GOLDINGTON GREEN ACADEMY

Supporting Pupils with Medical Needs

Safeguarding

Goldington Green Academy recognises it has a statutory duty under Section 175 of the Education Act 2002 to ensure arrangements are in place for safeguarding and promoting the welfare of children.
We recognise that children who are abused or witness violence may find it difficult to develop a sense of self-worth and that school may be the only stable, secure and predictable element in the lives of children at risk. Our school will endeavour to support these pupils by providing an ethos which promotes a positive, supportive and secure environment, providing a sense of being valued.
All staff, governors and volunteers must be made aware of, and adhere to the safeguarding policy and procedures within the school.
At Goldington Green we recognise our legal and ethical duty to keep pupils safe from radicalisation and extremism. As such we incorporate the principles of the PREVENT agenda into all practice including the curriculum. Additionally, we ensure that all speakers are carefully vetted by senior staff and that all material available in school, both electronic and otherwise, is suitable. We also ensure that sufficient training is in place so that all staff understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it. Staff know what measures are available to prevent people from becoming drawn into terrorism and how to challenge the extremist ideology that can be associated with it. Any concerns are dealt with in line with our safeguarding policy working in conjunction with Bedfordshire Police and other agencies as appropriate.

Equal Opportunities

The Equality Act 2010 makes it unlawful for staff to discriminate directly or indirectly, or to harass staff or pupils due to any of the nine protected characteristics.
Goldington Green Academy aims to create a culture that respects and values each other's differences, that promotes dignity, equality and diversity, and that encourages individuals to develop and maximise their true potential.
Everyone within the school community has a responsibility to ensure that this statement is adhered to. Senior Leaders in particular, should lead by example, identify any inappropriate behaviour when it happens and take prompt action to deal with inappropriate behaviour.
We aim to remove any barriers, bias or discrimination that prevents individuals or groups from realising their potential and contributing fully to our school's performance. In removing these barriers, we aim to develop a school culture that positively values diversity.
We are committed wherever practicable, to achieving and maintaining a workforce that broadly reflects the local community in which we operate.
Every possible step will be taken to ensure that individuals are treated fairly in all aspects of their employment, engagement or whilst volunteering at our school.

This policy sets out the duty on governing bodies of maintained schools, proprietors of academies and management committees of PRUs to make arrangements for supporting pupils at their school with medical conditions under Section 100 of the Children and Families Act 2014
http://www.legislation.gov.uk/ukpga/2014/6/section/100/enacted
In meeting the duty, the governing body, proprietor or management committee **must** have regard to the most current guidance issued by the Secretary of State under this section (Supporting pupils at school with medical conditions, https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

Main legislation addressed:-

- Supporting Pupils at school with Medical Needs 2014 (updated 2017)
- The Health and Safety at Work Act 1974
- The Management of Health and Safety at Work Regulations 1999
- The Education Act 2011
- The Medicines Act 1968

Contents

The staff at Goldington Green Academy are committed to providing pupils with a high-quality education whatever their health need, disability or individual circumstances. We believe that all pupils should have access to as much education as their particular medical condition allows, so that they maintain the momentum of their learning whether they are attending school or going through periods of treatment and recuperation. We promote inclusion and will make all reasonable adjustments to ensure that children and young people with a disability, health need or SEND are not discriminated against or treated less favourably than other pupils.

Principles

This policy and any ensuing procedures and practice are based on the following principles.

- All children and young people are entitled to a high-quality education;
- Disruption to the education of children with health needs should be minimised;
- If children can be in school they should be in school. Children's diverse personal, social and educational needs are most often best met in school. Our school will make reasonable adjustments where necessary to enable all children to attend school;
- Effective partnership working and collaboration between schools, families, education services, health services and all agencies involved with a child or young person are essential to achieving the best outcomes for the child;
- Children with health needs often have additional social and emotional needs. Attending to these additional needs is an integral element in the care and support that the child requires; and that
- Children and young people with health needs are treated as individuals, and are offered the level and type of support that is most appropriate for their circumstances; staff should strive to be responsive to the needs of individuals.

As a school we will not engage in unacceptable practice, as follows:

- Send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans;
- If a child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable;
- Prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively;
- Prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary;
- Penalise children for their attendance record if their absences are related to their medical condition e.g. hospital appointments;
- Require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs; nor
- Prevent children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany their child.

Definition of health needs

For the purpose of this policy, pupils with health needs may be:

- pupils with **chronic or short term health conditions or a disability** involving specific access requirements, treatments, support or forms of supervision during the course of the school day or
- **sick children**, including those who are physically ill or injured or are recovering from medical interventions, or
- Children with **mental or emotional health problems**.

This policy does not cover self-limiting infectious diseases of childhood, e.g. measles.
Some children with medical conditions may have a disability. A person has a disability if he or she has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. Where this is the case, governing bodies **must** comply with their duties under the Equality Act 2010. Some may also have special educational needs (SEN) and may have a statement, or Education, Health and Care (EHC) plan which brings together health and social care needs, as well as their special educational provision.

Goldington Green will follow the Special Education Needs & Disability (SEND) Code of Practice where pupils who have medical conditions requiring an Education, Health Care Plan (EHCP)

1.0 Roles and Responsibilities

All staff have a responsibility to ensure that all pupils at this school have equal access to the opportunities that will enable them to flourish and achieve to the best of their ability. In addition, designated staff have additional responsibilities as well as addition support and training needs.

Named person in school with responsibility for medical policy implementation

The member of staff responsible for ensuring that pupils with health needs have proper access to education is Sarah Sears. She will be the person with whom parents/carers will discuss particular arrangements to be made in connection with the medical needs of a pupil. It will be her responsibility to pass on information to the relevant members of staff within the school. This person will liaise with other agencies and professionals, as well as parents/carers, to ensure good communication and effective sharing of information. This will enhance pupils' inclusion in the life of the school and enable optimum opportunities for educational progress and achievement.
Day to day support may be delegated to appropriate staff.

Parents/carers and pupils

Parents hold key information and knowledge and have a crucial role to play. Both parents and pupils will be involved in the process of making decisions. Parents are expected to keep the school informed about any changes in their children's condition or in the treatment their children are receiving, including changes in medication. Parents will be kept informed about arrangements in school and about contacts made with outside agencies.

School staff

Any member of school staff should know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help. Staff must familiarise themselves with the medical needs of the pupils they work with. Training will be provided in connection with specific medical needs so that staff know how to meet individual needs, what precautions to take and how to react in an emergency.
Care plans are in the medical room and staff should ensure they are aware of these.

The Headteacher

The Headteacher is responsible for ensuring that all staff are aware of this policy and understand their role in its implementation. The headteacher will ensure that all staff who need to know are aware of a child's condition. S/he will also ensure that sufficient numbers of trained staff are available to implement the policy and deliver against all individual healthcare plans, including in contingency and emergency situations. The headteacher has overall responsibility for the development of individual healthcare plans. S/he will also make sure that school staff are appropriately insured and are aware that they are insured to support pupils in this way. S/he will contact the school nursing service in the case of any child who has

a medical condition that may require support at school, but who has not yet been brought to the attention of the school nurse.

The Governing body
The governing body is responsible for making arrangements to support pupils with medical conditions in school, including ensuring that this policy is developed and implemented. They will ensure that all pupils with medical conditions at this school are supported to enable the fullest participation possible in all aspects of school life. The governing body will ensure that sufficient staff have received suitable training and are competent before they take on responsibility to support children with medical conditions. They will also ensure that any members of school staff who provide support to pupils with medical conditions are able to access information and other teaching support materials as needed.

