

Stony Dean School

*Working to Inspire*

POLICY/ DOCUMENT

MANAGING MEDICINES POLICY

Approved by the Governing Body on:

**Signed: Signed:**

**Pp Chair of Governors M Pounce Headteacher: N Strain**

Date: 23rd September 2020 Date: 23rd September 2020

Review Date: 23rd September 2021 Review Date: 23rd September 2021

**Stony Dean School**

**Administration of Medicines in School Policy Revised September 2020**

**Aims**

To outline the policy and procedures for managing medicines in school so it is understood by staff, parents/carers and pupils. This policy sets out the school’s procedures for managing medicines and treatments safely and appropriately in school.

A policy needs to be clear to all staff, parents and students. It could be included in the prospectus, or in other information for parents. A policy should cover:

* procedures for managing prescription medicines which need to be taken during the school or setting ‘day’
* procedures for managing prescription medicines on trips and outings
* a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
* a clear statement on parental responsibilities in respect of their child’s medical needs
* the need for prior written agreement from parents for any medicines to be given to a student
* the circumstances in which students may take any non-prescription medicines
* the school or setting policy on assisting students with long- term or complex medical needs

**Parental responsibility**

Parents have the prime responsibility for their child’s health and should provide the school with information about their student’s medical conditions and relevant treatments.

It is their responsibility to notify the school of:

* any type or dose of medication to be administered
* any changes to the type or dose of medication with the new dosage and time the medication should be given on a label from a pharmacy or a letter from the GP or Consultant stating the change of dosage and/or time of medication

No medicines and treatments should be brought into school without the prior knowledge of the head teacher or designated support staff.

**School responsibility**

The school will ensure that they have sufficient members of staff who are appropriately trained to manage medicines and treatments. All staff will be aware of all students taking medication within their centre.

Where the school agrees to administer medicines or carry out other medical procedures staff will receive appropriate training and support from health professionals.

If a member of staff is in any doubt they should not administer the medicine but should check with the parents or a health professional before taking further action.

**NO MEDICATION WILL BE ADMINSTERED WITHOUT PRIOR CONSULTATION WITH, AND WRITTEN PERMISSION ( FORM 3A) FROM THE PARENT/CARER(APPENDIX 6)**

**Prescription medicines**

These medicines should only be brought into school where essential, i.e. that is where it would be detrimental to the student’s health if the medicine were not administered during the school day.

Parents should be encouraged to look at dose frequencies and timing so that if possible medicines can be taken out of school hours.

If medicines need to be brought into school the following procedure must be followed:

* **All medicines must be in their original container together with the contraindications leaflet**
* All medicines **MUST** be clearly labelled with:
  + the student’s name
  + the medication name and strength
  + the dosage and time the medicine should be given date dispensed and/or expiry date
  + length of treatment (number of days)
  + any other instructions
* Parents to provide appropriate dispensing tool
* Any changes to the type or dose of medication should be made following provision of new medication with a label from a pharmacy, or a letter from the GP or Consultant, stating the new dosage and/or time of medication

**NB A label ‘to be taken as directed’ does not provide sufficient information.**

Steroid creams are usually applied twice daily only – we would usually expect these to be applied at home.

Liquid medication should be measured accurately using a medicine spoon or syringe. Creams/lotions should be applied wearing a disposable glove. Inhalers should be maintained and checked for efficiency regularly as per medical care plan. Medication should not be added to food or drinks unless there is a specific reason.

* Staff must never accept medicines that have been taken out of their original container or make changes to the dosages even on parental instruction.
* If two or more medicines are required, these should be in separate, clearly and appropriately labelled containers.
* On arrival at school all medicines must be handed to the designated member of staff.
* All medicines received into school must be counted and documented. A running stock level must also be recorded.

A consent form (A ‘Request for School to Administer Medication’ – Form 3A) **see appendix 6** should be completed by the parent/carer. This will be kept in the medical folder in the medical room. A separate form will be required for each medication.

A record of the administration of each dose will be recorded in the Daily Medication Folder in the medical room.

Should the medicine need to be changed or discontinued before the completion of the course or if the dosage or time changes the school should be notified in writing by the parent/carer and accompanied by written advice from the medical practitioner prescribing the changes. A new supply of medication – correctly labelled with the new dose – should be obtained and a new consent form completed.

Should the supply need to be replenished this should be done in person by the parent or carer.

Buckinghamshire Health Professionals have advised that:

* where the dose is half a tablet then this must be cut using a tablet cutter at the time that the medication is required; tablet cutters are available from pharmacies who will also provide training
* half tablets should be retained but not issued at the time of the next dose; a fresh tablet should be cut
* half tablets should be returned to the parent for disposal.

Medicines that are no longer required in school 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).

**A Medical Care Plan,** must be formulated between the School and the parents. The care plans are kept with the relevant medication, in a folder in the medical room and a list of pupils with medical care plans is stored on the staff server in “pupil information” in the “briefing notes” folder.

**Controlled Drugs**

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 students at school. The most common is Methylphenidate (Ritalin, Equasym).

