCO);
- additional adult assistant or support staff (if applicable); and
- school staff who have agreed to administer medication or be trained in emergency procedures.

2.3.9 Others who may be able to offer a contribution are social services and voluntary organisations specialising in a particular medical condition can provide advice on good practice or produce school packs advising teachers on how to support pupils. (Part V lists some useful contact names and addresses).

2.3.10 The Plan should be tailored to the individual needs of the pupil but must include:

- child's name, date of birth, home address and phone number;
- phone numbers/addresses of contact persons;
- details of a pupil's condition;
- special requirements e.g. dietary needs, feeding requirements, toileting, pre-activity precautions;
- medication and any side effects;
- what constitutes an emergency;
- precise steps to be taken in an emergency;
- emergency phone numbers (GP, School Nurse/Community Children's Nurse, Health Centre, Hospital, 999);

- the role the school can play; and
- other health and social care professionals involved.

2.3.11 All relevant school staff in contact with the child should be aware of the requirements of the individual Medication Plan.

2.3.12 The Plan should be reviewed at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently. At least once during the year the staff involved should test the procedures to ensure that they remain effective.

2.3.13 Children with complex physical needs who have numerous medications which are administered via several routes, e.g. gastronomy, NG tube, which can be changed on a very frequent basis, would need in some instances a prescription sheet completed, signed and dated by their GP. This would have exact details of each drug on it including the route, time of administration, dose etc and also would require the signature of the person administering the drug.

Medication Plans: Proforma which may be adapted for use by schools *(these forms are downloadable as WORD documents at www.deni.gov.uk)*

Form AM1

This form must be completed for every pupil who requires a Medication Plan and must be kept in the pupil's main school file. It must be updated at least annually and earlier if there is a change in either the pupil's condition or medication/procedure.

A full Medication Plan will consist of Forms AM1, AM2 or AM3, AM4 and AM6. Form AM7 may also be needed for pupils with Epilepsy.

Form AM2

This form is to be completed by the parent. It enables the school to ensure the correct information has been received from parents and to monitor and correctly support the use of medication in the school. If a pupil requires several items of medication in school the appropriate details should be provided on the reverse of this form. On receipt of Form AM2 the school should complete the

"Agreement of Principal" Section. The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.

Form AM3

This form should be completed by the parent if they request their child to carry and administer their own medication, e.g. inhaler, insulin. On receipt of Form AM3 the school should complete the "Agreement of Principal" Section. The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to medication to be carried and self administered in school.

Form AM4

This is the school's Record of Medication administered to individual pupils in school. A copy of this form should be sent to the pupil's parents on a regular basis. When the form is fully completed a copy should be put in the pupil's main school file. If the pupil transfers before the form is fully completed a copy should be placed in the pupil's main school file for transmission to the next school.

Form AM5

This is the school's record of medication administered to all children.

Form AM6

This form must be completed when staff receive training for medical procedures. Training must be updated at least annually or more frequently if required.

Form AM7

Authorisation for the administration of rectal diazepam.

Note: Copies of the appropriate forms should be kept in the pupil's main school file and in the Medication Administration Records File.

Form AM1

Name of School ____________________

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

Date ____________ Review Date ____________

Name of Pupil ____________________

Date of Birth ____ / ____ / ____

Class ____________________

National Health Number ____________

Medical Diagnosis ____________________

____

Contact Information

1 Family Contact 1

Name ____________________

Phone No (home/mobile) ____________

(work) ____________

Relationship ____________________

2 Family Contact 2

Phone No (home/mobile) ____________

(work) ____________

Relationship ____________________

3 GP

Name ____________________

Phone No ____________

4 Clinic/Hospital Contact

Name ____________________

Phone No ____________

Plan prepared by

Name ____________________

Designation ____________ Date ____________

Describe condition and give details of pupil's individual symptoms

Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

Members of staff trained to administer medication for this child (state if different for off site activities)

Describe what constitutes an emergency for the child, and the action to take if this occurs

Follow up care

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of

Signed ______________________ Date ______________
Parent/carer

Distribution

School Doctor ______________ School Nurse ______________
Parent ______________ Other ______________

Form AM2

Name of School ____________________

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that school staff can administer the medicine.