0 -19 School health teams
Where the school health team is made aware by the school or the parent that a child has a medical condition which will require support in school, they are able to support the school in the production of the Individual Healthcare Plan, this may be done in conjunction with a specialist nurse, G.P other specialist.

Other healthcare professionals
GPs and Paediatricians may also notify the school nurse when a child has been identified as having a medical condition that will require support at school
Hospital and Outreach Education works with schools to support pupils with medical conditions to attend full time.

Staff training and support
In carrying out their role to support pupils with medical conditions, school staff will receive appropriate training and support. Training needs will be identified during the development or review of individual healthcare plans. The relevant healthcare professional will lead on identifying and agreeing with the school, the type and level of training required, and how this can be obtained. The school will ensure that training is sufficient to ensure that staff are competent and confident in their ability to support pupils with medical conditions, and to fulfil the requirements as set out in individual healthcare plans.
Staff will not give prescription medicines or undertake health care procedures without appropriate training. **A first-aid certificate does not constitute appropriate training in supporting children with medical conditions.**

This policy will be publicised to all staff to raise awareness at a whole school level of the importance of supporting pupils with medical conditions, and to make all staff aware of their role in implementing this policy. Information on how this school supports children with health needs is included in our induction procedure for all new staff.

2.0 Procedures

Notification
Information about medical needs or SEND is requested on admission to the school. Parents and carers are asked to keep the school informed of any changes to their child's condition or treatment. Whenever possible, meetings with the parents/carers and other professionals are held before the pupil attends school to ensure a smooth transition into the class.
The School Nursing Service offer all year R & Year 6 pupils, health screening. Any medical concerns the school has about a pupil will be raised with the parents/carers. Most parents/carers will wish to deal with medical matters themselves through their GP. In some instances, the school, after consultation with the parent/carer, may write a letter to the GP (with a copy to the parents) suggesting a referral to a specialist consultant where a full paediatric assessment can be carried out.

Individual Healthcare Plans
Not all children with medical needs will require an individual healthcare plan. The school, healthcare professional and parent should agree, based on evidence, when a healthcare plan would be inappropriate or disproportionate. If consensus cannot be reached, the headteacher will take a final view. *See appendix H for example letter.*

Individual healthcare plans will often be essential, such as in cases where conditions fluctuate or where there is a high risk that emergency intervention will be needed. Plans are also likely to be needed in cases where medical conditions are long-term and complex. Plans provide clarity about what needs to be done, when and by whom. A flow chart for identifying and agreeing the support a child needs, and developing an individual healthcare plan is provided at appendix I.

Individual healthcare plans should capture the key information and actions that are required to support the child effectively. The level of detail within plans will depend on the complexity of the child's condition and the degree of support needed. This is important because different children with the same health condition may require very different support. Individual healthcare plans, and their review, may be initiated, in consultation with the parent, by a member of school staff or a healthcare professional involved in providing care to the child. Plans will be drawn up in partnership between the school, parents, and a relevant healthcare professional, e.g. school, specialist or children's community nurse, who can best advise on the particular needs of the child. Pupils will also be involved whenever appropriate. Partners should agree who will take the lead in writing the plan, but this is usually the Medical Team. Plans are reviewed at least annually or earlier if evidence is presented that the child's needs have changed. Plans are developed with the child's best interests in mind and ensure that the school assesses and manages risks to the child's education, health and social well-being and minimises disruption (*see appendix J for example*).
Where a child has SEND but does not have an EHC plan, their special educational needs will be referred to in their individual healthcare plan. Where the child has a special educational need identified in an EHC plan, the individual healthcare plan will be linked to or become part of that EHC plan. Where a child is returning to school following a period of hospital education, the school will work with the appropriate hospital school or the Hospital and Outreach Education to ensure that the individual healthcare plan identifies the support the child will need to reintegrate effectively.

Pupils too ill to attend school
When pupils are too ill to attend, the school will establish, where possible, the amount of time a pupil may be absent and identify ways in which the school can support the pupil in the short term (e.g. providing work to be done at home in the first instance). The school will make a referral to the medical needs team as soon as they become aware that a child is likely to be or has been absent for 15 school days. Where children have long-term health needs, the pattern of illness and absence from school can be unpredictable, so the most appropriate form of support for these children should be discussed and agreed between the school, the family, the medical needs team and the relevant medical professionals.

3.0 Medicines in school

Managing medicines on school premises
Where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours. Medicines will only be administered at school when it would be detrimental to a child's health or school attendance not to do so.
No child under 16 will be given prescription or non-prescription medicines without their parent's written consent. This includes those prescribed on residential trips.
The school only accepts prescribed medicines that are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin which must still be in date, but will generally be available inside an insulin pen or a pump, rather than in its original container.
All medicines are stored safely. Children are informed of where their medicines are at all times and are able to access them immediately with the support of staff. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens are always readily available to children and not locked away. Asthma medication is stored in classrooms, allergy medication is in the medical room. Controlled drugs such as ADHD medication are securely locked in the medical room.
If it is necessary to store medicines in the fridge, this will be stated on the label. Medicine is stored in the fridge in the Small Kitchen which is not accessible to children, medicine should be stored on a separate shelf. A child under 16 will never be given medicine containing aspirin unless prescribed by a doctor. Medication, e.g. for pain relief, will never be administered without first checking maximum dosages on the administration of medication record, and when the previous dose was taken. Parents will be informed.

School staff may administer a controlled drug e.g. Ritalin, to the child for whom it has been prescribed. Staff administering medicines will do so in accordance with the prescriber's instructions. The school keeps a record of all medicines administered to individual children, stating what, how and how much was administered, when and by whom. Any side effects of the medication to be administered at school should be noted.
It should be noted that it is not permissible for anyone other than prescribed medical personnel, to issue medicines to employees whilst they are at work.

4.0 Administration of Regular Medication in Schools

Named Person – Mrs Pip Gilbert shall be responsible for medicines in school, together with Inclusion Lead.

Parental Responsibility
A written statement of parents' responsibility should be given to all parents detailing the need to;

a) Inform the school in writing of all medicines to be given at school, by completing a school medicine record (Appendix B). Records of use of asthma pumps must be recorded (Appendix C). If a pupil is to be given more than one medicine in school, a separate medicine record form should be completed for each,

b) Provide medicine to the school in the original container from the chemist and clearly labelled with:
   1. Child's name.
   2. Class.
   3. Name of medicine.
   4. Strength of medicine if appropriate.
   5. How much to be given (i.e. dose).
   6. When to be given.
   7. Expiry date if available.
   8. Any other instructions.

c) Notify the school in writing of any changes in medicines.

d) Make suitable arrangements to replenish the supply of medicines if necessary.

Medication should only be taken to school when absolutely essential. Parents should be encouraged to request, where possible, that medication be prescribed in dose frequencies which enable it to be taken outside school hours. Medication prescribed to be taken three times a day will not be administered as this can be given at home as the school nursing team confirm that such medication can be administered three times over 24 hours.

Paracetamol is the only pain relieving drug which may be given to pupils. On no account should aspirin or preparations containing aspirin such as "Disprin" be given to pupils. This is particularly important where children under 12 years of age are concerned. Paracetamol should NOT be given to children who are receiving other medication without written permission from parents. It should NOT be given to children with known liver or kidney disease **or after a recent head injury.** Paracetamol may be given for the relief of pain, headaches, painful or difficult menstruation, and sore throats. Prior to any medication being given a check should be made to ensure that the child has not taken any other medication earlier that day, including any medicine bought over the counter (e.g. Calpol, Lemsip). Always check and write down the time of the last dose of medication taken, what the medication was and the amount taken. Always check for any known allergies.

