

<b>Staffordshire County Council</b>		<b>Health and Safety Guidance</b>		
<b>Reference Number</b>	<b>G 11</b>	<b>Links to Policy HR 109 Medication Policy</b>		
<b>Guidance Title</b>	<b>CYPF - Medication Guidance</b>			

## Contents

1. Application
2. Introduction
3. Definitions
4. Guidance
  - 4.1 Responsible Persons and Settings Staff
  - 4.2 Local Procedures for Administering Medication
  - 4.3 Non Prescription Medicines
  - 4.4 Over the Counter (OTC) Medicines (Homely Remedies)
  - 4.5 Receipt of Medicines by the school or setting
  - 4.6 Administering Medicines – General principles
  - 4.7 “As Required” Medications (PRN)
  - 4.8 Consent Arrangements
  - 4.9 Self Management of Medication
  - 4.10 Refusing Medicines
  - 4.11 Controlled Drugs
  - 4.12 Storage of Medication
  - 4.13 Transport Issues
  - 4.14 Specialist Medication Activities
  - 4.15 Emergency Provision of Care
  - 4.16 Disposal of Medicines
  - 4.17 Disposal of Sharps
  - 4.18 Management of errors/incidents in Administration of Medicine
  - 4.19 Unaccounted for Drugs
  - 4.20 Individual Health Care Plan
  - 4.21 Staff training
  - 4.22 Medication and Children in Foster Care
  - 4.23 Management of Oxygen
  - 4.24 Specific Medical conditions – guidance
  - 4.25 Emergency Treatment of Seizures
  - 4.26 Health and Safety Issues
  - 4.27 Patient Information Leaflets
  - 4.28 Medicines for Staff
  - 4.29 Specific Risk Situations
  - 4.30 Equal Opportunities Statement
  - 4.31 Forms
5. Glossary of Terms
6. References

## Guidance Version Control

Version	Date Approved	Changes	Reason for Alterations
Issue1		Replaces individual schools and Vulnerable Children Guidance	

### 1. Application

This guidance document applies to all Children, Young People and Families (CYPF) settings (e.g. schools, early years, vulnerable children settings).

### 2. Introduction

Children, Young People and Families settings will frequently be required to manage medications in respect of children and young people within their care. This guidance is to assist managers and staff to enable this to be achieved in a safe and professional manner, whilst maintaining the respect and dignity of children and young people.

Children may need medication in the following circumstances:

1. During a short term illness or condition, such as the requirement to take a course of antibiotics
2. For treatment of a long term medical condition which may require regular medicines to keep them well.
3. Medication in particular circumstances, such as children with severe allergies who may need an emergency treatment such as adrenaline injection.
4. Daily medication for a condition such as asthma, where children may have the need for daily inhalers (and, potentially additional assistance during an asthma attack).

Most children with medical needs can attend school or a setting regularly and take part in normal activities, sometimes with support.

Where it is required an individual health care plan can help staff identify the necessary safety measures to support children with medical needs. Detailed advice on how to develop a health care plan is set out in 4.20.

School staff have no legal obligation to administer medicines to pupils unless they have been specifically contracted to do so. It is generally accepted, and stated in LA policies, that all staff are acting voluntarily. Staff may volunteer to assist in administering medicines to pupils but must be given training and guidance.

In addition to this guidance document, national government and professional bodies have produced guidance on the Management of Medication in settings where children live or attend education. Managers are advised to refer to this specific guidance in addition to that which is available here.

The Council fully indemnifies its employees against claims for alleged negligence, providing they are acting within the scope of their employment, have been provided with adequate training, and are following County Council medication guidelines.

### **3. Definitions**

**Manager** - Manager includes headteachers and other members of a school's senior leadership team or management of a residential setting.

**Setting** - Setting may refer to a school, residential home, foster care or any other establishment where children and young people may be likely to require the administration of medication.

### **4. Guidance**

#### **4.1. Responsible person and settings staff**

The Manager is designated the responsible person and must ensure that they have knowledge of the Council's Medication Policy HR 109, these guidelines and any national government or professional body guidance.

Where a qualified nurse is on site and is employed as such, they shall undertake their responsibilities within the guidance of the Professional Body - NMC (Nursing and Midwifery Council), and the council's medication policy and these guidelines.

Schools and settings may have specific roles for support staff that build the administration of medicines into their core job description.

Where they decide that they will administer medication, schools and settings should ensure that they have sufficient members of staff who are appropriately trained to manage medicines as part of their duties.

It is the responsibility of the Manager to ensure that all staff are trained appropriately and should have read and understood the current medication policy and this guidance document.

The Manager must ensure that staff have: -

- been authorised to administer medication by the settings Manager
- parental consent
- full knowledge of the Medication Policy and Guidance and any local arrangements or procedures.
- received training where this is required
- attended refresher training as required

Managers must create and maintain a list of all staff who have been authorised to administer medication and a sample of their signature and initials must be documented.

## **4.2. Local procedures for administering medication**

All settings must have clear written procedures / arrangements for the management of drugs and medication appropriate to the setting and the children and young people within it. All staff should be familiar with these arrangements.

Local procedures must reflect any National Minimum Standards that apply to your workplace setting (Residential Establishments/Residential Schools).

In schools, these arrangements (or the school's policy defining the non administration of medication) should be referred to in the arrangements section of each school's local health and safety policy and in the school prospectus.

Each settings own local procedures and arrangements should include the following:

1. Arrangements and procedures for managing medicines:
  - a. When on the premises
  - b. On trips and outings
2. The circumstances (if any) in which children may take any non-prescription medicines (in school settings DFE) Guidance suggest only medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber may be administered)
3. A clear outline of the roles and responsibility of staff involved in administering medicines or supervising the administration of medicines
4. A clear statement on parental responsibilities in respect of their child's medical needs
5. The need for prior written consent from parents for any medicines to be given to a child (For early years settings prior permission is a mandatory requirement)
6. The school or setting policy on assisting children with long-term or complex medical needs
7. The school or setting policy on children carrying and taking their medicines themselves
8. Staff training requirements for dealing with administration of medicines
9. Record keeping arrangements
10. Safe storage of medicines
11. Access to the school's emergency procedures
12. Any applicable risk assessment and management procedures

### **Minimising the need for medication in School hours**

It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable it to be taken outside school hours. Parents should be encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

### **Early Years settings**

There is a requirement in Early Years settings for children under 5 years of age or 5 before the 31<sup>st</sup> August for the setting to ensure any medication and or personal care needs are accommodated when required.

Where settings do not have a sufficient amount of staff to volunteer to undertake these tasks, the school or Early Years management must take relevant action to ensure the children's / pupil's needs are met.

### **Residential or other care settings**

In these settings medication is administered in line with County Council Policy and local procedures and arrangements.

### **4.3. Non-Prescription Medicines**

Staff should only give a non-prescribed medicine to a child where there is specific prior written permission from the parents/carers. In residential care this may be part of the care plan process.