Details of Pupil

Surname ____________ Forename(s) ____________

Address ____________________

____

Date of Birth ___ / ___ / ___ M ☐ F ☐

Class ____________________

Condition or illness ____________________

____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name/Type of Medication (as described on the container)

____

Date dispensed ____________

Expiry Date ____________

Full Directions for use

Dosage and method

____

____

____

____

NB Dosage can only be changed on a Doctor's instructions

Timing ____________________

Special precautions ____________________

Are there any side effects that the School needs to know about?

____

____

Self Administration Yes/No *(delete as appropriate)*

Procedures to take in an Emergency

____

____

____

Contact Details

Name ____

Phone No (home/mobile) ______________________

(work) ______________________

Relationship to Pupil ____

Address ____

____

I understand that I must deliver the medicine personally to ___________________ (*agreed member of staff*) and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature(s) ____________________________ *Date* ____________________

Agreement of Principal

I agree that __________________________ (*name of child*) will receive __________________________ (*quantity and name of medicine*) every day at ____________________ (*time(s) medicine to be administered e.g. lunchtime or afternoon break*).

This child will be given/supervised whilst he/she takes their medication by ___________________________ (*name of staff member*).

This arrangement will continue until ___________________________ (*either end date of course of medicine or until instructed by parents*).

Signed ____________________________ Date ____________________

(The Principal/authorised member of staff)

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.

Form AM3

Name of School ______________________________

TEMPLATE FOR A REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

This form must be completed by parents/carers.

If staff have any concerns discuss this request with healthcare professionals.

Details of Pupil

Surname ________________ Forename(s) ________________

Address ______________________________

____

Date of Birth ___ / ___ / ___

Class ______________________________

Condition or illness ______________________________

____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name of Medicine

____

Procedures to be taken in an emergency

____

____

____

Contact Details

Name ______________________________

Phone No (home/mobile) ________________

(work) ________________

Relationship to child ______________________________

I would like my child to keep his/her medication on him/her for use as necessary.

Signed ________________ Date ________________

Relationship to child ______________________________

Agreement of Principal

I agree that ____________________________ (*name of child*) will be allowed to carry and self administer his/her medication whilst in school and that this arrangement will continue until ______________________ (*either end date of course of medication or until instructed by parents*).

Signed ____________________________ Date ______________________
(The Principal/authorised member of staff)

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to the named pupil carrying his/her own medication.

Form AM4

Name of School ______________________________

RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD

Surname	
Forename(s)	
Date of Birth	____ /____ /____ M ☐ F ☐
Class	
Condition or illness	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Expiry date	____ / ____ / ____
Quantity returned	
Dose and frequency of medicine	

Checked by:

Staff signature ____________________ Signature of parent ____________________

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	____/____/____	____/____/____	____/____/____
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___/___/___	___/___/___	___/___/___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___/___/___	___/___/___	___/___/___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___/___/___	___/___/___	___/___/___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___/___/___	___/___/___	___/___/___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Form AM5

Name of School ______________________________

RECORD OF MEDICINES ADMINISTERED TO ALL CHILDREN

Date	Child's Name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print Name
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							
__/__ /__							

Form AM6

Name of School ____________________

TEMPLATE FOR A RECORD OF MEDICAL TRAINING FOR STAFF

Name ____________________

Type of training received ____________________

Name(s) of condition/ medication involved ____________________

Date training completed ____________________

Training provided by ____________________

I confirm that ____________________ has received the training detailed above and is competent to administer the medication described.

Trainer's signature ____________________ Date __________

I confirm that I have received the training detailed above

Trainee's signature ____________________ Date __________

Proposed Retraining Date __________

Refresher Training Completed -

Trainer ____________________ Date __________

Trainee ____________________ Date __________

Form AM7

Name of School ____

AUTHORISATION FOR THE ADMINISTRATION OF RECTAL DIAZEPAM

Child's name ____

Date of Birth ____ /____ /____

Class ____

GP ____

Hospital consultant ____

______________________________ should be given Rectal Diazepam ____mg

If he/she has a *prolonged epileptic seizure lasting over ______ minutes

or

*serial seizures lasting over ______ minutes.

An Ambulance should be called for *at the beginning of the seizure

or

If the seizure has not resolved *after ______ minutes.