Administration
The label on the medicine container should be checked against the school medicine record. Any discrepancy should be queried with the parent before administering a medicine. **Parents should confirm any changes of dose and the reason for it in writing.** For liquid medicines make sure a 5 ml medicine spoon or an oral dose dispenser (for quantities less than 5 ml) together with instructions has been sent in by the parent:

a) Confirm the identity of the pupil.

b) Check the school medicine record to see if the medicine is being given at the right time e.g. midday, before or after food etc, and has not already been given by another member of staff.
c) Check the name of the medicine on the container against the name of the school record.
d) Check the dose, e.g. 1 or 2 tablets, 5 or 10 mls, 1 or 2 puffs.
e) Measure the dose, without handling the medicine. If it is a liquid, shake the bottle before measuring and pour away from the label. If it is a soluble or dispersible tablet, add to half a glass of water and wait for it to dissolve or disperse.
f) Give the medicine to the pupil and watch him/her take it. Always give the pupil a glass of water to "wash" the medicine into the stomach.
g) Wash the spoon or oral dose dispenser if used.
h) Return the medicine and spoon etc to the appropriate storage area.

Recording (see Appendix A)
A record should be kept of doses given on the school medicine record (Appendix A), or Asthma record (Appendix B) The medicine record should be kept in the medical room.

Disposal
Medicines no longer required should not be allowed to accumulate. They should be returned to the parent in person for disposal. All medicines have an expiry date after which they should not be used. If the medicine has been dispensed in the manufacturer's original pack the expiry date will be known. If the expiry date is not known, medicines should usually be safe to use for up to 12 months after the date of dispensing, provided they are stored at the correct temperature.

Some medicines e.g. insulin, eye drops and eye ointments have to be discarded 4 weeks after opening (this information is stated on the pack). The date of opening must always be recorded on the container for these preparations.

Any medication which is out of date will be disposed of, any medication not collected by parents when a child leaves the school will be disposed of after two weeks, by being taken to a pharmacy by the named persons as above.
Sharps boxes will always be used for the disposal of needles and other *sharps. (*If you require advice on disposal of sharps or clinical waste such as nappies contact Bedford Borough Council 01234 718011 or email tradewaste@bedford.gov.uk).

Emergency Situations
Where a child has an individual healthcare plan, this will clearly define what constitutes an emergency and explain what to do, including ensuring that all relevant staff are aware of emergency symptoms and procedures. Other pupils in the school will be informed what to do in general terms, such as informing a teacher immediately if they think help is needed. If a child needs to be taken to hospital, staff will stay with the child until the parent arrives, or accompany a child taken to hospital by ambulance.
If a child without a healthcare plan has a medical emergency, the school will follow their emergency first aid procedures and first aid will be provided by a qualified member of staff until a paramedic arrives

Day trips, Residentials and Sporting Activities
Pupils with medical conditions are actively supported to participate in school trips and visits, or in sporting activities. In planning such activities, teachers will undertake the appropriate **risk assessment** and will take into account how a child's medical condition might impact on their participation.
Arrangements for the inclusion of pupils in such activities with any required adjustments will be made by the school unless evidence from a clinician such as a GP states that this is not in the child's best interests.
For residential visits, school staff may administer non-prescription medicines, provided that written consent and medication are provided by parents/carers in advance.

Home-to-School Transport Arrangements for children with Medical Needs
Where required the school will develop transport healthcare plans for pupils with life-threatening conditions. Relevant information will be shared with the local authority/ transport provider to ensure that risks are managed and all staff involved in the transportation of the child are informed.

Liability and Indemnity
The school's insurance arrangements are sufficient and appropriate to cover staff providing support to pupils with medical conditions. Staff providing such support are entitled to view the school's insurance policies.

Complaints
If parents or pupils are dissatisfied with the support provided they should discuss their concerns directly with the school in the first instance. If for whatever reason this does not resolve the issue, they may make a formal complaint via the school's complaints procedure

5.0 Defibrillator
We have two Defibrillators in school, one which is stored in the Medical room and the second in the new build hall cupboard. All first aid trained staff have been trained on the use of it in the event of an emergency.

Reviewed date: January 2024

Next review date: January 2025

Date: 23.1.24

Staff responsible: Pip Gilbert and Inclusion Lead

Appendix A: School Medical Record

SCHOOL MEDICINE RECORD

Child's Name
Class/tutor Group
Name of medicine

Strength of medicine if appropriate

How much to give (i.e. dose)

When to be given

Any other instructions (include details for inhalers if any)

Phone No. of parent or adult contact

Tick appropriate box

Medicine to be left at school ☐

Medicine to be taken home each day e.g.antibiotics ☐

In consideration for the Headteacher or the school staff agreeing to give medication to my/our above named child during school hours, I/we agree to indemnify the Headteacher, the school staff and the Local Education Authority against all claims. Costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Headteacher, the school staff. I acknowledge that the staff Goldington Green will not be held responsible if we do not administer the medicine on time, or are unable to do so. Parents/ carers may come in and administer medication themselves.

Parent/Carer's signature. _____Date_____

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

DATE													
TIME GIVEN													
SIGN													

Date medicine returned to parent on completion of course of medicine. _____

Bedfordshire Asthma Friendly Schools

Local Services, Local Solutions

NHS Bedfordshire Clinical Commissioning Group

Contents:

Introduction

Asthma is a long-term condition that affects your airways - the tubes that carry air in and out of your lungs. You could say that someone with asthma has 'sensitive' airways that are inflamed and ready to react when they come into contact with something they don't like.

Asthma tends to run in families, especially when there's also a history of allergies and/or smoking.

When a person with asthma comes into contact with something that irritates their sensitive airways even more (an asthma trigger), it causes their body to react in three ways:

1. the muscles around the walls of the airways tighten so that the airways become narrower
2. the lining of the airways becomes inflamed and starts to swell
3. sticky mucus or phlegm sometimes builds up, which can narrow the airways even more.

These reactions cause the airways to become narrower and irritated - making it difficult to breathe and leading to asthma symptoms, such as chest tightness, wheezing, or coughing.

In the UK, around 5.4 million people are currently receiving treatment for asthma. That's one in every 12 adults and **one in every 11 children**. Asthma affects more boys than girls. Asthma in adults is more common in women than men. Asthma can sometimes be defined as a type, such as 'occupational'. Approximately five per cent of people with asthma have severe asthma.

Having asthma has implications for a child's schooling and learning. Appropriate asthma care is necessary for the child's immediate safety, long-term well-being, and optimal academic performance. Whilst some older children may be fully independent with their condition younger children, children with learning difficulties or those newly diagnosed are likely to need support and assistance from school staff during the school day, to help them to manage their asthma in the absence of their parents/carers.

The 2010 Children, Schools and Families Act and the Children and Families Act 2014 introduce a legal duty on schools to look after children with medical conditions. This is inclusive of children with asthma and it is therefore essential that all school staff and those who support younger children have an awareness of this medical condition and the needs of pupils during the school day.

Purpose of this document

This policy sets out how we, as a school, support students with asthma. We work closely with students, parents/carers and health colleagues to ensure we have robust procedures in place to support asthma management.

This policy reflects the requirements of key legislation (appendix 1- Legislation) and in particular two key documents:

1. Supporting pupils at school with medical conditions (2014)[1]
2. Guidance on the use of emergency salbutamol inhalers in schools (2015)[2]

To enable schools to effectively manage children and young people with asthma in a school setting and be an Asthma Friendly School:

- The school should have an up to date asthma policy that is self-audited regularly.
- The school should have two designated asthma leads.
- The school will maintain a register of children and young people with asthma that will be shared with school, staff and the School Nursing Service.
- Every child with asthma should have personal asthma plan (where required), from their doctor or specialist healthcare professional, which is shared with school, staff and School Nursing Service.
- There will be whole school training around asthma, signs and symptoms and what to do in an emergency as part of medicines management training.
- Children and young people should have easy access to their inhalers and spacers. These may be kept by the child, in the classroom or in the main office as deemed appropriate by the child, parent/carer and school.