In schools, where the school policy arrangements agree to administer a non prescribed medicine the arrangements must set out the circumstances under which staff may administer non-prescribed medicines.

Criteria in the national standards for under 8s day care providers (child minding, day care, crèches, out of school care) make it clear that non-prescription medicines should not normally be administered.

Where a non prescribed medicine is administered to a child it should be recorded.

**Staff must never give a child under 16 aspirin or medicines containing ibuprofen unless prescribed by a doctor.**

### **4.4. Over the Counter (OTC) Medicines (Homely Remedies)**

Occasionally parents and carers or children themselves may wish to use "over the counter" remedies to treat minor symptoms for short periods. These can include alternative medicines such as herbal remedies, vitamins, and supplements.

The same procedure must be followed for recording the administration of OTC remedies as is required for prescribed medication and they should be entered on the medication record. OTC must be stored in the same way as prescribed medication.

Schools must define whether it is their policy to administer over the counter medicines, and this should be detailed in their written procedures and communicated to staff and parents. Schools should always encourage parents / carers to make arrangements for this type of medication to be administered at home wherever possible.

In residential or other child care settings where over the counter medicines may need to be administered, young persons (or their Parents/carers) may provide their own OTC remedies, or the Head of Care or the GP may recommend one. Authorised staff may then assist with administration or the self-administration within the guidance set out in 4.2. "Local procedures for administering medication." Advice should always be sought from

the pharmacist about any potential interactions between the non-prescription medicine and the child's regular medication.

Although the opportunity exists in residential care for a Head of Care to purchase a wide range of medicines for use with in the setting as homely remedies, this must be subject to careful control. An agreed list should be compiled in conjunction with the child's general medical practitioner, the pharmacist and the setting. The locally agreed list of homely remedies should only include those that can be bought over the counter from a community pharmacy, preferably from the one contracted to provide pharmaceutical advice to the setting.

If a GP prescribes an OTC remedy, it becomes a prescribed medicine and must be treated accordingly.

All OTC's should be checked to ensure that they have not expired.

**No more than two days of homely remedies medication are to be administered before seeking advice from the GP/Pharmacists.** The young person is to be monitored at all times through out this period.

#### **Self Administration of OTC medicines in non school settings**

If a child has the mental capacity to choose and wishes to buy their own remedies for minor ailments they should be supported in this decision, and encouraged to speak to a pharmacist.

Each setting must include the procedures to be followed where children are permitted to carry out self medication. See also section 4.9 on Self Management of Medication.

**Schools and settings must never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.**

#### **4.5. Receipt of Medicines by the school or setting**

Medicines must always be provided in the original container **as originally dispensed** by the pharmacist. This should be clearly marked with the young person's name, date of dispensing and the name of medication, and include the prescriber's instructions for administration

The label on the container supplied by the pharmacist must not be altered under any circumstances.

All medicines brought in to be administered by the setting, must be recorded. The record must show:

- Young Person for whom medication is prescribed or purchased.
- Date of receipt.
- Name and strength of the medicine.
- Quantity received.
- The dosage required to be administered

- The time of the required dose
- Expiry date of medicines
- Signature of the employees receiving the medicines

Where consent from parents and carers is also being sought at the same time the record should also include:

- Signature of the parent or carer.

### **Residential settings**

In addition to the above, upon admission to a residential setting, written confirmation of the medicine a young person is taking must be obtained from an authoritative source e.g. parent/social worker.

Employees must record requests for repeat prescriptions in order that they may be collected by a member of staff or accompany a young person to collect them.

Exceptionally, some children may prefer to collect the prescription themselves. In these situations consideration must be made for the age, ability and maturity of the child and must be reflected in the individual risk assessment. The young person, having collected their medicines, must be encouraged to hand medications over to a staff member.

Children and young people may self manage and administer medication (see section 4.9) following a risk assessment which must be recorded in their care plan.

At any given time the setting must be able to identify the medicines prescribed for each individual young person.

### **4.6. Administering Medicines - General Principles**

- A young person's privacy and dignity is paramount and medicines should always be administered in an area where this will not be compromised.
- If there are numerous children and young people requiring medication administration, e.g. residential special school, the use of a medicines trolley to transport medicines and associated paraphernalia should be considered as a last option.
- In all circumstances the medication administered must be recorded. Where a Pharmacy produced Medication Administration Record sheet (MAR) is available this should be used. If a Pharmacy produced Medication Administration Record sheet is not available the administration of medication should be recorded on the standard Medication Administration Record HSF 55.
- Under no circumstances must medicines prescribed be given to anybody except the person for whom it was prescribed.
- Medicines should be administered directly from the dispensed container. However, medication can be placed in a small pot after removing it from the dispensed container as a way of hygienically handing it to the child if necessary.
- Medication must never be secondary dispensed for someone else to administer to the child at a later time or date.
- The setting management must ensure that staff are appropriately trained and receive refresher training at suitable intervals where this is required.

- In some cases training must be by a suitable provider (e.g. health practitioner such as a nurse) and recorded.
- The name (or initials) of the member of staff responsible for administering the dose of the medicines must be included on the medicines administration record.
- All written records relating to medication must be completed in ink (preferably black).
- In residential settings all medication should be reviewed by the prescribing GP at least every 6 to 12 months.
- Medication must not be given to young persons covertly (e.g. hiding in food) without consultation with GP/Parents and the agreement documented.
- Crushing or dissolving medication can destroy the medication properties reducing its effectiveness. Crushing or dissolving of medication is not permitted unless a child or young person's health or wellbeing would be detrimentally affected. GP and parental approval must be sought and documented in the Care Plan and on a risk assessment to crush or dissolve medication.
- All records of requests for and administration of medicine must be in writing.
- All records of administration of medication to a young person must be retained in line with document retention schedules.
- Where temporary or relief staff required to administer medication the setting Manager must ensure they have received instruction/training and that they are assisted by a member of staff who is able to recognise each young person to whom medication is being dispensed.

#### **4.7. "As Required" Medication (PRN)**

Instructions such as "when required" or "as necessary" must be discouraged, but when they appear on prescribed medication, advice from Parents/Carers and GPs with a knowledge of the young person should be documented in an "As required (PRN) Protocol". The protocol will identify any signs, symptoms and advice and will outline the necessity for administration of the medication when the young person is unable to do so. A signed record must be kept of all advice and decisions made using HSF34.

PRN medication must be dispensed with a standard label with the "as required" medication details. This alerts the person administering the medication that the preparation is PRN. The decision on whether the PRN medication is needed must be based on the individual's PRN protocol. When a PRN medication is administered a record of the administration must be made using the Medication Administration Record (MARS) HSF 55.

#### **4.8. Consent Arrangements**

No medication should be given to a young person without written consent obtained from the person with parental responsibility for the child. Procedures must be in place to ensure that this consent is obtained, these may take the form of a

- Parental Consent Form; or;
- Included as part of a Care Plan regime.