(**please delete as appropriate*)

Doctor's signature ________________ Parent's signature ________________

Date ____ /____ /____

NB: Authorisation for the administration of rectal diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state: when the diazepam is to be given e.g. after 5 minutes; how much medicine should be given; if a second dose of Rectal Diazepam can be given; and how the child presents before, during and after a seizure.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

This form should be completed in conjunction with Form AM7.

Records of administration should be maintained using Form AM4 or similar.

SAMPLE CONTACT FORM

SUPPORTING PUPILS WITH MEDICAL AND ASSOCIATED NEEDS

LOCAL CONTACT NUMBERS

(Please complete as appropriate for your school)

______________________________ **School**

Principal ______________________________

Authorised person ______________________________

SENCO ______________________________

School Nurse ______________________________

______________________________ **Education and Library Board**

SEN Section ______________________________

Educational Psychology ______________________________

Health and Safety ______________________________

______________________________ **Health Board/Trust**

School Doctor ______________________________

School Nurse ______________________________

Local Hospital ______________________________

Local GP Surgeries ______________________________

Community Paediatrician ______________________________

School Health Service ______________________________

Part III: Emergency Procedures

Emergency Medication

3.1 As part of general risk management processes all schools and settings should have arrangements in place for dealing with emergency situations. All staff should be informed annually of pupils with a medical condition and/or Medication Plan.

3.2 Any individual can take action to preserve life provided that the action is carried out with the best of intentions and is performed in good faith. Teachers and other staff are expected to use their best endeavours at all times in emergencies. In general the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency. Advice and training is available from the School Health Service regarding possible medical emergencies.

3.3 These are mainly related to four conditions:

- Acute asthmatic attack requiring more inhalers/attention than usual routine doses.
- Diabetic hypoglycaemic attack requiring Glucose (glucose tablets or hypostop).
- Anaphylactic reaction requiring Adrenaline (e.g. EpiPen® or Anapen®).
- Prolonged epileptic seizures requiring Rectal Diazepam.

3.4 The potential for an emergency to arise will be reflected in the pupil's Medication Plan which will incorporate a plan of action to take should an emergency occur. More detailed information for specific conditions is provided in Part IV.

3.5 Where a pupil experiences an emergency event with no relevant previous history, staff are expected to take all reasonable steps within their own competencies and experiences to assist the pupil and obtain the appropriate help.

3.6 Where a pupil with a known medical condition and who has a Medication Plan experiences a medical emergency, staff will be expected to follow the advice given in that Medication Plan. Temporary staff, who may be in attendance and may not have the level of awareness and understanding of permanent staff, are expected to act within their own competencies and experience and obtain appropriate help.

Emergency Procedures

3.7 All staff should know how to call the emergency services. All staff should also know who is responsible for carrying out emergency procedures in the event of need. Other children should know what to do in the event of an emergency, such as telling a member of staff. Guidance on calling an ambulance is provided on the example Emergency Call form, which is provided at the end of this Section. One copy should be displayed by the office telephone as an aide-memoire with school details in case of an emergency.

3.8 Parents must be immediately alerted. A pupil taken to hospital by ambulance should be accompanied by a member of staff who should remain until the pupil's parent arrives. Where possible, the member of staff should have details of any health care needs and medication of the pupil and or a copy of the Medication Plan. Health professionals are responsible for any decisions on medical treatment when parents are not available.

3.9 Staff should never take children to hospital in their own car; it is safer to call an ambulance. In remote areas a school might wish to make arrangements with a local health professional for emergency cover.

3.10 Individual Care or Medication Plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

3.11 The incident should be fully recorded.

3.12 Staff Handbooks should detail the schools emergency procedures.

In all emergency situations a teacher or other member of school staff will be expected to act as a responsible adult or parent in the best interests of the child in recognition of their duty of care.

If in doubt phone for the emergency services.

EMERGENCY CALL FORM

TO BE DISPLAYED BY THE OFFICE TELEPHONE

REQUEST FOR AN AMBULANCE

to:

Dial 999, ask for ambulance and be ready with the following information.