1 Department of Health (2014) Supporting Pupils at school with medical conditions available at https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions—3

2 Department of health (2015) Guidance on the use of emergency salbutamol inhalers in schools https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416468/emergency_inhalers_in_schools.pdf

Asthma Friendly School Statement
We are an asthma friendly school and have audited our school practices and procedures in line with the recommendations in this policy. This means we advocate inclusion, are clear on our procedures and have designated Asthma Leads to ensure these are adhered to.

We welcome parents/carers' and students' views on how we can continue to improve and build upon our standards.

The school recognises that asthma is a prevalent, serious but manageable condition and we welcome all students with asthma.

We ensure all staff are aware of their duty of care to students. We have a 'whole school' approach to regular training so staff are confident in carrying out their duty of care, and students know what to do if a child with asthma feels unwell.

Our two School Designated Asthma Leads are:

1 Mrs Pip Gilbert. Role: School Business Manager

2 Deputy Headteacher - Inclusion

Designated asthma leads ensure procedures are followed and a 'whole school' approach to training is delivered.

This policy will be reviewed annually by:

Senior Management Team, Chair of Governors and The designated Asthma Leads

We commit to auditing our procedures yearly and publishing our annually reviewed Asthma Policy on our school website.

Signed

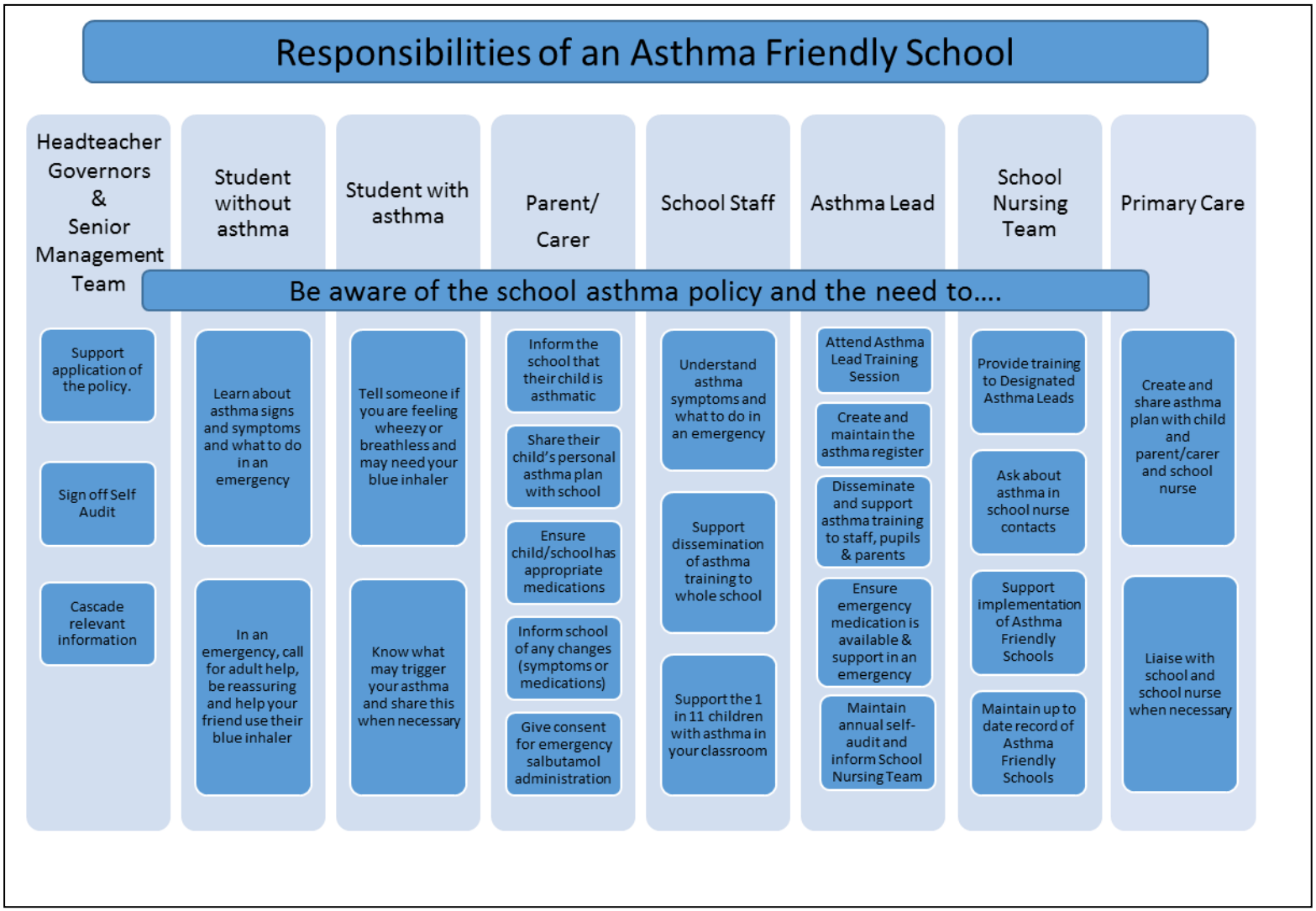
……..
Date

……..

Review Date

……..

Summary of Asthma Friendly School Policy



Responsibilities:

Head teachers, Governors & Senior Management Team:

- Support school community to implement the policy.
- Signing off of the self-audit.
- Cascade relevant information to school staff and pupils.

Students:

Without asthma

- Learn about asthma, the signs and symptoms and what to do in an emergency.

With asthma

- Tell someone if you are feeling wheezy or breathless and may need your inhaler.
- Know what things can makes your asthma worse and tell a member of staff, so they can help you avoid it.
- Attend school asthma support sessions.

Parents/Carers:

- Inform the school if their child has asthma.
- Ensure their child has an up to date personal asthma plan (where required) from their doctor or specialist healthcare professional which is shared with the school.
- Inform the school of any changes to their child's condition.
- Ensure their child has regular reviews with their doctor or specialist healthcare professional.
- Parents need to confirm in writing, where consent is not given to the school, to administer salbutamol in the case of an emergency (see Appendix 7).

Medicines

- Inform the school about the medicines their child requires during school hours.
- Provide the school with one inhaler and spacer, labelled with their full name and date of birth, in the original packaging detailing the prescription.
- It is the parent's responsibility to ensure new and in date medicines come into school on the first day of the new academic year. Ensure that their child's medicines are within their expiry dates and dispose of out of date medicines.
- Inform the school of any medicines the child requires while taking part in visits, outings, field trips and other out-of-school activities such as school sports events

School Staff:

Knowledge

- Read and understand the school's asthma policy and attend school asthma training yearly (as part of the medicines management training, as directed by the head teacher).
- Be aware of the potential triggers, signs and symptoms of asthma and know what to do in an emergency.
- Know which students have asthma.
- Be aware that asthma can affect a student's learning and provide extra help when needed.

- Be aware of children with asthma who may need extra support.