In the event of life threatening emergencies or under parts of The Mental Capacity Act 2005, consent for administration may not be necessary, but accurate documentation must be completed (see section 4.8.1. on Emergencies below). A young person's parents/carer should be informed if they have required any form of medication in an emergency whilst they are in the care of any setting.

### **Obtaining consent - communication and language difficulties**

Where the young person/parent/carers first language is not English, consideration should be given to the use of an interpreter. Where it is not possible to gain consent due to communication/comprehension difficulties, advice must be sought from the General Practitioner (GP). The outcomes must be recorded on the young persons care plan if one is required.

For someone with hearing or sight impairment it may be necessary to arrange for communication materials or advice specific to their needs or provide assistance in using different communication means such as sign language.

### **Cultural and Religious requirements**

Britain is a multi-cultural and multi-faith society. Care must be taken to respond sensitively to individuals and not to make assumptions because of their ethnicity or religion. It is important that young people and their carers are asked about any cultural or religious needs relating to the taking of medication or any prohibitions that apply.

All information on relating to the cultural or religious requirements of a child or young person must be accurate and up to date as this may have an impact on how they wish to receive care.

This information must be recorded as part of a care plan (if one is required) or in the child's personal records.

Further information can be found at [www.sdhl.nhs.uk/documents/cultural.html](http://www.sdhl.nhs.uk/documents/cultural.html)

### **4.8.1. Do Not Resuscitate Agreements (DNR) and Emergency Management Plans (EPM)**

An Emergency Management Plan (EMP) may be in place for some children and young people which may lead to the need to implement a Do Not Resuscitate Agreement (a DNR Agreement) in an emergency.

An EMP/DNR is implemented as a choice for some people to help preserve their dignity at the end stage of life. A DNR agreement may be in place for service users of any age originating from discussions with Health Professionals, carers or parents and in some cases the service user themselves.

The EMP ensures that there is a well discussed and agreed plan, which can be adhered to and implemented by **all** health practitioners and those providing care.

The plan must outline the detail of when the DNR Agreement may be invoked, and the circumstances which may arise. Staff must be fully aware of the care plan information of the service user and have been briefed on the signs and symptoms associated with a deterioration in the condition or health of the service user.

### **Staff awareness**

Where a EMP/ DNR Agreement is in place for a child or young person ALL staff in the establishment, setting or service must be made aware through a formal documented procedure which protects the wishes of the service user and also confidentiality. Ensure current copies of the EMP/DNR Agreement are available for **ALL** staff working within the setting(s).

### **Following the Emergency Management Plan Agreement**

Should the situation arise where the EMP/DNR Agreement should be followed staff are advised to call the Emergency Services and fully explain the situation to them both over the telephone and upon arrival at the premises. The DNR Agreement **MUST** be handed to the emergency health professionals upon their arrival.

Basic care (comfort, care, support, reassurance) should still be provided by staff to keep the service user comfortable and to maintain their dignity whilst waiting for health professionals to arrive.

### **First Aid**

There may be situations where first aid should be provided to a child or young person which does not invoke the Emergency Management Plan. Within all settings there are staff that will regularly undergo training to update their qualifications regarding First Aid and these staff must be made aware of when first aid may be required for a child or young person with a EMP/DNR.

### **Reviewing the Emergency Management Plan and DNR Agreement**

Ensure that the DNR Agreement has been reviewed a minimum of annually or as necessary with representation from the appropriate setting(s), health, parents or carers and if relevant the child or young person themselves.

### **Off site activities**

If a child or young person is being offered an activity away from the usual setting the DNR Agreement must be taken and handed to the appropriate health professionals as considered necessary. All staff working with a child or young person with a DNR Agreement on 'off site' activities **must** have access to a phone.

## **Transporting children or young person with an Emergency Management Plan / DNR Agreement**

All escorts and/or drivers transporting a child or young person with a EMP / DNR Agreement **must** be aware of the existence a EMP/ DNR Agreement and must follow procedure that has been agreed beforehand, for example this may include, stopping the vehicle and dialling 999, then handing the EMP/DNR Agreement over to the appropriate Health Professionals, upon arrival, within a sealed envelope clearly marked 'Private and Confidential.'

**Note** Health professionals involved in respect of **all** clinical procedures have the ultimate Duty of Care responsibilities for administering the EMP Plan / DNR Agreement. Health colleagues will be considered as follows: the School Nurse, Ambulance Paramedics, Community Paediatricians and qualified medical professionals to level 5 and above.

### **4.9. Self-Management of medication**

It is good practice to support and encourage children, who are able, to take responsibility for managing their own medicines from a relatively early age and schools and other settings should encourage this.

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent or setting staff.

The age at which children are ready to take care of, and be responsible for, their own medicines, varies. There is no set age when this transition should be made, and there may be circumstances where it is not appropriate for a child of any age to self-manage. Where this is agreed it must be added to the Parental Consent Form. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

If children can take their medicines themselves, staff may still be required to supervise and suitable storage arrangements must still be provided (see Storage of Medication 4.12).

#### **4.9.1. Carrying medication**

Local procedures and arrangements should say whether children may carry, and administer (where appropriate), their own medicines, bearing in mind the safety of other children and medical advice from the prescriber in respect of the individual child.

#### **4.9.2. Self Management of Controlled Drugs**

Where children have been prescribed controlled drugs staff must 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. (See Controlled Drugs)

### **4.10. Refusing Medicines**

If a child refuses to take medicine, staff must not force them to do so, but should note this in the records and follow agreed procedures. The procedures to follow in this situation may be set out in the procedures or local arrangements or in an individual child's health care plan. Parents should be informed of the refusal as soon as practicable and the refusal should be recorded on the Medication Administration Record sheet.

If a refusal to take medicines results in an emergency, the school or setting's emergency procedures should be followed.

#### **4.11. Controlled Drugs**

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. A Pharmacist will give advice as to whether a medication is a controlled drug or not.

Some controlled drugs may be prescribed as medication for use by children, e.g. methylphenidate.

Settings must consider the area of Controlled Drugs in their local procedures document and in some settings (e.g. schools) a Drugs Policy may also need to be in place.

A child who has been prescribed a controlled drug may legally have it in their possession, although it is advisable for schools and settings to store a controlled drug in line with the guidance in section 4.12.3.

To keep up to date with the medications classified as a controlled drug please view the Home Office information.

<http://www.homeoffice.gov.uk/documents/cdlist.html>

#### **Controlled Drugs Register**

It is essential practice for each setting to keep a separate record of controlled drugs to include the receipt, administration and possible disposal of controlled drugs. These records must be kept in a bound book or register with numbered pages (This can be purchased from a pharmacist).

The book will include the balance remaining for each product with a separate record page being maintained for each child. It is recommended that the balance of controlled drugs be checked at each administration and also on a regular basis e.g. monthly. The book should be locked away when not in use.

#### **Administration of Controlled Drugs**

Any authorised member of staff may administer a controlled drug to the child for whom it has been prescribed and they should do so in accordance with the prescriber's instructions in the presence of another member of staff as witness.