1. Your telephone number (insert telephone number here).

2. Give your location as follows: (insert school address and postcode).

3. Give exact location within the school (insert brief description).

4. Give your name.

5. Give brief description of pupil's symptoms.

6. Inform ambulance control of the best entrance and state that the crew will be met and taken to the pupil.

SPEAK CLEARLY AND SLOWLY

Part IV: Common Conditions – Practical Advice on Asthma, Epilepsy, Diabetes, Anaphylaxis and Attention Deficit Hyperactivity Disorder (ADHD)

Introduction

Medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis) and ADHD. **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.** Further information, including advice specifically for schools, is available from a number of organisations listed in Part V.

ASTHMA

What is Asthma?

Asthma is a condition that affects the airways - the small tubes that carry air in and out of the lungs. It is the most common, long term condition for children and young people in the UK. One in ten children has asthma in Northern Ireland.

The most common symptoms of asthma are coughing, a wheezing or whistling noise in the chest, tightness in the chest and shortness 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 and young people may only get symptoms from time to time.

However staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse. Nor will children know 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 a child's symptoms are getting worse and what to do when this happens.

All staff in early years settings and schools should receive regular training about asthma (early years carers can access training through Asthma UK

Northern Ireland). In addition, all schools should keep an asthma register to record the details of individual's asthma triggers and the medicines they take. School asthma cards (available from Asthma UK) are a useful way of collating and storing these details.

Children with significant Asthma should have an individual Medication Plan.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers.

Relievers (usually blue) are medicines that should be taken immediately when asthma symptoms start. They quickly relax the muscles surrounding the narrowed airways making it easier to breathe again. Relievers are essential in treating asthma attacks. Every child and young person with asthma should have a reliever inhaler and always take one to school with them.

Preventers (brown, red, orange or white inhalers, sometimes tablets), are usually taken outside of school hours in the early morning or evening. Preventers control the swelling and inflammation in the airways, stopping them from being so sensitive and reducing the risk of severe attacks. The protective effect builds up over a period of time so they need to be taken every day. However not all children and young people with asthma will need or be prescribed preventer medicines.

It is essential that all pupils and children have immediate access to their reliever inhalers when they need them. Relievers should always be available during physical education, sports activities and educational visits.

A spacer device is used with most aerosol inhalers to improve the delivery of medicine directly to the lungs. Children may need some help to use their inhaler and spacer. However it is good practice to encourage children with asthma to take charge of and be able to use their own inhaler from an early age. Children who are able to use their reliever inhaler themselves should be allowed to carry it with them. If the child is too young or immature to take personal responsibility for their reliever, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.

NB: In the management of the acute asthma attack the reliever should be used in combination with a spacer device.

Apart from the reliever inhaler that is brought in daily by the child or young person, all parents should provide a spare inhaler for the school or setting, so that if a child or pupil forgets or loses their own, a spare is available. In early years settings and at primary school, spare inhalers should be kept in the child's individual classroom. At secondary school, a central room that is never locked should be used to store spare inhalers. It is the parent/carer's responsibility to ensure that all inhalers that are taken to school (or the setting), and left there as spare, are still in date. **Relievers should never be locked away in a room or drawer.**

Common signs of an asthma attack

- Coughing
- Shortness of breath
- Wheezing
- Tightness in the chest
- Being unusually quiet
- Difficulty speaking in full sentences
- Tummy ache (sometimes in younger children)

What to do in an asthma attack

- Keep calm.
- Encourage the child or young person to sit up and slightly forward. Do not hug or lie them down.
- Make sure the pupil takes two puffs of reliever (blue) inhaler immediately (preferably through a spacer).
- Loosen tight clothing.
- Reassure the child.

If there is no immediate improvement

Continue to make sure the pupil takes one puff of reliever inhaler every minute for five minutes or until their symptoms improve.

Call 999 urgently if:

- the symptoms do not improve in 5-10 minutes;
- the pupil is too breathless or exhausted to speak;
- the child or young person's lips are blue; or
- if you are in any doubt.

Continue to give the child one puff of their reliever inhaler every minute until the ambulance or doctor arrives.

An Asthma School Card (available from Asthma UK) is a useful way to store written information about the individual child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent/carer and the child's doctor.

For children and young people with severe asthma, it may also be helpful to draw up a more detailed written school Medication Plan agreed to by the child's parent/carer, the school and the child's doctor.