The school should be in agreement with the parents of a student prescribed a controlled drug to store it safely and administer it to the student for whom it has been prescribed.

A record must be kept of all supplies received, all doses administered, and all unwanted supplies returned to parents for audit and safety purposes **(see Appendix** **6).**

**Controlled drugs must be kept in a locked non-portable cupboard.**

The drugs must be administered within the prescribed instructions. Misuse of a controlled drug, such as passing it to another student or person for use (including

‘borrowing’ another student’s identical drug) is an offence.

**Return from prolonged absence**

Some students with complex medical and health care needs will experience long term medical support, occasionally resulting with prolonged absences from school. A long term sickness is described as ‘*an absence lasting more than 2 weeks, but for this guideline it is defined as 4 or more weeks (as per the scope of this guideline and previous NICE guidance). Recurring long-term sickness absence has been defined as more than 1 episode of long-term sickness absence, with each episode lasting more than 4 weeks*’.

In the event of a long term absence, a return to school plan will be devised between the parent/carer and a member of staff at Stony Dean School. This will document the medical and psychical support, or reasonable adjustments required for the student to be able to access the school day. In this process, medical advice from relevant professionals such as a GP, nurses and allied health professionals will be considered to help with the transition back into the school day.

As part of this plan, the student will have a completed Medical Care Plan or an existing Medical Care Plan will be updated in line the new medical advice.

**Emergency Medication**

If any medications are required in an emergency the student should have a written Medical Care Plan (Appendix 7, Form 2).

Emergency medication, such as Epipens and Reliever Inhalers, are subject to the same request and recording systems as non-emergency medicines.

**Students who require medicines for urgent life threatening conditions MUST**

**have these available in school or they will be unable to remain in school.**

All students who require Reliever Inhalers will contact the school nurse if they need to be used. In addition to this parents/carers are advised to provide a spare for the school to store in case the original is lost or damaged.

Where there is a student who requires an Epipen, 2 should be kept in school one within the Centre where the student is situated and one should be kept in school in the medical room in a non-locked cupboard.

**It is the responsibility of parents/carers to ensure that their child is trained and competent to self-administer their emergency medicines.**

This type of medication must be readily available in an unlocked cupboard. The students care plan with parent consent should be stored with the medicine, giving clear instructions on how to manage a student in medical crisis. All staff must be made aware of where the emergency medication is stored.

Where school staff administer treatment and medication to a student in an emergency, training sessions must be arranged by the school and updated annually.

**Non-Prescription medicines**

Staff should **never** give a non-prescribed medicine to a student unless there is specific prior written permission from the parents.

Where the head agrees to administer a non-prescribed medicine it **must** be in accordance with the employer’s policy.

The employer’s policy should set out the circumstances under which staff may administer non-prescribed medicines.

Staff should check **Form 3A** in order to ensure that the medicine has been administered without adverse effect to the student in the past and that parents have certified this is the case. – a note to this effect should be recorded in the written parental agreement for the school/setting to administer medicine.

**Paracetamol Administration**

If a child requires Paracetamol parents will be contacted by the school nurse and asked for verbal consent giving permission to administer Paracetamol (500 mg tablet form only). 12 and over 2x500mg

This will be administered for:-

* Headache – not associated with head injury
* Toothache
* Painful periods
* Early symptoms of mild ear ache
* Early symptoms of cold and flu

Only one tablet will be given and only administered if a **permission form 3A** has been signed by the parent/carer. This will only be administered after 12.00 pm. If this does not relieve the symptoms within 30 minutes then the parents/carer will be contacted.

Paracetamol administered to students must be recorded with the date, time and

dose in the First Aid record book kept in the medical room.

All medicines bought by the school must be counted and recorded.

**A student under 16 should never be given any medicines, including Aspirin or medicines containing Ibuprofen unless consent has been given by parents via form 3A.**

**Application of Creams and Lotions**

Non prescribed creams and lotions may be applied at the discretion of the Headteacher in line with this policy but only with written consent from parents/carers (appendix 6).

Parents and carers are responsible for sending in the cream, labelled for the individual student. If they wish cream to be applied the label needs to specify where to apply the cream/lotion.

Sun cream needs to be supplied by parents/carers. We ask parents and careers to apply sun block in the morning before coming to school. Students may bring in their own creams but parents and carers must ensure it is in date and of at least SPF 25 and above. It should be kept in a safe place (ie with student’s tutor) during the school day.

**Alternative Medication**

Alternative medication, including homeopathic medication and herbal remedies, will not be administered.

**Documentation**

Each student receiving long term prescription medication will have the following documentation:

* completed up to date Medical Care Plan
* signed request for the school to administer medicines from the parents/carers **(Form 3A)**
* student record of all medication administered

Each student receiving non-prescription medication will have the following documentation:

* signed medication consent form (**Form 3A**)
* student record of all medication administered

Each student receiving short-term medication (less than 14 days) will have the following documentation:

* signed medication consent **form 3A**
* student record of all medication administered

**Offsite Activities and Educational Visits**

The named leader of the activity must ensure that all students have their medication, including any emergency medication available. The medication will be carried by a named member of staff. This also includes asthma inhalers and other relief medication. Copies of record forms and consent forms are also taken to ensure normal administration procedures are followed**.**

We encourage students with medical needs to participate in safely managed visits. Stony Dean School has clear guidelines and has risk assessments and care plans in place for visits.

Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular student. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. **A copy of any Medical Care Plans should be taken on visits** in the event of the information being needed in an emergency.

If staff are concerned about whether they can provide for a student’s safety, or the safety of other students on a visit, they should seek parental views and medical

advice from the school health service or the student’s GP. See DfES guidance on planning educational visits.

**Sporting Activities**

Most students with medical conditions can participate in physical activities and extra- curricular sport. There should be sufficient flexibility for all students 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 student’s ability to participate in PE should be recorded in their individual Medical Care Plan. All adults should be aware of issues of privacy and dignity for students with particular needs.

Some students may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers.

**Insurance**

All staff are covered by the Local Authority insurance cover.

**Training**

Training needs are reviewed annually according to the needs of the pupils. Training for specific conditions is provided for the whole staff every two years. This should be arranged by Admin support SLT/SMT.

**Management of Medication**

Some medicines may be prescribed on an ‘as required’ basis i.e. only to be administered under certain circumstances. Most commonly this may be reliever inhalers for asthma, rectal diazepam for epilepsy and ibuprofen as pain control.

The circumstances for which the medicines should be administered should be entered on the student’s Medical Care Plan. A parental agreement **Form 3A** should be completed and signed. This obviates the necessity of contacting the parent before administering such medicines.

**Refusing Medicines**

If a student refuses medication staff will not force them to take it.

The refusal will be noted and parents contacted by telephone. A copy will be put on the student file.

In the event of a student refusing emergency medication parents/carers will be contacted immediately by telephone. The emergency services will be contacted immediately and a member of school staff will accompany the student to hospital to allow parents time to arrive.

**Storage of Medicines in School**

Students must bring all medications to Reception and if there is no consent form attached, parents must be contacted and sent a **Form 3A** to be completed and returned to the school office. A phone call is insufficient evidence to administer any medication without written consent.

All medication, with the exception of emergency medication and medication requiring refrigeration, will be kept in a locked cupboard in the medical room.

Medication requiring refrigeration will be stored in the fridge in the medical room inside a plastic closed container clearly labelled MEDICATION.

Emergency medication will be stored out of the reach of students, in the medical room. All members of staff working in the school will need to be made aware of the location of the emergency medication.

All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available and should not be locked away.

A regular check of the medicine cupboard will be made every term by the administration member responsible for medicines. Medication remaining should be returned to Parents/carers and any medication remaining in the medicine cupboard at the end of the Summer term will be locked away. The School Nurse should then contact parent/carer in writing (e-mail preferred) to confirm the amount of medication being returned and/or discuss remaining medication.

Any medication which is not collected and is no longer required will be disposed of safely at a pharmacy in Amersham. No medication will be disposed of into the sewage system or refuse.

Asthma inhalers should be labelled clearly with the student’s name and kept in the medical room. They must travel with the students for all off site visits.

**Administering Medication**

If a student requires medication it should be administered by A. Kimber or J Watson. If this is not possible, the medication should be given by the Receptionist or Office Manager. Staff should initial the Regular Daily Medication Sheet to indicate they have administered the medication. The number of tablets administered should be counted and noted in the column marked “Medication Received” and the number of tablets remaining should be noted in the columned marked “Total Number of Tablets”.

Any member of staff who agrees to accept responsibility for administering prescribed medicines to a student should have appropriate training and guidance. They should also be aware of possible side effects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

**Home to School Transport**

Where pupils have life threatening conditions, specific Medical Care Plans should be carried for off site visits. The Local Authority and its transport contractors will be notified of particular issues for individual students.

**Emergency Procedures**

A member of staff should always accompany a student taken to hospital by ambulance, and should stay until the parent arrives. Staff should never take students to hospital in their own car, it is safer to call an ambulance.

Individual Medical Care Plans should include instructions as to how to manage a student 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.

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| --- | --- | --- | --- | --- |
| **HAZARD/RISK** | **WHO IS**  **AT RISK?** | **NORMAL CONTROL MEASURES**  (Brief description and/or reference to source of information) | **ADDITIONAL CONTROL MEASURES**  (to take account of local/individual circumstances) | **RISK**  **RATING H/M/L** |
| Wrong  medication administered  Wrong dosage | Pupils | * The school’s Health and Safety Policy makes reference to/includes the school’s arrangements for managing the   + administration of medications * No medication permitted into the school unless there is written parental consent stating the name of the pupil, the medication, and the frequency and dosage to be administered * A log is kept of all medication administered * Medicines to be provided in the original container, labelled with the name of the appropriate pupil *  Stored in a secure place, under lock and key (no medicines stored in first aid kits) | Detailed guidance, including forms to use,  can be found in ‘Managing Medicines in  Schools and Early Years settings |  |
|  |  | * Pupils must not be given any medicines unless by written parental request * No student under 16 to be given aspirin containing medicine unless prescribed or consent given. * Any specific training required by staff on the administration of medication eg epi-pen will be provided   + by the school nurse * All emergency medicines (asthma, inhalers, epi-pens etc) are locked away in the Medical Room cabinet) * Any written agreements between the parents and the school must be reviewed periodically to ensure it   + remains accurate * Pupil’s medical needs are catered for on educational   + visits and school trips |  |  |
| **REVIEWS 23/09/2020** | | | | |
| **REVIEWED BY: Alsuin Kimber** | | **COMMENTS:** | | |
| **REVIEWED BY: Alexandra Glazebrook** | | **COMMENTS: Records and Logs seen. Policy and Logs discussed. Alsuin to regularly check all aspects of the policy with the school practice and to ensure that annual training is delivered to staff. Pupil Medical Care Plans to be kept with each medicine. Training log to be created and reviewed when required for updates.** | | |