The administration of controlled drugs is recorded using the Controlled Drugs Register which can be purchased from a pharmacist and on the Medication Administration Record sheet HSF 55.

Staff MUST NOT sign the record of administration unless they have been involved in the administration of the medication.

The recommended procedure for the administration of controlled drugs is as follows:

1. Check the child's Confirmation Medication Details sheet HSF 30 for details of dosage required etc.
2. Verify the quantity of medication as stated on the controlled drug register to ensure that the dose has not already been given.
3. Ensure two members of staff are present; one member of staff must witness the other administer the medication to the young person.
4. Both staff must sign the Medication Administration Record sheet and controlled drug register to confirm that the dose was given and the amount remaining.

If medication is refused or only partly taken both staff must witness the disposal of the remaining medication and record the details and sign to that effect.

If a dose of medication is refused or only partly taken then the parents/carer or GP should be contacted for advice on any adverse reactions and risk to the young person.

### **Return or Discontinued Controlled Drugs**

A controlled drug, as with all medicines, should be returned to the parent/carer when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy).

In residential settings the following procedure is to be implemented for the return of or discontinued controlled drugs:

- A carbonated book should be used to record the receipt and return of controlled drugs.
- A separate page should be used for each young person.
- Two staff, one being the senior member of staff on duty must record and sign to show the amount of medication received or returned to the parent/carer or pharmacist.
- The parent/carer or pharmacist must sign the book to confirm their receipt or delivery of medication.
- All entries into the book must be signed and dated.

### **4.12. Storage of medication**

All medication is to be stored in the original container issued by the Pharmacist and must be stored away from public areas, sources of heat, moisture or direct sunlight, as these elements can cause the medicines to deteriorate.

Medicine cupboard/cabinets must of a suitable size to store all medication, and have a quality lock fitted where this is assessed as required.

The medication storage container must be secured to a wall and where portable storage device is used it must be secured to a wall when not in use.

The medicine cupboard should be reserved for medicines, dressings and reagents only and the following must be stored separately within the cupboard:

- External use only medicines

- Oral medicines
- Injectables, suppositories & pessaries
- Blood and urine testing reagents (either in a separate area or stored segregated in external medicines section)

The key to the medicine cupboard will be retained for the duration of the working day by an identified person. This will be delegated as necessary, and access should be restricted to authorised members of staff only.

Duplicate keys must be kept in a locked cupboard or drawer at all times, with access restricted to authorised members of staff only.

#### **4.12.1. Medication requiring storage by refrigeration**

##### **Significant quantities/regularly**

Where significant quantities of medicines are administered on a regular basis, a lockable drug fridge is advised. The temperature of the fridge is to be monitored and recorded daily. Stock should be rotated as it is received. Never mix the remains of an old prescription with a freshly supplied prescription.

##### **Small quantities**

In settings where low quantities are administered, medicines may be stored in a domestic fridge located in a staff only area, in a (if necessary) locked container labelled "medicines - authorised access only".

In the event that medicines are stored outside the required range usually between 2-8°C, staff should contact the dispensing pharmacist for advice. The refrigerator should be cleaned and defrosted regularly.

#### **4.12.2. Storage of Monitored Dosage Systems (MDS)**

MDS will need special consideration with regard to storage. Adequate lockable storage must be provided at all times for medicines supplied in MDS containers.

In community settings council employees should encourage parents and carers to store young person's medication in a safe location that is accessible.

#### **4.12.3. Storage of Controlled Drugs**

In all settings, controlled drugs must be stored behind **double lock and key**. This must be a metal cupboard with an inner lockable cupboard or a metal lockable container within a cupboard. The cupboard must be secured to the wall.

Controlled drugs must be checked in by two members of staff, one of which must be authorised to carry out this duty. All records must be recorded in the controlled drugs register which can be purchased from the Pharmacist and on the Medication Administration Record sheet.

#### **4.12.4. Storage of medication for young persons self managing their medication**

The storage of medication being self managed by young persons must form part of a risk assessment and Care Plan if necessary.

In the case of a medical emergency school or setting staff must have access to any personal lockable containers, with the permission of the young person. This information should be communicated to young person's parent/carer and their written authorisation should be recorded.

Professionals (Designated Nurse for Looked After Children and Care Leavers or School Nurses) may be consulted for advice concerning transition to independence.

### **Self managing general medication**

Where a young person is self managing medication in a school or other setting, this must be agreed by all parties (and may be included in a care plan where required).

It is good practice to offer storage arrangements for all types of medication which is being self managed by the young person as this approach offers effective safety and security for other young persons who could otherwise access the medication.

### **Self managing Controlled Drugs**

Where children and young people have been prescribed controlled drugs and are self managing medication, staff must be aware of the storage requirements for controlled drugs and implement them. Controlled drugs must be stored behind a double lock and key e.g. this may be a personal lockable container/locker inside another lockable container to which the young person may have direct access to when required, if it is agreed that it is appropriate.

### **Medical Equipment**

Some children and young people may be prescribed, as part of ongoing medical treatment, the use of certain medical equipment. This could include range of testing devices – such as blood/urine testing equipment and sharps, such as needles. All equipment should, as far as possible, be kept in its original container/packaging.

It is important to record on the young persons file the type of equipment being used, and any make or model numbers, and to date the record. All medical equipment will be kept locked away however a risk assessment needs to be undertaken for individual children as to their ability to manage their condition and carry or access equipment themselves. For example, in the case of a diabetic when blood and urine testing equipment may be needed urgently.

## **4.13. Transportation issues**

### **4.13.1. Transporting medication**

When medication is transported, it must be placed in a suitable lockable carrying case or box that is secure during transportation. Controlled drugs must be kept in a lockable container within a lockable container. The Medication Container must be kept out of public vision at all times.

During community outings, trips and educational visits, medication (with the exception of emergency medication) can be left in a vehicle if necessary. It must be a container as detailed above and the vehicle must be locked.

#### **4.13.2. Home to School Transport**

Where the County Council arrange home to school transport, children must be safe during the journey. Most pupils with medical needs do not require supervision on school transport but appropriately trained escorts should be provided where this is necessary. Guidance should be sought from the child's parent/carers and health professionals as to whether supervision may be required

Drivers and escorts must know what to do in the case of a medical emergency. If the administration of medicines during home to school transport is likely and it is agreed that the driver or escort will administer (i.e. in an emergency) they must receive training and support and fully understand what procedures and protocols to follow. Where training has not taken place, drivers and escorts must phone the emergency services when an emergency occurs. Drivers and escorts must be clear about roles, responsibilities and liabilities with regard to the administration of medication. Where pupils have life limiting conditions, specific Health Care Plans should be carried on vehicles.

Schools and parents must advise the Local Authority and its transport contractors of particular issues for individual children.

For more information on transport please see the County Council's Driving for Work Guidance G21. (Due for launch 2011)

#### **4.13.3 Holidays, Outings and Educational Visits**

Where required, Staff will take charge of the medicines and return the remainder on return to the setting or to parents/carers as appropriate.