Supporting asthma management in your school

- Allow all students to have immediate access to their emergency medicines. All students are encouraged to carry and administer their own inhaler when their parents/carers and health care provider determine they are able to start taking responsibility for their condition. Students, who do not carry and administer their own inhaler, should know where their inhalers are stored.
- Ensure students have the appropriate medicines with them during activity or exercise and are allowed to take it when needed.
- Ensure students who carry their inhalers and spacers with them, have them when they go on a school trip or out of the classroom.
- All staff attending off site visits should be aware of any students on the visit with asthma. They should be trained about what to do in an emergency.
- Ensure students with asthma are not excluded from activities they wish to take part in.
- Understand asthma and the impact it can have on students. If school identify a pattern or are concerned about an individual student they will inform parent/carer and advise medical advice should be sought.
- Get involved in the whole school training around asthma and use opportunities such as Personal Social Health Education (PSHE) to raise pupil awareness about asthma (see link for materials) www.asthma.org.uk

Communication and record keeping

- Maintain effective communication between parents/carers and the school including:
  - Informing parents/carers if their child has been unwell at school or if there is a pattern of asthma symptom.
  - Communicate any parental/staff concerns and updates to the designated Asthma Leads.
  - Liaise with parents/carers, the student's healthcare professionals, and special educational needs coordinator and welfare officers if a child is falling behind with their work because of their condition.

- If an inhaler has been used
  - Staff must record the usage in the record of emergency inhaler administered form. (see Appendix 2 – Record of emergency inhaler administered to pupils).
  - Staff must inform the designated asthma lead if a school emergency inhaler has been used.
  - Parents should be notified when the emergency inhalers has been used (see Appendix 3).

Designated Asthma Leads:

The Designated Asthma Lead will:

- Attend the Asthma Lead training provided by the School Nursing Service, updating knowledge and skills at least every 3 years.
- Ensure there is an up to date school asthma register (see Appendix 6).
  - All children on the register have opt out consent status recorded for use of emergency salbutamol inhaler, their own inhaler and spacer and personal asthma plan shared with the school (see Appendix 7).
  - Share the asthma register with staff and the School Nursing Service.

- Parents/carers should be notified by the designated asthma lead if a student is using their inhaler an additional 3 times per week, over what is stated on their care plan. (See Appendix 4 Specimen letter (increased inhaler use)).
- If a student refuses to use their inhaler or spacer the parent should be informed. (See Appendix 5 – Specimen letter (refusal to use inhaler/spacer))
- Arrange school-based asthma support sessions, these can be through assemblies, parent updates, form time or PSHE time.
- Carry out an Asthma Friendly School Audit annually with Senior Team and publish the policy on the school website (See Appendix 8 - audit checklist).
- Be confident to support in an emergency situation.

Medicines

Asthma Leads will ensure that:

- Schools have an adequate supply of Emergency kits and know how to obtain these from their local pharmacy (for further information please see resources page).
    - Emergency kits are checked regularly and contents replenished immediately after use (See Appendix 9).
    - The blue plastic inhaler 'housing' is cleaned and dried and returned to the relevant Emergency kit after use.
- Individual spacers are washed regularly according to instructions; washed in warm soapy water and left to dry for approximately 15 minutes.
- Expiry dates of all medicines are checked monthly and impending expiry date are communicated to parent/carer.

School Nursing Team:

- Provide a rolling programme of Asthma Leads training. Staff to attend every 3 years.
- Deliver medicines management training to schools.
- Ask about asthma in appropriate school nurse contacts.
- Liaise with the child, parent/carer, school and other healthcare professionals to support effective asthma management where required.
- Support schools with the implementation of Bedfordshire Asthma Friendly Schools.
- Keep up to date records of training offered and attended.

PE and activities

- Children and young people with asthma will have equal access to extended school activities school productions, after school clubs and residential visits.
- PE teachers will be sensitive to students who are struggling with PE and be aware that this may be due to uncontrolled asthma. Parents/carers should be made aware so medical help may be sought.
- Staff will have training and be aware of the potential social problems that students with asthma may experience.
- Staff use opportunities such as personal, social and health education (PSHE) lessons to raise awareness of asthma amongst students and to help create a positive social environment and eliminate stigma. School staff understand that pupil's with asthma should not be forced to take part in activity if they feel unwell.
- Staff are trained to recognise potential triggers for pupil's asthma when exercising and in other settings and are aware of ways to minimise exposure to these triggers.

- Physical Education (PE) teachers should make sure students have their inhalers with them during PE and take them when needed, before during or after PE.
- Risk assessments will be carried out for any out of school visit and asthma is always part of this process. Factors considered include how routine and emergency medicines will be stored and administered and where help could be obtained in an emergency. We recognize there may be additional medicines, equipment or factors to consider when planning residential visits. These may be in addition to any medicines, facilities and healthcare plans that are normally available in school.
- In an emergency situation school staff will be required under common law duty of care, to act like any reasonable parent. This may include administering medicines. We have posters on display in school that reiterates the steps to take during an emergency.

School environment

- The school environment, as far is possible, is kept free of the most common allergens that may trigger an asthma attack.
- Smoking is explicitly prohibited on the school site.
- We are aware that chemicals in science, cookery and art have the potential to trigger an asthma response and will be vigilant to any student who may be at risk from these activities. We will not exclude students who are known to have specific chemical triggers but will endeavour to seek an alternative.
- Cleaning and grass cutting should, where possible, be carried out at the end of the school day. When not possible, staff will reduce exposure where possible by shutting windows and/or offering alternative places for break or lunchtimes to students where this is a trigger.
- Staff will be made aware of high air pollution, high pollen days and reduce exposure or modify student activities/medications accordingly.

Students who miss time off school due to their asthma

- As a school we monitor student absence. If a student is missing a lot of time off school due to their asthma or we identify they are constantly tired in school, staff will make contact with the parent to work out how we can support them.
- The school will liaise with the School Nurse and/or other health professional to ensure the student's asthma control is optimal.

Asthma Attacks

- Staff are trained to recognise an asthma attack and know how to respond. The procedure to be followed is clearly displayed on posters. Please also see appendix 10 for sample poster.
- If a child has an asthma attack in school a member of staff will remain with them throughout, and administer their inhaler in accordance with the emergency procedure. (**No student will ever be sent to get their inhaler** in this situation, the inhaler will be brought to the student).
- Emergency services and parents/carers will be informed.
- A member of staff will accompany the student to hospital until their parent/care giver arrives.

Safe Storage and Disposal

- All inhalers are supplied and stored, wherever possible, in their original containers. All medicines need to be labelled with the student's name and date of birth, the name of the medicine, expiry date and the prescriber's instructions for administration, including dose and frequency. All medicines are kept in the medical room, except for inhalers which are stored in pupil's classrooms.
- Medicines are stored in accordance with instructions paying particular note to temperature.

- All inhalers and spacers are sent home with students at the end of the school year. Medicines are not stored in school over the summer holidays.

Emergency medicine

- Emergency medicines are readily available to students who require them at all times during the school day whether they are on or off site.
- Students who are self-managing are reminded to carry their inhalers and spacers with them at all times.

Disposal

- Parents/carers are responsible for collecting out of date medicines from school.
- A named member of staff is responsible for checking the dates of medicines and arranging for the disposal of those that have expired. This check is done at least 3 times a year.
- Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled. Schools should be aware that to do this legally, they should register as a lower-tier waste carrier, as a spent inhaler counts as waste for disposal. Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years (https://www.gov.uk/waste-carrier-or-broker- registration).

Appendix 1 – Legislation

The Children and Families Act 2014
Section 100 of the Children and Families Act 2014 introduced a legal duty on schools to look after children with medical conditions. This is inclusive of children with diabetes. Schools must make arrangements to support pupils at school with medical conditions and have regard to the statutory guidance: Supporting pupils at school with medical conditions.