All children and young people with asthma should have regular asthma reviews (every six to twelve months) with their doctor or asthma nurse. Parents should arrange the review and should receive a written personal asthma action plan to help them manage their child's condition at home. Keeping a personal asthma action plan at school is not usually necessary for most pupils at most schools. (Boarding schools are the exception).

If a child's asthma is getting worse, a personal asthma action plan shows the parent/carer how to change their medicines accordingly. These changes are usually to medicines they take out of school hours. However, when advice from the child's doctor or nurse changes, parents/carers should make sure their child's school asthma card is updated.

Many children and young people will experience asthma symptoms during or after exercise, however like everybody else, children and young people with asthma need regular exercise. The majority should be able to take part in any sport or activity they enjoy, as long as their asthma is under control and they take the necessary precautions.

When exercising children and young people with asthma should:

- Increase their fitness levels gradually.
- Always have their reliever inhaler with them when they take part in physical activity or exercise.
- Take their reliever inhaler immediately before they warm up (if they have exercise induced asthma.
- Always warm up and down thoroughly.
- Avoid coming into contact with things that trigger their asthma.
- Stop, if they start having asthma symptoms during exercise. The child or young person should then take their reliever inhaler and wait until they feel better (at least five minutes) before starting again.

Certain types of sport are better for people with asthma than others. Swimming is an excellent form of exercise for children and young people with asthma, however chlorine and swimming in cold water can be a trigger for some. Team sports such as football or hockey are less likely to cause asthma symptoms because they are played in brief spurts with short breaks in between. Long distance or cross country running are particularly common triggers because they take place outside in cold air, without short breaks.

Out There and Active posters and cards for schools, pupils and parents, (available from Asthma UK), are a useful way of reminding staff about how to control asthma while exercising.

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 also be encouraged to recognise when their symptoms inhibit their ability to participate.

Children and young people with asthma may not attend school or the setting on some days due to their condition. Children may also have sleep disturbances due to night symptoms, which might affect their concentration. Teachers should first talk to the child's parents/carers, as they may need to take their child to their doctor or nurse for an asthma review. The school nurse and Special Education Needs Co-ordinator should also be informed as appropriate.

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 school asthma policy can also be incorporated into part of the health and safety, first aid or general health policy. The asthma section should set out specific actions and include key information like what to do in an asthma attack (a school policy guide is available from Asthma UK and can be downloaded from their website). The school environment should be made asthma friendly, by removing as many potential asthma triggers as possible.

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, their delivery and what to do if a child has an asthma attack.

Asthma UK has produced a **School Pack** which provides information on asthma, asthma in PE and sports, what to do when a child with asthma joins the class and on developing a good school asthma policy, with an example. A free copy of the School Pack can also be ordered on 020 7704 5888: additional copies cost £2. **Asthma UK Adviceline:** Tel 08457 01 02 03.

Asthma UK Publications

To download a copy of the Asthma at School policy guide - **www.asthma.org.uk** To request School Cards, Pre School Cards or Out There and Active resources for your school - **ni@asthma.org.uk**

EPILEPSY

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream

school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual medication 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.

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

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

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

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

Medicine and Control

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

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. 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.

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

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure;
- the child has injured themselves badly;
- they have problems breathing after a seizure;
- a seizure lasts longer than the period set out in the child's health care plan;
- a seizure lasts for five minutes if you do not know how long they usually last for that child;
- there are repeated seizures, unless this is usual for the child as set out in the child's Medication Plan.

Such information should be an integral part of the school or setting's emergency procedures as discussed in Part III but also relate specifically to the child's individual Medication Plan. The Medication Plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra nasally, may be prescribed as an alternative to rectal diazepam. Instructions for use must come from the prescribing doctor. An authorisation form AM7 should be completed and form part of the full Medication Plan.

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.

If the school can arrange for 2 adults, one the same gender as the pupil, to be present for the administration of intimate or invasive treatment, this can ease practical administration of treatment and minimise the potential for accusations of abuse. Staff should protect the dignity of the pupil as far as possible, even in emergencies.[7]

The **National Society for Epilepsy (NSE)** has **Information on Epilepsy: Education and Epilepsy** which looks at epilepsy and learning, special needs, examinations, practical activities, medication, the Disability Discrimination Act, and teaching pupils with epilepsy. UK Epilepsy Helpline: 01494 601400. **http://www.epilepsynse.org.uk/**

Epilepsy Action (British Epilepsy Association) has information for schools in **Epilepsy - A Teacher's Guide**. This looks at classroom first-aid, emergency care, medication and school activities. The Freephone Helpline is 0808 800 5050. The website **http://www.epilepsy.org.uk/**provides a downloadable template for a Healthcare Plan.