Where a young person is self medicating this should continue whilst on holiday or educational visit, but consideration must be given to the locations, activities and the storage of the medicines to ensure that they are kept safe and secure for the young person.

#### **4.13.4 Individual Transport Health Care Plans**

In some cases individual transport health care plans will be required (e.g. for children with more complex medical needs). These will require input from parents and the responsible medical practitioner for the child concerned. The care plans should specify the steps to be taken to support the normal care of the pupil during transport as well as the appropriate responses to emergency situations. Additionally trained escorts may be required to support pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

#### **4.13.5 Allergic Reactions**

Some children and young people are at risk of severe allergic reactions. Settings must plan to reduce the likelihood of the risk of allergic reactions by ensuring that service users/children do not come into contact with the material or foodstuffs which may cause a reaction. For example; where allergies are known to be food related risks can be minimised by not allowing anyone to eat on vehicles.

Where it is necessary, escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate. **These pens must only be used for those children for whom they are prescribed.**



#### **4.14 Specialist Medication Activities (this includes invasive treatments)**

A wide range of specialist medication activities may at times be required within a school or setting. These activities are best carried out by medical professionals whenever possible.

In some circumstances specialist medication activities may be carried out by school or setting staff after the following checklist has been completed:-

##### Stage 1

- A multiagency group meeting including the young person's health professional, other health agencies, parents/carer etc. At this meeting the School/Setting Manager needs to develop a clear understanding of what is required to complete the specialist medication activity. The health professionals attending must determine that the medication activity/treatment is suitable to be completed by a non medical professional (e.g. does it require an individual to make a medical assessment/judgment or have detailed medical knowledge/skills). The discussion and outcomes of this meeting must be accurately recorded. It is important that the decision reflect both health professionals views and service/schools views as to if the specialist medication activity is suitable to (and can safely) be completed in the setting/school environment.
- A risk assessment for the activity and control measures must be developed.
- The individuals care plan must be reviewed and amended where necessary to reflect the requirements of the medication process.
- Training requirements must be discussed with the health professionals and arranged to be delivered by a suitable health professional. This training must be refreshed at least annually. Agree with the health professionals how staff competency is to be monitored.

Discuss these requests with appropriate professionals and support services within the council including the Strategic Health and Safety Service and Special Educational Needs Inspector, Legal Services and Insurance Services.

The school or setting need to determine if they have the resources, suitable staff volunteers/staff with job descriptions covering such activities to undertake the medication activity.

The decision must not be taken in isolation, the school or setting will need to consider the impact of this activity on staffing resources based on other medication needs presently being managed within the school/setting, to determine whether they can manage the adjustments required. It is also important that the school/settings ability to manage specialist medication activities is reviewed at regular intervals with input from health professionals.

If the specialist medication activity need is to be completed by school/setting staff then it is important that the following actions are completed and suitable management arrangements are implemented:-

## Stage 2

- Completion of an Individual Risk Assessment for the Service User/Pupil detailing the safe working practices to be followed. This document must be effectively communicated to all relevant parties.
- Individual Care Plan once developed must be signed by relevant parties including young persons medical/health professionals.
- Suitable training by health professional. It is not appropriate for staff to be trained by parents/carers or other staff at the school.
- Upon completion of the training the staff required to complete the specialist medication activity must be confident in what is required, and receive regular refresher training to ensure these skills are maintained.
- Training and refresher training must be recorded.
- Ensure that arrangements to monitor staff competency are agreed with the health professionals.
- Recording arrangements to detail when the specialist medication procedure has been completed and communication parents/carers must be put in place.
- Ensure care plan is reviewed with young person's medical/health professional at regular intervals and when any changes or concerns arise.

The School Headteacher/Setting Manager is responsible for monitoring staff resources to undertake the specialist medication and activities and must provide staff with the authorisation to carry out the specialist medication activities once they are satisfied that all aspect of this section have been completed. The authorisation to staff must be clear about the types of administration they are authorised to perform and when they are authorised to perform these activities.

Where the decision is that the school/setting staff can not accommodate completion of the specialist medication activity then Health involvement needs to be sought and specialist advice taken from council Assistant Directors within the CYPF Directorate, especially if this will impact on young person's access to education.

### **4.15 Emergency Provision of Care**

As part of general risk management processes all schools and settings should have arrangements in place for dealing with emergency situations. This should be part of the setting's first aid policy and emergency plans. All staff should also know who is responsible for carrying out emergency procedures.

Individual health care plans should include instructions as to how to manage a child in an emergency, and identify the role and responsibilities of staff during the emergency. Where possible staff and other children should know what to do in the event of an emergency, and all staff should know how to call the emergency services.

A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

Staff should never take children to hospital in their own car unless accompanied by another member of staff and only then in extreme emergencies.

The existence of a EMP/DNR Agreement (see 4.8) must also be taken into consideration when an emergency occurs.

#### **4.16 Disposal of Medicines**

**In event of the death of a young person, all medicines must be retained for at least 7 days in case they are required by the Coroner's Office.**

Medication **should not be disposed of by via the sink, toilet or dust bin, this is both illegal and unsafe.**

#### **Schools and Early Years Settings**

School and early years settings must not undertake to dispose of any medication, except in the case of spoiled doses. Any unused medication must be returned to the parent/carer. Any other arrangements must be formally recorded and agreed by all parties.

#### **Other settings**

The medicines that are held in a setting at any given time should be appropriate to the current therapy of the child. Any surplus or unwanted medicines should be returned to the parent/carer/pharmacy as appropriate.

The manager responsible for medicines must check medicines held at the beginning of every week, to remove out of date or discontinued medicines. Discontinued medicines awaiting disposal should be kept segregated from medicines that are currently in use, i.e. in labeled bag in locked cupboard.

In special school or residential care settings, it may be necessary for small quantities of medication to be kept in the setting medication cupboard for longer periods such as weekends or short holidays.

When a child leaves the setting the medicines should be returned to the child's parents or carers unless they have positively consented to their safe disposal or passed to another authoritative source e.g. Social Worker.

In situations where medication may need to be returned to the pharmacy, a record should be made of the name, quantity of the medicine, reason and the date of disposal, which should be certified by two staff members. The pharmacist should be asked to sign for all the returned medication.

A complete record of medicines leaving the setting must be recorded.

#### **4.17 Disposal of Sharps**

Where any staff on site (whether settings staff or community based colleagues e.g. nurses) use syringes and needles, it is their responsibility to ensure safe disposal of these items into a sharps box.

**Used needles and syringes are not to be re-sheathed. They are to be disposed of immediately into the sharps box.**

Where regular use of needles is required, consideration should be given to the use of retractable needles. Young persons self-administering insulin or any other medication

with a syringe, must be assisted by staff in the proper disposal of sharps. A sharps box will be provided, but kept safe by staff, and locked away if necessary.