The Education Act 2002
Sections 21 and 175 detail how governing bodies of maintained schools must promote the wellbeing of pupils and take a view to the safeguarding of children at the school.

Section 3 of the Children Act 1989
This places a duty on a person with the care of a child to do all that is reasonable in the circumstances for the purposes of safeguarding and promoting the child's wellbeing. With relation to a child with asthma, this will mean knowing what to do in the event of an emergency.

Legal duties on local authorities
Local authorities have legal responsibilities to help make sure schools can meet the duties relating to children with asthma. These duties both refer to all children in the local authority and they do not depend on the kind of school the child attends.

Section 10 of the Children Act 2004
This is a particularly important piece of legislation if schools are struggling to get the support and training they need to allow them to look after a child with asthma properly.

Section 10 essentially means the local authority must make arrangements to promote cooperation between the authority and relevant partners. Relevant partners include the governing body of a maintained school, the proprietor of an academy, clinical commissioning groups and the NHS Commissioning Board.
They must make arrangements with a view to improving the wellbeing of children, including their physical and mental health, protection from harm and neglect, and education.

Section of 17 of the Children's Act
This gives local authorities a general duty to safeguard and promote the welfare of children in need in their area. If a school is looking after a child with asthma so poorly that the child is put in danger, the local authority must step in.

Legal duties on the NHS Section 3 of the NHS Act 2006
This gives Clinical Commissioning Groups (CCGs) a duty to arrange for the provision of health services to the extent the CCG considers it necessary to meet the reasonable needs of the persons for whom it's responsible. What this means is that CCGs should provide the healthcare the people in its area need, if these needs are reasonable.
This section also provides for CCGs to arrange such services as it considers appropriate to secure improvements in physical and mental health of, and in the prevention, diagnosis and treatment of illness, in the persons for whom it's responsible.
In relation to children with asthma, this means that a CCG should, within reason, make sure support and health care is in place to improve their health or at least keep them healthy. Poor management of asthma at school will obviously affect the health of a child. If a school is unable to get the support it needs to help manage a child's asthma successfully then both the local authority and the local CCG have a responsibility to the child's health and welfare.

Equality Act (2010)
The equality act says that types of discrimination are illegal, defining discrimination as when a person with a disability is treated less favourably, because of his or her disability, than a person who does not have a disability. The Equality Act 2010 defines a disability as a 'physical or

mental impairment' that has 'a substantial and long- term adverse effect' on an individual's ability to carry out 'normal day-to-day activities'. A substantial adverse effect is a negative effect that is more than trivial, and the effect is long-term if it has lasted or is expected to last for more than twelve months. Whilst only a court or tribunal can decide whether a person with diabetes is covered by the definition, in many cases diabetes is covered by the definition in the Act. Education and early years providers have a duty to make reasonable adjustment for people with disabilities and failure to make reasonable adjustments is a form of discrimination. The Act covers all schools and providers of early years settings that are covered by the early years framework in England, including maintained (non-fee paying) and fee-paying schools.

Appendix 2 - Record of emergency inhaler administered to pupils.

Name of school/setting_____

Date	Child's name	Time	Name of medicine	Dose given	Spacer cleaned	Signature of staff	Print name

Parents should be notified if a student is using their inhaler more frequently than 3 times per week more than stated on their care plan. For example, some students will use their inhaler routinely before PE.

Please be aware of those students who carry their own inhaler and self-medicate.

Appendix 3 - Specimen letter (emergency inhaler used)

To inform parents of emergency salbutamol inhaler use

SCHOOL NAME HERE

Child's name: .....

Class: .....

Date: .....

Dear .....

This letter is to formally notify you that…….has had problems with their breathing today.

This happened
when…….

They did not have their own asthma inhaler with them, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given …… puffs.

Although they soon felt better, we would strongly advise that your child is seen by their own doctor as soon as possible.

Please can you ensure your child brings in a working in-date inhaler and spacer for use in school both should be clearly labelled with your child's name and date of birth

Yours sincerely,

Appendix 4 - Specimen letter (increased inhaler use)

To inform parents/carers of pupil increased inhaler use (3X more than stated on personal asthma plan)

School name here

Date

Dear .....

<insert child's name> has required their reliever inhaler on the following occasions this week.

Mon (date) – state am or pm or both ☐
Tues (date) – state am or pm or both ☐
Wed (date) – state am or pm or both ☐
Thurs (date) – state am or pm or both ☐
Fri (date) – state am or pm or both ☐

We have been advised to inform you of this in line with our asthma policy as you may wish to take your child to see their GP or practice nurse for a review.

Yours sincerely,

Appendix 5 - Specimen letter (refusal to use inhaler/spacer)
(A telephone call maybe more appropriate)

To inform parent of student refusal to use inhaler or spacer

School name here

Date

Dear .....

We have been advised to inform you that ..... has declined to use their inhaler today.

We have been advised to inform you of this in line with our asthma policy as you may wish to discuss this with your child.

Yours sincerely,

Appendix 6 - School Asthma Register

School Name -

Name	Class	Date of birth	Parent/carer opted out of emergency inhaler use	Relevant Information

Appendix 7 – Parent Asthma Letter

Dear Parent/Guardian

We are currently reviewing our asthma policy and would kindly ask you to up-date the information regarding your child so we can ensure our school records are accurate.

As part of our work to review our asthma policy we will have an Emergency inhaler on site. This is a precautionary measure. You still need to provide your child with their own inhaler and spacer as prescribed. If you **do not** wish for us to use the schools inhaler in an emergency, please fill in the details below and return to school as soon as possible.
Please note that everyone with asthma should use a spacer with their inhaler in order to deliver maximum benefit to the lungs. If your child does not have a spacer or has not had an asthma review in the past 12 months, please book an appointment with your GP as soon as possible.

Please complete the information below and return to school

Many Thanks

Yours Sincerely

1. I can confirm that my child has been diagnosed with asthma ☐
2. I can confirm my child has been prescribed an inhaler ☐
3. My child has a working, in-date inhaler, and Spacer clearly labelled with their name, which they will bring with them to school every day. ☐
4. I will have provided the school with a spare inhaler and spacer ☐
5. Please tick if you **DO NOT** wish the school to use the schools inhaler in an emergency ☐

Signed: _____

Date: _____

Print name: _____

Child's name: _____

Class: _____

Appendix 8 – Self Audit Checklist

Name of School: Goldington Green Academy
Asthma Leads: Pip Gilbert, Sarah Sears
Date of Audit:
Date of Follow up:

Bedfordshire Asthma Friendly School Checklist			
Action	**Details**	**Yes/No**	**Action required**
1 Policy **School's policy should be available to view. All staff should be aware of where it is kept.**	Policy reviewed by SLT and Chair of Governors. Amended the Template policy to reflect internal procedures. All staff and parents are aware of the policy. Policy on School Website. Date for review. Named contact that has responsibility for review of policy. Asthma Leads are easily identified by staff members.		
2 **Asthma Register**	Register Should clearly state name and DOB of student and if parents/carers have opted out to administer emergency inhaler. Ensure register is updated regularly with new/newly diagnosed students. Register to be readily displayed/available to all school staff.		
3 **Emergency Kits/Procedures**	Emergency Kits (minimum of 2 in any school) conveniently located at key points throughout the school. Staff aware of where these are, have easy access to kits and know what to do in an emergency. Emergency Kit for off - site activities/evacuation of building. Emergency kits contain checklist and clear procedures on monitoring use and contents.		