**APPENDIXES**

1. Asthma Policy
2. Epilepsy Policy
3. Diabetes Policy
4. Anaphylaxis Policy
5. Enteral Feeding Policy
6. Dysphagia Policy
7. Medical Care Plan template **Form 2**
8. Parental Agreement for school/setting to administer medicine **Form 3A**
9. Stony Dean School Statement of Intent
10. Responsibility of Headteacher
11. Procedures for admin staff in the event of a seizure

**APPENDIX 1**

**ASTHMA POLICY FOR STONY DEAN SCHOOL**

Stony Dean School:

* Welcomes pupils with asthma.
* Recognises asthma as an important condition.
* Encourages and helps students with asthma to participate fully in school life.
* Recognises the need for immediate access to inhalers.
* Attempts to provide a school environment as favourable as possible to asthmatic students.
* Ensures all staff are aware of asthma and know what to do in the event of an attack and will if necessary give emergency treatment.
* Will inform parents of attacks and any treatment given.
* Does not assume responsibility for the routine treatment of asthma (preventative therapy) which remains the prerogative of the parent in conjunction with their GP.

**Common Signs of an Asthma Attack**

Coughing, shortness of breath, wheezing, tightness in the chest, being unusually quiet, difficulty speaking in full sentences.

**DO**

* Keep calm – do not panic
* Encourage the pupil to sit up and forward - do not lie them down
* make sure the pupil takes two puffs of their reliever inhaler (usually blue)
* Ensure tight clothing is loosened
* Reassure the pupil

**If no immediate improvement –** continue to make sure they take one puff of the reliever every minute for five minutes or until their symptoms improve.

**Call 999 or a doctor urgently if:**

* The pupils symptoms do not improve in 5-10 minutes, they are too breathless to talk, their lips are blue, or if you are in any doubt.
* If symptoms do not improve continue to give 1 puff of the reliever every minute until help arrives.
* Any pupil who has had an asthma attack will need a review by their GP/ Asthma Nurse as soon as possible.
* **A student should never be left to sleep off an asthma attack because the symptoms appear to have disappeared. The student may have gone into**
  + **‘silent asthma’ a state of collapse.**
*  **If you are in any doubt ALWAYS call for an ambulance**

**RECORD KEEPING FOR ASTHMA**

On school entry students with asthma or those possibly asthmatic should be identified. If parents have indicated positively on the admission form then this should result in a completed consent **Form 3A**. In addition these students should be brought to the attention of the school nurse as soon as is practical. An asthma Medical care plan should be commenced.

A list of asthmatic students should be maintained on SIMS and list of pupils with medical care plans stored on the staff server in “pupil information” in the “briefing notes” folder.

A record of use of the students’s inhaler must be kept on the log sheet with all details

completed.

A copy of the notification letter should be kept on the student’s record.

If the same student has to use the inhaler more than once a term they should be brought to the attention of the school nurse. This may indicate a student is inadequately treated and therefore at risk.

**APPENDIX 2**

**EPILEPSY**

**What is Epilepsy?**

Students 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. Most students 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 students experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual Medical Care Plan, setting out the particular pattern of an individual student’s epilepsy. If a student 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 student 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 student lost consciousness

• whether the student was incontinent

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

What the student 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 student 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 student 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 student loses consciousness. Such seizures might start with the student crying out, then the muscles becoming stiff and rigid. The student may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the student’s colour may change to a pale blue or grey colour around the mouth. Some students may bite their tongue or cheek and may wet themselves.

After a seizure a student may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some students 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 student 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 students 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 student’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 students with epilepsy can use computers and watch television without any problem.

Students 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 student and parents as part of the Medical Care Plan.

During a seizure it is important to make sure the student is in a safe position, not to restrict a student’s movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the student’s head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the student 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 student’s first seizure
* the student has injured themselves badly
* they have problems breathing after a seizure
* a seizure lasts longer than the period set out in the student’s Medical Care Plan
* a seizure lasts for five minutes if you do not know how long they usually last for that student
*  there are repeated seizures, unless this is usual for the student as set out in the student’s Medical Care Plan

Most seizures last for a few seconds or minutes, and stop of their own accord. Some students 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.

Stony Dean School has training in the administration of rectal and oral diazepam from local health services. Staying with the student 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. For more information on administration of rectal diazepam and midazolam, see Forms 9 and 10.