Each setting should access local arrangements for the supply and disposal of sharps boxes using a registered contractor.

#### **4.18 Management of Errors/Incidents in Administration of Medicines**

In the event that medication has been administered incorrectly or the procedures have not been correctly followed, then the following procedure is to be implemented: -

- Ensure the safety of the young person. Normal first aid procedures must be followed which will include checking pulse and respiration.
- Telephone for an ambulance if the child's condition is a cause for concern.
- Notify the Manager/Person in Charge.
- Contact the young person's Parents/Carers as soon as practicable.
- Contact the young person's GP/Pharmacist for advice if necessary. (Out of hours contact NHS Direct).
- Document any immediate adverse reactions and record the incident in the young persons file/Care Plan using the Medication Incident Report Form HSF36.
- The Settings Manager must complete the Medication Incident Report Form HSF 36 and, if injury results, the County Council Accident Investigation Report HSF40.
- The Setting Manager must commence an immediate investigation about the incident, inform the the Strategic Health and Safety Team, and, where applicable inform any relevant regulatory body. Statements should be taken from both staff and young persons if they are self medicating.
- The medication administration record sheet should reflect the error.
- Young person's parent/carer/guardian should be informed formally in writing.

It is recognised that despite the high standards of good practice and care, mistakes may occasionally happen for various reasons. Every employee has a duty and responsibility to report any errors to his/her manager. Managers should encourage staff to report any errors or incidents in an open and honest way in order to prevent any potential harm or detriment to the young person. Managers must handle such reporting of errors in a sensitive manner with a comprehensive assessment of the circumstances.

A thorough and careful investigation taking full account of the position of staff and circumstances should be conducted before any managerial or professional action is taken.

Any investigation must observe the conventions as set out in the County Council's Disciplinary Policy.

## 4.19 Unaccounted for Drugs

If medications are unaccounted for this must be regarded as a serious situation and a potential disciplinary matter for staff. The Managers must decide on the action to be taken, dependant upon the circumstances. As a minimum a full internal investigation must be carried out by the setting manager/headteacher and the Strategic Health and Safety Team must be informed.

The Manager may determine that the situation is sufficiently serious to warrant informing the police. In any case where **controlled drugs are unaccounted for, the police should be informed** and a police investigation may take place.

In a school setting the Headteacher may wish to inform the Governing Body.

## 4.20 Individual/Health Care Plan

### 4.20.1 Developing a Care Plan *(from Managing Medicines in Schools and Early Years Settings March 2005)*

Not all children who have medical needs will require an individual plan. The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed, who will carry out that support and how the setting will deal with any problems or emergencies.

The Care Plan may also include individual risk assessments which have taken place as decisions have been made about the child's medication or care. An individual health care plan clarifies for staff, parents and the child the help that can be provided. It is important for staff to be guided by the child's GP or paediatrician as well as parents and carers.

Staff should agree with parents how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.

Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child. In addition to input from the child's GP/Paediatrician or other health care professionals (depending on the level of support the child needs).

Those who may need to contribute to a health care plan include:

- The head teacher or head of setting
- The parent or carer
- Health Visitor/School nurse/Looked After Children's Nurse/Community Paediatric Nurse as appropriate.
- The child (if appropriate)
- Early Years practitioner/class teacher (primary schools)/form tutor/head of year
- Care assistant or support staff (if applicable)
- Staff who are trained to administer medicines
- Staff who are trained in emergency procedures

### 4.20.2 Co-ordinating Information

Co-ordinating and sharing information on an individual pupil with medical needs, particularly in secondary schools, can be difficult. The manager should decide which member of staff has specific responsibility for this role. This 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.

#### **4.20.3 Information for Staff and Others**

Staff who may need to deal with an emergency will need to know about a child's medical needs. The head should make sure that all staff (including supply and temporary staff) know about any medical needs.

#### **4.20.4 Off-site Education or Work Experience**

Where students have special medical needs the school will need to ensure that the care plan and any risk assessments take into account those needs when the young person is on work experience. Parents and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

#### **4.20.5 Confidentiality**

The headteacher/setting manager and staff should always treat medical information confidentially. Managers should agree with the child where appropriate, or otherwise the parent/carer, who else should have access to records and other information about a child or young person.

When the medical status of a staff member or service user is known, either through recorded information or verbally, the indisputable "need to know" is the criteria for disclosure not "want to know."

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.

#### **4.21 Staff Training**

A health care plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies.

The employer should arrange appropriate training in collaboration with local health services if necessary. All such training must be recorded.

When staff agree to assist a child with medical needs, or to assist or administer medication, they should receive appropriate instruction and/or training. Where there is a need to maintain a training record, this should be recorded using the form, and training records kept in an in house training record. (An example of this form is County Council form HSF37)

Staff must:

- Be conversant with the County Council's Medication Policy and guidance as well as any local procedures.
- Have basic knowledge of medication and its use before assisting or administering.
- Understand the safe procedures for handling medications and understand their responsibilities in the administration of medication

- Be able to administer medications safely and effectively
- support service users who self-administer
- Ensure knowledge of emergency procedures in the event of an incident i.e. overdose, administration of wrong medication etc.
- Ensure that accurate records are maintained for administration.
- Ensure that all medication is clearly identified in an original container with recipient's name on.
- Complete any records as required.
- Possess a basic knowledge and understanding of the County Council Policy on Infection Control.
- Be aware of potential cultural, religious, language and communication needs of children/young people in relation to health and medication.
- Be aware of needs of children/young people with disabilities, and the effects of such factors as sight, hearing or physical dexterity in relation to medication.
- Appreciate the role of other professionals in relation to medication
- Have a good understanding of their role and responsibilities in relation to the safe storage, administration, disposal etc of medication.

### **Training to carry out any Specialist Medication Activities**

Only staff who are trained and deemed competent should perform any invasive medical procedures, such as those indicated in 4.14 above.

### **4.22 Medication and Children in Foster Care**

There are many reasons children and young people may be placed in a Foster Care setting. The ethos is very much to provide an environment which is family focused. To install strict medication management regimes may be both impracticable and inappropriate. However, the County Council has a duty of care to the children, young people and Foster Carers and the following management system is required.

1. All Foster Carers should have written information from the Directorate indicating when they are allowed to give consent for medical treatment.
2. Foster Carers are to be given clear guidance about roles and responsibilities for consent to treatment.
3. Foster Carers have a right to a full description of the medical needs of the young person.
4. Foster Carers will have a written health record for the young person, Health Plan and where possible the Red Book/Parent Held Record, which will be sent with the young person as they move.
5. Unless the young person is of the appropriate age to consent to a health assessment being undertaken, their parent(s)/ guardians will be asked to sign the Consent to Health Assessment form, agreeing to the assessment being completed.