Action	Details	Yes/No	Action required
4 **Individual Health Care Plan (IHCP)** **Recording use of students' medications** **Students who self-manage** **Storage of inhalers/spacers**	Students have a care plan prepared by GP/healthcare professional and it is easily located in school. Students have access to their inhaler. Records kept of medication usage and parents informed promptly of any incidents/usage outside of care plan. Check that if recording takes place in more than one location i.e. classroom and office – the record is amalgamated to clearly reflect frequency of use. Ideally there should be 1 record. Students should be encouraged to self-manage their condition where appropriate. Where students self-manage a spare inhaler and spacer must be kept in school. Asthma medication and spacer is clearly labelled and stored in a cool location. Expiry dates are checked regularly by staff and replaced when required. Inhaler is administered via a spacer. Spacers are washed in accordance with the policy.		
5 **Whole School Training**	Asthma training should be taken up by school staff annually, as part of medicines management training. Asthma support is planned for the whole school community/pupils by the designated Asthma Leads.		

Appendix 9 - The Emergency Kit Checklist:
An emergency asthma inhaler kit should include:

	Yes	No	Checked by/date
A salbutamol metered dose inhaler			
Once used the spacer should be washed in accordance with the guidance, in warm soapy water and leave to air dry			
Instructions on using the inhaler and spacer/plastic			
Instructions on cleaning and storing the inhaler			
Manufacturer's information;			
A checklist of inhalers, identified by their batch number and expiry date, with monthly checks			
A note of the arrangements for replacing the inhaler and			
A list of children permitted to use the emergency inhaler as detailed in their individual healthcare plans (asthma			
A record of administration (i.e. when the inhaler has been used).			
Pen			
Asthma Leads Details 1.Mrs Pip Gilbert 2.Mrs Sarah Sears			

Appendix 10 – Sample Poster

You're having an asthma attack if any of the following happens:

- Your reliever isn't helping or lasting over four hours
- Your symptoms are getting worse (cough, breathlessness, wheeze or tight chest)
- You're too breathless or it's difficult to speak, eat or sleep
- Your breathing is getting faster and it feels like you can't get your breath in properly

If you go to A&E (Accident and Emergency) or are admitted to hospital, if possible take your written asthma action plan with you so staff can see details of your asthma medicines.

Useful resources:
Where to find more information online

Legislation

http://www.legislation.gov.uk/ukpga/2010/26/pdfs/ukpga_20100026_en.pdf

http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf

Department for Education Guidance

Emergency asthma inhalers in schools

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416468/emergency_inhalers_in_schools.pdf

https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

Bedfordshire School Nursing Service

http://www.sept.nhs.uk/schoolnursingbeds

Asthma UK For more information and training:

https://www.asthma.org.uk/

Appendix C: Epilepsy

EPILEPSY

1. Definition/Description

1.1 Epilepsy results from abnormal electrical activity in the brain causing physical effects which depend on the area of brain involved (fits, seizures).

1.2 There are many kinds of epilepsy and definitions and terminology are constantly changing. The most common kinds are:-

a) Absences (petit mal); - The child appears vacant for a few seconds, but does not fall to the ground or twitch. He/she then carries on as if nothing has happened, and is usually unaware of the 'absence'.
b) Major seizures (tonic-clonic convulsion, grand mal, fit) - There is generalised twitching or jerking with loss of consciousness and often incontinence. On recovery the child may be drowsy, have a headache, be anxious or confused. Major seizures are alarming to witness.
c) Focal or partial seizures. - These may involve twitching of one area of the body, without loss of consciousness, or simply behaviour changes and/or a state of unaltered consciousness (dazed appearance).
d) Note c) can progress to b) and some children have more than one type of attack.

2. Frequency

2.1 About 6 in every 1000 children have epilepsy. Most are well controlled and will never have a fit in school (some only have fits during sleep).

2.2 A very few have frequent fits.

3. Treatment

3.1 There are several anti-epileptic drugs in common use, and a lot more being evaluated.

3.2 Different drugs work best for different kinds of epilepsy.

3.3 Most children will take their medication twice a day at home, but a few will need a dose in school.

3.4 The regular medication will not cut short an existing seizure. Other medication such as rectal valium (diazepam) may do so. If a child has been prescribed rectal valium, members of staff may wish to learn how to administer it. Some children can be vulnerable to consecutive fits which, if left uncontrolled, can result in permanent damage. In an emergency situation it is necessary for rectal diazepam to be administered.

4. Implications of Epilepsy

4.1 Epilepsy is common in children with learning difficulties: the converse is not true.

4.2 Uncontrolled ‘absences’ can be very frequent, merging into each other (non-convulsive status epilepticus) producing a withdrawn child who cannot learn. Establishing control may produce a dramatic difference.

4.3 Most anti-epileptic drugs can have side effects, particularly drowsiness and poor concentration. It may be necessary to tolerate some side-effects, and their effect on learning, in order to maintain control, but marked drowsiness, or frequent seizures should be reported to parents so that they can inform the doctor and consider changes in treatment.

4.4 Some epileptic children may be “triggered” by flashing lights. They may not be able to watch TV or use VDUs, or extra care may need to be taken about distance from the screen and ambient lighting. Check with parents and school doctor/nurse if this is suspected.

4.5 Most epileptic children can participate safely in most activities, but will need extra supervision for swimming, PE activities involving climbing and practical classes (science, technology). A few severely affected children may not be able to do these things, and may need to wear protective headgear.

4.6 There are career implications, and epileptic pupils should receive careers advice as early as possible.

4.7 The effect of epilepsy on the child’s friends should be remembered, and it may be necessary to organise discussions for their benefit (do not embarrass the sufferer).

5. Management of a Major Seizure

5.1 These are alarming to witness and other children may need a lot of reassurance afterwards.

5.2 When a fit occurs, try to prevent injury – if possible move the furniture rather than the child. Do not try to force anything into the mouth.

5.3 As soon as possible (when major twitching stops) put the child in the recovery position. Keep calm, and try to keep the rest of the class away – if possible screen the area where the child is.

5.4 As the child starts to come round, talk reassuringly, but encourage him/her to continue resting quietly. Many children like to sleep for a time after a fit, but some can rejoin normal activities within a few minutes.

5.5 It is not necessary to send the child home unless very drowsy or confused, but each instance should be judged individually.

5.6 If the fit persists for more than 5-10 miinutes then call an ambulance.

5.7 If a child has been prescribed rectal valium and a named member of staff has been trained on a volunteer basis to administer it then it should be given in accordance with the specific training for that child. This will greatly benefit the child. There would have been discussion with parent and doctor of this issue prior to the event.

5.8 Always inform the parent that a fit has occurred, even if the child does not need to go home or to hospital. A note to take home at the end of the day will often suffice.

6 Further Information

6.1 The National Society for Epilepsy produces a number of helpful leaflets and a video for teachers. The British Epilepsy Association also provides informative material.

National Society for Epilepsy
Chesham Lane
Chalfont St Peter
Bucks
SL9 ORJ

Tel: 01494 601300
UK Epilepsy Helpline: Tel: 01494 601400

British Epilepsy Association
New Anstey House
Gateway Drive
Yeadon
Leeds
LS19 7XY

Tel: 0113 2108800
Email epilepsy@bea.org.uk
Freephone Helpline: 0808 800 5050
Email helpline: helpline@bea.org.uk

Appendix D: Diabetes

DIABETES

1. Definition

Diabetes occurs when the body's production of insulin is inadequate to deal with the sugars and starches derived from food and circulating in the blood.

2. Treatment

2.1 Insulin has to be supplied (by injection) and the amount balanced against food intake and energy requirements.

2.2 This is a complex process and many different regimes are in use, tailored to the individual in terms of diet, as well as type and frequency of insulin injections. It is not always beneficial to try to reduce the frequency of injections.