Students 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

student, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the student as far as possible, even in emergencies.

**APPENDIX 3**

**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 student’s needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age students have diabetes. The majority of students 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. Students with Type 2 diabetes are usually treated by diet and exercise alone.

Each student may experience different symptoms and this should be discussed when drawing up the medical care 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.

**Medicine and Control**

A medical care plan must be drawn up for the student.

The diabetes of the majority of students is controlled by injections of insulin each day. Most younger students 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 will be necessary for an adult to administer the injection. Older students may be on multiple injections and others may be controlled on an insulin pump. Most students 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 students 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 blood glucose levels of students with diabetes needs to remain stable and their levels may be checked by taking a small sample of blood and using a small monitor at regular intervals. This may need to be done during the school lunch break, before PE or more regularly if their insulin needs adjusting.

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

Students 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 student 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 students 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 student with diabetes:

• hunger

• sweating

• drowsiness

• pallor

• glazed eyes

• shaking or trembling

• lack of concentration

• irritability

• headache

• mood changes, especially angry or aggressive behaviour

Each student may experience different symptoms and this should be discussed when drawing up a medical care plan.

If a student has a hypo, it is very important that the student 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 student and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the student has recovered, some 10-15 minutes later.

An ambulance should be called if:

• the student’s recovery takes longer than 10-15minutes

• the student becomes unconscious

Some students 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 student is unwell, vomiting or has diarrhoea this can lead to dehydration. If the student is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the student will need urgent medical attention.

**APPENDIX 4**

**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 blood pressure 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.

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

**Medicine and Control**

A medical care plan must be drawn up for the student.

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.

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

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 student 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. Refresher training should be provided annually.

Day to day policy measures are needed for food management, awareness of the student'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 important to ensure that the catering supervisor is fully aware of the student's particular requirements. A ‘kitchen code of practice’ could be put in place.

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

Students 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 students 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.

**Appendix 5**

**Enteral Feeding Policy**

**What is Enteral Feeding?**

Enteral feeding refers to intake of food or medications through the gastrointestinal (GI) tract. The GI tract consists of the mouth, oesophagus, stomach, and intestines.

Enteral feeding may mean nutrition taken through the mouth or through a tube that goes directly to the stomach or [small intestine](https://www.healthline.com/human-body-maps/small-intestine). In the medical setting, the term enteral feeding is most often used to mean tube feeding.

Enteral feeding can be used a sole means of receiving nutrition and medication or it can be used with conjunction with oral feeding and drinking. This is dependent on the individual’s abilities and medical needs.

The main types of enteral feeding tubes include:

* [Nasogastric tube (NGT)](https://www.healthline.com/health/nasogastric-intubation-and-feeding) starts in the nose and ends in the stomach.
* Orogastric tube (OGT) starts in the mouth and ends in the stomach.
* Nasoenteric tube starts in the nose and ends in the intestines (subtypes include nasojejunal and nasoduodenal tubes).
* Oroenteric tube starts in the mouth and ends in the intestines.
* [Gastrostomy](https://www.healthline.com/health/feeding-tube-insertion-gastrostomy#after-the-procedure) tube is placed through the skin of the abdomen straight to the stomach (subtypes include PEG, PRG, and button tubes).
* Jejunostomy tube is placed through the skin of the abdomen straight into the intestines (subtypes include PEJ and PRJ tubes)

**School requirements**

In order to support pupils who require enteral feeds during the school day, some members of staff are trained to administer either bolus or pump feeds via either a Gastrostomy, Jejunostomy or Naso-gastric tube as required. In order to provide safe and accurate administration of enteral feeds the following principles must be maintained:

* The storage and administration of children’s feeds follows the school’s procedures at all times.
* Staff who administer feeds all have the necessary training before they do so.
* There is a robust system in place to ensure the competency of staff is regularly assessed.
* Feeds can only be administered if parental consent has been given.

Procedures for the Administration of Enteral Feeds

Bolus feeds

* Staff can only give the feed prescribed for that individual child
* Before administering, all feeds must be checked against the consent form, Form 3A and record chart, ensuring the correct feed, amount and time along with the expiry date. The designated member of staff is responsible for compiling the record chart.
* The equipment is prepared including feeding sets, syringes and extension sets (these items are for the individual child only and should be stored when not in use in the child’s named container).
* Strict hygiene is to be observed, including hand washing and the wearing of gloves throughout the procedure.
* The extension set must be primed with water and attached to the Mic-key or Mini button.
* The tube should be flushed with water as directed in the feeding regime.
* A large syringe or feeding set (primed with milk) is then attached to the gastrostomy, extension set or naso-gastric tube and the prescribed amount of feed is given slowly by gravity.
* After the feed is finished the tube should be flushed with water as directed in the feeding regime and signed for on the record chart
* The extension set is then detached and washed in cool soapy water until tubing is clear along with any re-usable syringes and stored in the child’s named container.