6. Children are entitled to seek medical treatment without the consent of their parent / guardian, foster carer or social worker.
7. The young person can choose to attend the Health Assessment alone or with their parent/ guardian, foster carer or social worker.
8. Failure to obtain consent from the young person's parents will not be allowed to override their need for health care.
9. Where written information is supplied, this may be made available in an appropriate language or format if required.
10. Foster Carers are to receive basic training on health issues, with particular attention given to issues around Hepatitis B, Hepatitis C and HIV infections. This can be provided through e learning or DVD upon request.
11. Foster Carers will ensure that medications are safely stored and appropriately labelled out of the reach of children and young people. However, where a young person is able to self medicate they must be able to access the medication as necessary and arrangements made to enable them to store it in an appropriate safe place.
12. All medication must be in a suitably labelled container as dispensed by the pharmacist.
13. Foster Carers will complete the relevant documentation for any medications e.g. the Medication Administration Record.
14. The Foster Carer must sign and date the Medication Administration Record after each administration. Medication should be taken in front of the Foster Carer. This record will be checked every 3 months during the supervisory visit by the Fostering Social Worker.
15. If a mistake occurs, then IMMEDIATE medical assistance must be sought either through A&E or the young person's GP so as to prevent any harm to the young person and the incident reported to the social worker. A Medication Incident Form HSF 36 must be completed and sent to the Service Manager, Fostering Services. In the case of Family Short Breaks the Medication Incident form must be forwarded to the Head of Services – Disability Resources.
16. All Foster Carers will be advised to seek immunisation against Hepatitis B through their own GP. If Foster Carers are unable to access immunisation through their GP, they should contact their Fostering Social Worker.
17. When completing the Placement Plan and Agreement, medication issues will be discussed with the parent / guardian and documented. The parents will generally maintain parental responsibility and will need to be consulted with prior to consent to receiving medication being given. Where Staffordshire County Council have joint parental responsibility, consent procedures will be clearly documented.



## 4.23 Management of Oxygen

### Oxygen Use

The fundamental indication for the administration of oxygen is the presence of hypoxia. This could be for one of the following reasons:-

- Cyanosis of recent origin as a result of pulmonary disease
- Shock, severe haemorrhage and coronary occlusion
- Chronic obstructive airway disease
- Heart failure
- Emphysema
- Lung cancer

### Prescription and Supply of Oxygen and Equipment

A young person may be prescribed oxygen as part of their treatment programme either by a Consultant or by the General Practitioner.

The oxygen supply service is contracted out to different suppliers by area. The GP sends the prescription directly to the supplier who then delivers the oxygen.

Staff must be **authorised and trained to administer oxygen** and are permitted to change cylinders providing they have received instruction from the oxygen supplier.

#### Within Community Settings:-

The changing of oxygen cylinders is generally a responsibility of the community nurse and advice and guidance must be sought before any employees of the council undertake such activities in community settings. However employees can, where identified in the individual care plan, assist a young person to self medicate oxygen.

#### Within School and Early Years:-

Where a young person is attending or wishes to attend the setting, it is the Manager's responsibility to liaise with the young person's parent/carer to ensure that suitable oxygen cylinders are available for travelling between their home and the school/setting. Where this may be on County Council Transport the Transport Team and Contractors must also be made aware of the requirements in order to arrange the most appropriate transport and provide training to drivers and escorts as necessary.

Smoking in the vicinity of oxygen cylinders is strictly prohibited.

Detailed advice on the Administration, Storage and Transport of Oxygen is provided in a separate guidance document available on the Strategic Health and Safety Service intranet site. A General Risk Assessment must be completed for the Administration, Storage and Transportation of Oxygen (see example in the Appendices to this guidance).

## 4.24 Specific Medical conditions – guidance

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This section 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 and young people are assessed on an individual basis.

## **ASTHMA**

### **What is Asthma?**

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

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

### **Medicine and Control**

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

**Children with asthma need to have immediate access to their reliever inhalers when they need them.** Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do. Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits. For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting. **Schools must not provide communal emergency inhalers. Only an inhaler provided for the specific individual should be used.**

The signs of an asthma attack include:

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

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

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

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

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting. Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

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

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

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

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

## **EPILEPSY**

### **What is Epilepsy?**

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of 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 health care plan, setting out the particular pattern of an individual child's epilepsy. If a child experiences 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 health care plan

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115-117 but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

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 epilepsy medication is needed and will be available from local health services. Staying with the child afterwards is important as medication may cause drowsiness.

Further advice and guidance on the emergency treatment of seizures including administration of rectal diazepam or midazolam as first aid measures is available in G51 Emergency Treatment of Seizures Procedures.

## **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 health 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**

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 health care 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
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care 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 or setting's emergency procedures but also relate specifically to the child's individual health care plan.

## **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 child should be watched carefully. They may be heralding the start of a more serious reaction.

### **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.

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

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 head, 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.

Studies have shown that the risks for allergic children are reduced where an individual health care 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 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 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.

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.

### **Any Other Health Condition**

An individual care plan will need to be drawn up for each child who has any significant health condition not been mentioned in this document which might impact on their education or care.

Please consult with the school health advisor/nurse, or Community Paediatrician for further information.

### **4.25 Emergency Treatment of Seizures**

Managers must ensure that they have local procedures documenting the procedures to be followed by staff. Managers must be familiar with the Council's Guidance document on the Emergency Treatment of Seizures (G51) and where necessary local procedures must incorporate the principles detailed in this good practice guide.

These procedures must be followed in the event of a young person requiring the administration of buccal Midazolam or rectal Diazepam. It also includes guidance and information for managers and staff involved in the safe and appropriate administration of such medications.

In the event of a young person requiring the emergency administration of Medication, a protocol must be drawn up detailing the circumstances and situations when it should be administered. The GP/Consultant and the relevant manager must sign the protocol and if appropriate the young person and parent/carer.

A record of administration must be completed whenever buccal Midazolam or rectal Diazepam is administered.

All staff administering medication for the Emergency Treatment of Seizures must have received training in accordance with the guidance document.

### **4.26 Health and Safety Issues**

Staff should avoid direct contact with medicines. Where this is unavoidable staff should contact the dispensing pharmacist for advice, e.g. when staff have to apply steroid creams **directly** to a child, non latex gloves must be used.

Infection control principles must be followed by staff administering medication and staff must be familiar with effective hand washing principles. See the County Council Infection Control Policy (HR53) for more detail. An intranet based training video and open learning booklet can be found on the Health and Safety Intranet site

<http://www.intra.staffordshire.gov.uk/hs/>

### **4.27 Patient information Leaflets**

A patient information leaflet (PIL) will be supplied by the pharmacist with each medicine (including those supplied in monitored dosage systems) and these should be made available to the child if requested.

#### **4.28 Medicines for a staff members own use**

An employee may need to bring medicine into school /setting for their own use. All staff have a responsibility to ensure that these medicines are kept securely and that young people will not have access to them, e.g. locked desk drawer or staff room.

Adequate safeguards must be taken by employees, who are responsible for their own personal supplies, to ensure that such medicines are not issued to any other employee, individual or young person.