DIABETES

What is Diabetes?

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

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

Each child may experience different symptoms and this should be discussed when drawing up the Medication Plan. 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.

[7] See DE Circular 1999/10 Pastoral care in Schools: Child Protection

Medicine and Control

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

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

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

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

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. 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 (a hypo) 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.

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; local of concentration
- headache
- irritability
- mood changes, especially angry or aggressive behaviour.

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

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

An ambulance should be called if:

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

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

Such information should be an integral part of the school's Emergency **Procedures, as discussed at Part III, but should also relate specifically to the child's individual Medication Plan.**

Diabetes UK, www.diabetes.org.uk, has information on Diabetes in School, which discusses insulin injections, diet, snacks, hypoglycaemia reaction and how to treat it. The leaflet **"Children with diabetes at school - What all staff need to know"** can be ordered from Diabetes UK Distribution (tel 0800 585 088).

ANAPHYLAXIS

What is Anaphylaxis?

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

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

The most severe form of allergic reaction is anaphylactic shock, when the bloodpressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths - adult and junior.

Any, or all, of the following symptoms and signs may be present in an acute allergic reaction.

Antihistamine should be given at the first sign of an allergic reaction and the child closely observed. Antihistamine dose may need to be repeated if the patient vomits.

For a child who has asthma, if there is any sign of breathing difficulty then their reliever inhaler (usually blue) should be administered.

Minor reactions (needing oral antihistamine):

- Feeling hot/flushing
- Itching
- "Nettle sting like" rash/welts/hives (urticaria)
- Red, itchy watery eyes
- Itchy, runny or congested nose or sneezing
- Swelling: face, lips, eyes, hands
- Tummy pain
- Vomiting or diarrhoea
- Metallic (funny) taste in the mouth

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

If the reaction continues to progress despite antihistamine and any of the following symptoms/signs are seen, then the EpiPen® /Anapen® should be administered into the muscle of the upper outer thigh and an ambulance called immediately.

Severe reactions (needing EpiPen/Anapen):

- Difficult/nosy breathing, wheeze, breathlessness, chest tightness, persistent cough
- Difficulty talking, change in voice, hoarseness
- Swelling, tightness, itchiness of the throat (feeling of 'lump in throat')
- Impaired circulation - pale clammy skin, blue around the lips and mouth, decreased level of consciousness
- Sense of impending doom ("I feel like I am going to die')
- Becoming pale/floppy
- Collapse

If an EpiPen® /Anapen® is administered, the child should be kept lying down, with feet raised (e.g. on a chair) to assist circulation.

They should transfer to hospital in this "head-down" position. Raising the patient's head or assisting them to sit or stand up can result in an acute severe deterioration of the allergic reaction.

Occasionally, a second EpiPen® /Anapen® may be required if there has been no improvement in the child's condition 5 to 10 mins after administering the first EpiPen/Anapen.

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.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the Principal, the child's parents and medical staff involved.

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 and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

In other circumstances (with an appropriate Patient Group Direction[8]) a school nurse might hold a certain number of Epipens®, not individually named, and could use these to administer emergency medication (e.g. antihistamine/adrenaline) to a patient who has not previously had this prescribed, but who is demonstrating the clinical features of a significant allergic reaction. This would cover those rare cases where a pupil presents with a first reaction in school. Teenagers with nut allergy are a particularly vulnerable group in this respect, a recognised factor in fatal reactions is failure to carry their own medication. Therefore a back up system in schools, governed by a Patient Group Direction would be a beneficial safety net.