Pump feeding

* Staff can only give the feed prescribed for that individual child.
* Before administering, all feeds must be checked against the consent form, Form 3A and record chart, ensuring the correct feed, amount and time along with the expiry date.
* The equipment is prepared including the child’s individual feeding pump, feeding sets, syringes and extension sets (these items are for the individual child only and should be stored when not in use in the child’s named container).
* Strict hygiene is to be observed, including hand washing and the wearing of gloves throughout the procedure.
* The extension set must be primed with water and attached to the Mic-key or Mini button.
* The tube should be flushed with water as directed in the feeding regime
* The giving set must be primed with milk before attaching to the pump.
* The pump rate and dose should be checked against the consent chart and signed for on the record form both at the beginning and the end of the feed.
* After the feed is finished the tube should be flushed with water as directed in the feeding regime and the extension set is then detached and washed in warm soapy water until tubing is clear along with any re-usable syringes and stored in the child’s named container.

Additional Information

If a pupil has difficulties tolerating Enteral feeding (for example, retching, vomiting or loose stools) this should be reported to the Parent/Carer or Children's Community Nurse for advice.

Additional water may be required in hot weather. This should be discussed with the Parents/Carer or Children's Community Nurses.

Additional training for conducting enteral feeds can be arranged via the Abbotts nursing team.

All supplies for the Enteral feeding tubes, milk feeds and feeding pumps are managed by the Community Children's Nurse and are either ordered by the Nurse or sent in by the parents/carers.

Details of individual arrangements are recorded in the Medical Room in the Feeding Regime File.

References:

GAIN, Guidelines for caring for an infant, child, or young person who requires enteral feeding, 2015

Pentalnd School, <https://pentlandfieldschool.co.uk/assets/uploads/PF_-_Medication_Policy_October_2017.pdf>, 2017

Aylesbury Vale Clinical Commissioning Group, Good practice guideline for adults who are tube fed and cared for by care homes or care agencies,

**Appendix 6**

**Dysphagia Policy**

**What is dysphagia?**

Dysphagia is the term used to describe a swallowing disorder usually resulting from a neurological or physical impairment of the oral, pharyngeal or oesophageal mechanisms.

The normal swallow has 4 phases:

1. oral preparatory

2. oral

3. oropharyngeal

4. oesophageal

Oropharyngeal dysphagia can result from a number of factors. The causes may be:

• Neurological – including diseases/injuries or abnormalities of the central nervous system, anterior horn cell, peripheral nervous system and/or neuromuscular junction.

• Physical - related to head and neck impairments such as cancer and or surgery-e.g., glossectomy

• Respiratory disease e.g. COPD

• Psychological

(RCSLT 2009)

**What is the impact?**

Difficulty with swallowing may have life threatening consequences and can lead to an impaired quality of life. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences for both the person and members of the family. Aspiration of food, drink and saliva is frequently caused by oropharyngeal dysphagia and can lead to aspiration pneumonia (Marks & Rainbow, 2001).

Dysphagia can present in many ways, and the patient may demonstrate one or several of the following symptoms:

* Food spillage from lips
* Taking a long time to finish a meal
* Poor chewing ability
* Dry mouth
* Drooling
* Nasal regurgitation
* Food sticking in the throat
* Poor oral hygiene
* Coughing and choking
* Regurgitation
* Weight loss
* Repeated chest infections

Speech and Language Therapists (SaLT) have a unique role for the assessment, diagnosis and management of oropharyngeal dysphagia. The aims and objectives of speech and language therapy interventions for dysphagia depend on the type and nature of the dysphagia, the underlying cause, and the needs and preferences of the individual. Considering the safety of the swallow, managing aspiration and preventing complications are of paramount concern. In children the aims and objectives will change as appropriate to the age as the child’s anatomy and neurological abilities alter with growth and development (Logeman 1998).

The overall aims of the SaLT working with an individual with dysphagia include:

• detailed and accurate assessment (there may be multiple assessments over time) leading to accurate diagnosis of dysphagia which may assist with the differential medical diagnosis.

• ensuring safety (reducing or preventing aspiration) with regards to swallowing function.

• balancing these factors with quality of life, taking into account the individual’s preferences and beliefs.

• working with other members of the team, particularly dieticians, to optimise nutrition and hydration.

• stimulating improved swallowing with oral motor/sensory exercises, swallow techniques and positioning.

(RCSLT 2009)

**School responsibilities**

Stony Dean School is undergoing supervision with the PACE center via a formal contract to support the students with their swallowing care plans and support their ongoing needs. This contract stipulates that over the next academic year Stony Dean School will ensure they have a qualified member of staff to be able to support the needs of the students with dysphagia and swallowing difficulties.

Whilst in the process of receiving education and training to Specialist Dysphagia Practitioner level, SaLT’s will work under direct and/or indirect supervision in accordance with the recommendations set out by the assessment centre responsible for their education programme. The assessment centre’s recommendations may be expected to include a minimum number of logged or directly/indirectly supervised hours covering areas of training which may include:

• Observation of skilled SaLTs

• Directly and indirectly supervised work with clients

• Discussion sessions with a clinical supervisor

• Criteria for transitioning to independent working

Advice and guidance will be distributed to the relevant members of staff responsible for the students swallowing needs and will be reviewed and monitored by a qualified certified SaLT. This includes the distribution and review of swallowing plans termly.