#### **4.29 Specific Risk Situations**

##### **Alcohol or Other Substances**

If in any doubt about whether it is appropriate or safe to give a medicine (e.g. if the young person is under the influence of alcohol or other substance), advice should be sought from the Community Pharmacist/GP/NHS Direct.

##### **Pregnancy**

If staff become aware that a young person is pregnant, staff must **check immediately** with GP/NHS Direct/Community Pharmacist, that any medication is not contraindicated during pregnancy and if any action is required. It is generally advised that non prescribed medication should not be taken during pregnancy without advice from a health professional.

#### **4.30 Equal Opportunities Statement**

The County Council is fully committed to ensuring equality in the delivery of this guidance to all young people, regardless of their gender, ethnicity, sexuality and ability.

This document has been prepared in consultation with representatives from all service and school settings from within the CYPF Directorate.

#### 4.31 Medication Records/Standard Forms

Other forms are available for use for in [Managing Medicines in Schools and Early Years Settings - Every Child Matters](#)

HSF 30	Confirmation of Medication Details
HSF 31	Service User Self Medication Assessment
HSF 32	GP Consent Form – Self Medication
HSF 33	GP Consent Form – Over the Counter Medication (Homely Remedies)
HSF 34	Protocol for Administration of PRN Medication
HSF 35	Receipt of Medication- Transport
HSF 36	Medication Incident Report Form
HSF 37	Medication Policy and Procedures In-house Training Record
HSF 55	Medication Administration Record sheet

#### 5. Glossary of Terms

**Administer** - supporting young persons to 'administer their medicines' can include reminding someone to take or use their medicines, removing the medicine from the container and putting in young persons hand or in a container, helping a young person to actually take a medicine by supporting their hands, opening a medicine container or reading the labels on a medicines container.

**Assist** - this can include helping young persons to read labels, reach containers that are stored securely, removing lids from containers, removing tablets and capsules from their foil packaging, reminding young persons to take their medicines or physically helping them use their hands to get medicines into their mouths or creams, etc. to parts of their body where they are needed.

**Buccal** – pertaining to the cheek or to the mouth

**Prompt** - this may be by telling a young person its time to take their medicines, by handing a young person a medicine container at the time to take their medicines or by setting an alarm to go off when it is the correct time to take their medicines.

**Observe** - this may be watching over a young person while they take or use their medicines and only offering assistance such as removing lids from containers if the young person is struggling.

**Dispense** - carers should only dispense tablets/liquids/capsules for young persons out of containers that have come from the community pharmacy and only at the point where a young person is going to take a medicine. If a carer needs to dispense a dose for a later administration it must be into a suitable container that can be left safely where no-one can tamper with it and they must be sure the young person understands when it is to be taken and is capable to taking it on their own.

**MAR** – Medication Administration Record

**PRN** – As necessary / when required

**Rectal** – Relating to the rectum

**OTC** – Over the counter (medication)

## **6. References**

**Managing Medicines in Schools and Early Years Settings**

DFES and DH March 2005

**Staffordshire County Council  
General Risk Assessment Record Form**

1. **Section/Service/Team**..... 2. **Assessor(s)**.....

3. **Description of Task/Activity/Area/Premises etc.** ..... **Oxygen (Administration and Storage)**

<b>What are the hazards?</b>	<b>Who might be harmed and how?</b>	<b>What are you already doing?</b> List the control measures already in place	<b>What is the risk rating – H, M, L?</b> See section 5	<b>What further action, if any, is necessary, if so what action is to be taken by whom and by when?</b>	<b>Action Completed</b> State the date completed and sign.	<b>What is the risk rating now – H, M, L?</b> See section 5
1. Transportation of oxygen cylinders.	Staff and service users, from fire explosion and contact with moving cylinders.	<ul style="list-style-type: none"> <li>• Green diamond safety sign is displayed on the vehicle</li> <li>• Cylinders are secured to prevent them from moving around.</li> <li>• ‘Trem’ card is carried on the vehicle.</li> <li>• Vehicle is stopped if administration is required.</li> <li>• Service users are only transported with portable oxygen cylinder. Appropriate fire extinguisher is on the vehicle</li> <li>• Strict ‘No Smoking’ rules enforced.</li> </ul>	Medium			

2. Administration of oxygen.	Staff, service users, from inappropriate handling, use.	<ul style="list-style-type: none"> <li>• Staff receive instruction/ training in the operation of the oxygen cylinders.</li> <li>• Oxygen is only used in a well-ventilated area, away from naked flames and heat.</li> <li>• Lubricants and tapes are not used on the cylinder.</li> <li>• All cylinders are regularly checked to ensure there is no damage to the cylinder, hose, pipes, and valves.</li> </ul>	Medium			
3. Manual handling	Staff, could suffer sprains and strain from moving oxygen cylinders	<ul style="list-style-type: none"> <li>• Manual handling policy in place and communicated to staff.</li> <li>• Staff receive appropriate moving and handling training.</li> <li>• Staff wear appropriate clothing and footwear</li> </ul>	Medium			

4.Fire or explosion	Staff, service users visitors, could be injured by fire or explosion from inappropriate storage/use	<ul style="list-style-type: none"> <li>• Staff receive instruction/ training in the operation of the oxygen cylinders.</li> <li>• The location of oxygen cylinders are identified on the fire plan</li> <li>• Oxygen cylinders are stored in an upright position and under cover to protect the valves from the changes in the weather.</li> <li>• The storage area is only used for oxygen cylinders.</li> <li>• Appropriate fire fighting equipment is near to storage area.</li> <li>• Storage areas are no smoking.</li> <li>• Quantities kept to a minimum.</li> <li>• The location of oxygen cylinders are identified by the use of a green diamond safety sign</li> </ul>	Medium			
---------------------	---	--	--------	--	--	--

**4. Tick if any of the identified hazards relate to any of the following specific themes:**

Hazardous Substance	Manual Handling	Display Screen Equip	Fire	Work Equip / Machinery	Stress	Individual Person such as Young Person New/ Expectant Mother or Service User
✓	✓		✓			✓

If any are ticked a specific risk assessment form must be completed separately. For example a COSHH form must be completed if a hazardous substance is used.

**5. Risk Rating**

The risk rating is used to prioritise the action required. Deal with those hazards that are high risk first.

Risk Rating	Description	Action Priority
High	Where harm is certain or near certain to occur and/or major injury or ill-health could result	Urgent action



Medium	Where harm is possible to occur and/or serious injury could result e.g. off work for over 3 days	Medium priority
Low	Where harm is unlikely or seldom to occur and/or minor injury could result e.g. cuts, bruises, strain	No action or low priority action

**6. Assessment**

**Signature of Assessor(s):**

**Print Name:**

**Date Assessed:**

**Signature of Line Manager:**

**Print Name:**

**Review Date:**

**7. Communication and Review**

This risk assessment should be communicated to all employees and relevant persons who may come into contact with the hazards being assessed. The assessment must be reviewed annually or following a significant change, accident or violent incident