Studies have shown that the risks for allergic children are reduced where an individual medication plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

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

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 practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is

8 A patient group direction (PGD) is a written direction relating to supply and administration, or administration of a Prescription Only Medicine (POM), to persons generally, (subject to specified exclusions) and is signed by a doctor or dentist, and by a pharmacist.

important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the Principal 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.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

The **Anaphylaxis Campaign** website contains Guidance for schools, which discusses anaphylaxis, treatment, setting up a protocol, and support for pupils and staff. It also includes a sample protocol. The Anaphylaxis Campaign Helpline is 01252 542029. The Anaphylaxis Campaign has also published the **Allergy in Schools** website which has specific advice for pre schools, schools, school caterers, parents, students and nurses.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

What is ADHD?

Attention Deficit and Hyperactivity Disorder (ADHD) is characterised by inattention, over activity and impulsiveness and is usually present from early childhood. It can have a very detrimental effect on the child's life and development. Education is often disrupted, family life is commonly stressful and peer relations may suffer. In the majority of cases, ADHD will persist into the post primary school age group.

Medication and Control

Many sufferers will be prescribed medication, commonly methylphenidate (Ritalin®, Equasym®). A single dose is effective for about 4 hours. Commonly children will have a dose at about 8 am, when they leave home for school and

therefore need a second dose around 12 noon, which will usually need to be administered at school.

Concerta XL® and Equasym XL® are modified release formulations of methylphenidate providing prolonged action. Dosage is on a once daily basis aimed at providing effective cover throughout the school day and evening, facilitating, for example, homework activity.

Part V: Useful Contacts and Internet Resources

This Section contains the addresses of useful contacts and internet addresses, mainly in the voluntary sector. It also has a sample Contact Sheet which schools may find useful to complete with relevant local information.

CONTACTS

Name	Address	Contact Details
The Anaphylaxis Campaign	PO Box 275 FARNBOROUGH GU14 6SX	Helpline: 012 52 542029 Fax: 012 52 377140 **www.allergyni.co.uk** **www.anaphylaxis.org.uk** **info@anaphylaxis.org.uk** **www.allergyinschools.org.uk**
Asthma UK Northern Ireland	Peace House 224 Lisburn Road BELFAST BT9 6GE	Tel: (018) 9066 9736 Helpline: (084)57010203 **ni@asthma.org.uk** **www.asthma.org.uk**
NI - ADD Attention Deficit Disorder	NI-ADD Support Centre 71 Eglantine Avenue BELFAST BT9 6EW	Tel: (028) 9020 0110 Fax:(028) 9020 0112 **Email: niaddfsguk@netscape.net**
Autism NI	Knockbracken Healthcare Park Saintfield Road BELFAST BT8 8BH	Tel: (028) 9040 1729 Fax: (028) 9040 3467 **info@autismni.org** **www.autism.org**

Name	Address	Contact Details
National Autistic Society	The National Autistic Society 57a Botanic Avenue BELFAST BT7 2GL	Tel: (028) 9023 6225 Fax: (028) 9027 4547 **www.nas.org.uk** **regina.cox@nas.org.uk**
RNIB – Royal National Institute for the Blind	RNIB NI 40 Linenhall Street BELFAST BT2 8BA	Tel: (028) 9032 9373 Fax: (028) 9027 8119 **rnib@rnib.org.uk** **www.rnib.org.uk**
The Cedar Foundation	1a Upper Lisburn Road BELFAST BT10 0GW	Tel: (028) 9062 3382 Fax: (028) 9062 8620 **info@cedar-foundation.org** **www.cedar-foundation.org**
Scope (Cerebral Palsy)		Tel: (020) 7619 7100 Helpline: 0808 8003333 **cphelpline@scope.org.uk** **www.scope.org.uk**
Cystic Fibrosis Trust	Selshion Manor Selshion Lane PORTADOWN Co Armagh	Tel: (028) 3833 4491 Fax: (028) 3833 4491 **enquiries@cftrust.org.uk** **www.cftrust.org.uk**
RNID – Royal National Institute for the Deaf	Wilton House 5 College Square North BELFAST BT1 6AR	Tel: (028) 9023 9619 Fax: (028) 9031 2032 **brian.symington@rnid.org.uk** **www.rnid.org.uk**