SaLTs may delegate certain therapy tasks to other team members. This may include assisting and supervision of oral intake. The decision to delegate must be clinically led and documented.

SaLTs remain responsible for the care plan even when it is carried out by another person, providing that:

• The written instructions are correctly followed by the named person, and

• There has been no deterioration in the client or client’s physical condition, and

• The patient is on the SLT’s caseload for dysphagia intervention.

Any recommendation or advice should be recorded in the client’s medical records and pupil file.

Respiratory arrest, choking and other adverse events must be recorded in detail in the health care record immediately following the event in the incident should be reported on the incident reporting system

References

Royal College of Speech and Language Therapists, RCSLT resource manual for commissioning and planning services for SLCN; dysphagia, RCSLT 2009 (update 2014)

NHS Southern Health, Dysphagia (swallowing disorder) Policy, <https://www.southernhealth.nhs.uk/_resources/assets/inline/full/0/71352.pdf>, 2019

**Appendix 7**

**Medical Care Plan**

**Form 2**

|  |  |
| --- | --- |
| **Name of school/setting** | STONY DEAN |
| **Child’s name** |  |
| **Group/class/form** |  |
| **Date of birth** |  |
| **Child’s address** |  |
| **Medical diagnosis or condition** |  |
| **Date** |  |
| **Review date** |  |

**Family Contact Information**

|  |  |
| --- | --- |
| **Name** |  |
| **Phone no (work)** |  |
| **Phone no (home)** |  |
| **Mobile no** |  |

|  |  |
| --- | --- |
| **Name** |  |
| **Phone no (work)** |  |
| **Phone no (home)** |  |
| **Mobile no** |  |

**Clinic/Hospital Contact**

|  |  |
| --- | --- |
| **Name** |  |
| **Phone no** |  |

**G.P.**

|  |  |
| --- | --- |
| **Name** |  |
| **Phone no** |  |

**Describe medical needs and give details of child’s symptoms**

|  |
| --- |
|  |
|  |
|  |
|  |

**Daily care requirements (e.g. before sport / at lunchtime)**

|  |
| --- |
|  |
|  |
|  |
|  |

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

|  |
| --- |
|  |
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|  |

**Follow up care**

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| --- |
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**Who is responsible in an emergency (state if different for off-site activities)**

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| --- |
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**Form copied to**

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|  |

**APPENDIX 8**

**PARENTAL AGREEMENT FOR SCHOOL/SETTING TO ADMINISTER MEDICINE. Form 3A**

The school will not give your child medicine unless you complete and sign this form.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date for review to be initiated by |  | | | | |
| Name of school/setting |  | | | | |
| Name of child |  | | | | |
| Date of birth |  |  |  | |  |
| Group/class/form |  | | | | |
| Medical condition or illness |  | | | | |
| **Medicine** |  | | | | |
| Name/type of medicine  *(as described on the container)* |  | | | | |
| Expiry date |  |  |  | |  |
| Dosage and method |  | | | | |
| Timing |  | | | | |
| Special precautions/other instructions |  | | | | |
| Are there any side effects that the school/setting needs to know about? |  | | | | |
| Self-administration – no |  | | | | |
| Procedures to take in an emergency |  | | | | |
| Prescription/Non-Prescription  (Delete as appropriate) | Prescription | | | Non-prescription | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | | | | | |
| Name |  | | | | |
| Daytime telephone no. |  | | | | |
| Relationship to child |  | | | | |
| Address |  | | | | |
|  |  | | | | |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school’s policy.

**Prescribed Medication**: I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. *(delete as appropriate)*

**Non-prescription medication**: I confirm that I have administered this non-prescription medication,without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication. *(delete as appropriate)*

If more than one medicine is required a separate form should be completed for each one.

Signature(s) Date

**APPENDIX 9**

**STATEMENT OF INTENT**

This policy and its supplements should be read in conjunction with the Buckinghamshire County Council Health and Safety Policy. It sets down the local organisation and arrangements established by the governing body to implement that policy.

The Governing Body of Stony Dean School is committed to high standards of health, safety and wellbeing and will take all reasonable steps to meet its responsibilities under the Health and Safety at Work Act, the Management of Health and Safety at Work Regulations, other relevant health and safety legislation and the Regulatory Reform (Fire Safety) Order and also to ensure that the County Council’s health and safety policies and procedures and other documentation listed below are implemented with regard to the provision of:

* a safe and healthy working environment with adequate control of health and safety
  + risks arising out of the school’s activities;.
* an effective local organisation within the school to implement the policy;
* full and effective consultation with employees on matters affecting their health and safety;
* effective communication throughout the school on health and safety matters;
* competent specialist advice on health and safety matters when this is not available in the school;
* sufficient information, instruction and training for staff on health and safety;
* staff who are competent to carry out their work to meet their health and safety responsibilities and have been provided with adequate training and development to do this;
* the effective management of contractors;
* the effective monitoring and review of the implementation of the health and safety policy and health and safety performance.

**Responsibilities of the Governing Body**

The Governing Body recognises its responsibilities as set out in the Local Authority’s scheme

of delegation and will endeavour to ensure that the local authority’s policy is implemented

with regard to its responsibility for:

* Complying with the County Council’s Health and Safety Policy, Organisation and
* Arrangements;
* Formulating and ratifying the establishment’s Health and Safety Statement and Health and Safety Plan;
* Regularly reviewing health and safety arrangements (at least once annually ) and implementing new arrangements where necessary;
* Ensuring that the site and premises is maintained in a safe condition and that appropriate
* funding is allocated to this end from the school’s delegated budget;
* Ensuring that risk assessments are made and recorded of all the schools work activities including those off site which could constitute a significant risk to the health and safety of employees or other persons;
* Ensuring that the statement and other relevant health and safety documentation from the
* Local Authority is drawn to the attention of all employees;
* Prioritising action on health and safety matters where resources are required from the establishment’s budget, seeking further advice where necessary and ensuring that action is taken;
* Reporting to the Local Authority any hazards which the establishment is unable to rectify from its own budget;
* Seeking specialist advice on health and safety which the establishment may not feel competent to deal with;
* Promoting high standards of health and safety within the establishment;
* Ensuring active and reactive monitoring of health and safety matters within the school including health and safety inspection reports and accident reports;

The Governing Body requires the support of all staff to enable the maintenance of high standards of health and safety in all the schools activities.

This Statement includes a description of the establishment’s organisation and its arrangements for dealing with different areas of risk. Details of how these areas of risk will be addressed are given in the arrangements section.

**APPENDIX 10**

**ORGANISATION**

**Responsibilities of the Headteacher**

The Headteacher is responsible for:

* Being the “Responsible Person” under the Fire Safety Order within the School.
* Nominating themselves or a senior manager as Health and Safety Co-ordinator;
* Ensuring that subordinate managers meet their health and safety responsibilities;
* Ensuring that the arrangements for consultation with staff on health and safety matters are implemented;
* Ensuring effective communication on health and safety matters within the school;
* Ensuring and County Council and school health and safety policies and procedures are implemented;
* Undertaking risk assessments in relation to directly managed staff, for example, stress risk assessments, return to work risk assessments, personal emergency evacuation plans;
* Ensuring that incidents, accidents and near misses are reported to the County Council and HSE as appropriate;
* Completing the school’s Annual Health and Safety Compliance Report to the Strategic; Director Children and Young People’s Services;
* Ensuring that termly health and safety inspections are carried out and that a report is given to the Chairman of Governors and is placed on the staff room health and safety notice board;
* Ensuring that remedial action is taken following health and safety inspections;
* Ensuring health and safety monitoring is undertaken, including:

o Accident, incident and near miss reporting and investigation;

o Specific equipment which requires statutory testing;

o Termly health and safety inspections;

o Job risk assessments are completed and health and safety issues are included

in staff appraisals and performance management;

o Providing an annual health and safety report to the Governing Body.

o Making recommendations to the Governing Body in relation to external

independent audits carried out by the County Council or other bodies

* Reporting to the School’s Governing Body any health and safety issues which cannot
  + be resolved;
* Ensuring the requirements of the Occupier’s Liability Acts 1957/1984 are complied
  + with;
* The day to day management of health and safety matters in the establishment in accordance with the health and safety policy and ensuring the health and safety arrangements are carried out in practice;
* Ensuring that risk assessments are made and recorded of all the schools work activities including those off site which could constitute a significant risk to the health and safety of employees or other persons;
* Ensuring that termly health and safety inspections are carried out, where practicable with the health and safety governor;
* Ensuring that information received on health and safety matters is passed to the appropriate people;
* Identifying staff health and safety training needs and arranging for training to be provided as appropriate;
* Attending the establishment’s health and safety committee;
* Drawing up the establishments annual health and safety action plan;
* Co-operating with and providing necessary facilities for trades union safety representatives;
* Participating in the County Council health and safety auditing arrangements and ensuring audit action plans are implemented;
* Monitoring purchasing and maintenance of equipment and materials and ensuring that it complies with current health and safety standards;
* Monitoring contractors and ensuring that only competent, approved contractors are engaged to work on the school site;
* Seeking specialist advice on health and safety matters where appropriate;
* Ensuring that a procedure is in place to deal safely with persons on the premises who may be under the influence of alcohol or drugs;

**Note**: in the absence of the Headteacher these responsibilities fall to the immediate deputy

**APPENDIX 11**

**PROCEDURES IN THE EVENT OF A SEIZURE**

In the event of a seizure, 1 x **staff** **present** to start timing

**1 x Staff** to call **School Nurse** 07502 373484 or **Office** ext 201/205 to locate medical staff then **remove other pupils from classroom**

**School medical staff** to locate medical care plan and any specified medication and attend and follow plan.

**Action by Office Team**

**Alert** whole **Admin Team** and **Senior Leadership Team** (whomever takes the call issues directives)

**Call ambulance** if required (see medical care plan and medical staff)

One member of Admin Team to go to classroom as First Aider

Inform parents/Carers and keep informed of incident if paramedics have been consulted.