Name	Address	Contact Details
National Deaf Children's Society	Wilton House 5 College Square North BELFAST BT1 6AR	Tel: (028) 9031 3170 Fax: (028) 9031 3170 Email: **pauline@ndcsni.co.uk** **www.ndcs.org.uk**
Net Doctor		**www.netdoctor.co.uk**
Diabetes UK	Bridgewood House Newforge Business Park Newforge Lane BELFAST BT9 5NW	Tel: 028) 9066 6646 Email **n.ireland@diabetes.org.uk** **www.diabetes.org.uk**
Disability Action	2 Annadale Avenue BELFAST BT7 3JH	Tel: (028) 9029 7880 Fax: (028) 9049 1627 **hq@disabilityaction.org** **www.disabilityaction.org**
Down's Syndrome Association	Knockbracken Healthcare Park Saintfield Road BELFAST BT8 8BH	Tel: (028) 9070 4606 Fax: (028) 9070 4606 **www.downs_syndrome.org** **downs.syndrome@cinni.org**
NI Dyslexia Association	17a Upper Newtownards Road BELFAST BT4 3HT	Tel: (028) 9065 6212
National Eczema Society	Hill House Highgate Hill LONDON N19 5NA	Tel: (020) 7281 3553 Fax: (020) 7281 6395 **www.eczema.org**

Epilepsy Action (British Epilepsy Association)	Room 110 Bostock House Royal Hospital Trust BELFAST BT12 6BA	Tel: (028) 9063 4942 Fax: (028) 9031 5914 **mclarke@epilepsy.org.uk** **www.epilepsy.org.uk**
MENCAP	Segal House 4 Annadale Avenue BELFAST BT7 3JH	Tel: (028) 9069 1351 Fax: (028) 9064 0121 **www.mencap.org.uk** **mencapni@mencap.org.uk**
Muscular Dystrophy Campaign	Forster Green Hospital 110 Saintfield Road BELFAST BT8 4HD	Tel: (028) 9079 0708 Fax: (028) 9079 6672 **www.muscular-dystrophy.org** **n-ireland@muscular-dystrophy.org**
NI ME (Myalgic Encephalomyelitis) Association	Bryson House 28 Bedford Street BELFAST BT2 7FE	Tel: (028) 9043 9831 Fax: (028) 9043 9831 **www.nimea.org**
Association for Spina Bifida & Hydrocephalus (NI Region)	Graham House Knockbracken Healthcare Park Saintfield Road BELFAST BT8 8BH	Tel: (028) 9079 8878 Fax: (028) 9079 7071 **niro@asbah.org** **www.asbah.org**
Belfast Education and Library Board	40 Academy Street BELFAST BT1 2NQ	Tel: (028) 9056 4033 **www.belb.co.uk**
North-Eastern Education and Library Board	County Hall 182 Galgorm Road BALLYMENA Co Antrim BT42 1HN	Tel: (028) 2565 3333 **www.neelb.org.uk**

Organisation	Address	Contact
South-Eastern Education and Library Board	40 Grahamsbridge Road Dundonald BELFAST BT16 2HS	Tel: (028) 9056 6200 **www.seelb.org.uk**
Southern Education and Library Board	3 Charlemont Place ARMAGH BT61 9AX	Tel: (028) 3751 2200 **www.selb.org**
Western Education and Library Board	Campsie House 1 Hospital Road OMAGH Co Tyrone BT79 0AW	Tel: (028) 8241 1411 **www.welbni.org**
Association of Teachers and Lecturers (ATL)	The Gas Office 10 Cromac Quay Ormeau Road BELFAST BT7 2JD	Tel: (028) 9032 7990 Fax: (028) 9032 7992 **www.atl.org.uk/ni**
Irish National Teachers Organisation (INTO)	23 College Gardens BELFAST BT9 6BS	Tel: (028) 9038 1455 Fax: (028) 9066 2803 **info@ni.into.ie**
Ulster Teachers Union	94 Malone Road BELFAST BT9 5HP	Tel: (028) 9066 2216 Fax: (028) 9068 3296 **office@utu**
SEN – Special Educational Needs Advisory Centre	C/o Down's Syndrome Association Graham House Knockbracken Healthcare Park Saintfield Road BELFAST BT8 8BH	Tel: (028) 9070 5654 Fax: (028) 9070 5633 **www.ipsea.org.uk** **ipsea.info@intamail.com**

Any additions or changes should be notified to:

Special Education Branch
Department of Education
Rathgael House
43 Balloo Road
BANGOR
Co Down
BT19 7PR

Tel: 028 9127 9603