2.3 Control is easier to establish in some children than others.

2.4 If the balance between insulin, food and activity is not maintained, the blood sugar will rise or fall. Both may cause problems, but the effects of high blood sugar occurs fairly slowly and are not usually relevant in school.

2.5 Low blood sugar (hypoglycaemia, insulin reaction) occurs much more quickly and requires prompt treatment with some form of sugar. If a diabetic child is unwell, it is safe to assume low blood sugar and give sugar. If you are right, the child will recover rapidly; if you are wrong, a little extra sugar will do no harm.

3. Recognition of Low Blood Sugar (Hypo)

3.1 A 'hypo' often occurs after exercise or before a meal, but not exclusively so. Diabetic children must therefore have their meals punctually.

3.2 The symptoms of a 'hypo' are variable. Most diabetic children will know when an attack is starting and how to treat it.

3.4 Parents will know how their child is affected, and should be asked to complete a card giving these details (cards are available from the British Diabetic Association) which should be readily available for reference.

Signs to look for are paleness, sweating, anxiety, drowsiness, confusion, behaviour changes (some may be tearful, some aggressive and rude). Sufferers may complain of blurred vision, headaches or nausea

4. Treatment of a 'Hypo'

4.1 Give sugar in an easily absorbed form (3 Dextrosol tablets, 55 mls Lucozade,) or, if the child is well enough to eat, whatever snack is usually carried. If there is no improvement within a few minutes, repeat the treatment.

4.2 If there is still no improvement, or if at any stage the child becomes unconscious or has a fit, then call an ambulance. Inform the parents but do not send the child home unless recovery is complete.

4.3 *Never* send a child who has had a 'hypo' home alone in case of another one, and *never* send an unwell diabetic child to the medical room unaccompanied in case of fainting on the way.

4.4 It is important to give sugar quickly, and therefore a supply should be available wherever a diabetic child is (older children may carry their own).

4.5 Because of the effect of exercise, it is vital that the PE teachers of diabetic children have a supply of sugar available on playing fields and at swimming pools, which may be some distance from the school buildings. This also applies on school trips, when extra food should also be taken in case of unexpected delays.

4.6 Remember to inform parents of all 'hypos' as their frequency is a guide as to how good control of the diabetes is.

5. General Considerations

5.1 Many diabetic children are advised to take a snack before exercise to prevent 'hypos'. This must always be allowed, and a supply of whatever the child likes kept in school.

5.2 It must also be understood that diabetic children must not be delayed at mealtimes and that there may be occasions when they need to eat a sweet in class to prevent a 'hypo'.

5.3 Most diabetic children can go on all school trips, but extra food should always be carried in case of unexpected delays.

6. Further Information

6.1 The Community Dietician can help with school meals and general advice.

6.2 The hospital diabetic clinic can provide a great deal of information and advice.

6.3 Diabetes UK produces a number of leaflets and a School Pack. Diabetes UK, 0207 636 6112, 10 Queen Anne Street, London W1M OBD.

6.4 Diabetes Information Centre, 01582 497152, 6/8 Lewsey Road, Luton. Community Dietician (Luton), 01582 497162, Luton and Dunstable Hospital.

Appendix E: Heart Problems

HEART PROBLEMS

1.0. Description

1.1 Children with heart problems need to maintain basic fitness as far as they are able, and overprotection can be just as harmful as pushing them too hard.

1.2 Most such children have a good idea of their abilities, and, unless there are specific instructions to the contrary, verified by a doctor, they should be allowed to take part in all normal school activities, including games and PE (indoor and outdoor) as far as they feel able. However, they must also be allowed to drop out and rest if they need to do so and must not be pushed into continuing until they feel ready. Very few will misuse this facility.

1.3 Some children with heart problems go blue very readily. This is alarming but not necessarily serious especially in cold weather. The normal colour will usually return once the child is warm and rested. If not, and if there are other symptoms (unusual breathlessness, dizziness, chest pain), then the parents should be contacted.

2.0 Further Information

From your school doctor and nurse.

British Heart Foundation 0207 79350185, 14 Fitzhardinge Street, London W1H 6DH.

Appendix F: ADHD

ATTENTION DEFICIT (HYPERACTIVITY) DISORDER – AD(H)D

1.0 Description

1.1 This disorder is characterised by inattention, impulsivity and hyperactivity. All three components are usually present, but in varying degree. The usual age of onset is 3-7 years, though it may be present from birth. There may be a hereditary element, particularly in girls. Recent work has shown abnormally low levels of neurotransmitter substances in the brains (especially the frontal lobes) of AD(H)D sufferers. A reduced level of glucose utilisation during brain activity has also been demonstrated.

1.2 Inattention is manifested by difficulty in concentrating, poor short term memory, appearing not to listen, constantly forgetting and losing things. Some children, particularly girls, frequently day dream, and may be thought to have “absences”.

1.3 Impulsivity is a tendency to act before thinking. These children interrupt, blurt out answers, have difficulty taking turns, may be easily led, and fail to recognise danger until too late.

1.4 Hyperactive children are always on the move, fidget even while seated, leave their seats on the slightest pretext, and are often noisy and talkative.

1.5 Only symptoms which have been present for at least 6 months, in at least two situations, (e.g. home and school) and are causing significant impairment, can be regarded as relevant. It is vital to remember this when completing checklists, as most of the symptoms of AD(H)D occur sometimes in most children.

1.6 Management is most appropriately arranged through a multi-disciplinary approach.

1.7 Teachers can help by providing a structured environment, breaking work into small manageable chunks, and making sure the child actually listens to instructions, which should be as short as possible. Rewards are more effective than punishment.

1.8 Behaviour management strategies can be suggested by the SLE for Behaviour and by the Child and Family Psychiatric Services.

A few children may be helped by dietary manipulation.

For those children who have not responded to the above measures, medication may be suggested.

2.0 Medication

2.1 This usually takes the form of stimulants, which have been shown to increase the amount of neurotransmitter substances available in the brain.

2.2 The most commonly used are Ritalin (methylphenidate), which is the same chemical family as amphetamines (speed) and is therefore a controlled drug, even though there is no evidence of addictive properties. Schools are advised to keep no more than a week's supply of Ritalin tablets for each pupil (residential schools may be exempt) and must be kept in a locked cupboard.

2.3 Ritalin is short acting – each dose lasts only about 4 hours, sometimes less. It is normally given in the morning and at lunchtime, and sometimes at teatime. The total dose, and the exact timing will vary from child to child. Schools may take the parents' word for the dose, but may prefer to get written confirmation from the child's medical advisor.

2.4 Ritalin is best given with or after food, in order to avoid appetite suppression and in general is not advised late in the day as it may prevent sleep (though a few children sleep better with a dose shortly before bedtime).

2.5 It is effective in 70-90% of cases and the effect is often dramatic. The best results are obtained when it is combined with behaviour management strategies.

3.0 Further Information

3.1 There is a very large volume of information available (including a website). Anyone interested should contact AD(H)D Information Service, P.O.Box 340, Edgware, Middlesex, HA8 9HL, Telephone 020 8905 2013. School nurses and doctors can also provide information.

Appendix G: Anaphylaxis

Appendix G

ANAPHYLAXIS

1.0 Description

1.1 There is a severe allergic reaction in which the body endangers itself in trying to get rid of a foreign substance. When a school becomes aware that a child is known to suffer from severe allergies, it is advisable to arrange a meeting with parents, relevant school staff, school doctor/nurse in order to draw up guidelines which meet the individual needs of the child and to arrange training for staff as appropriate.

1.2 It is important to realise that the stages described below may merge into each other as the reaction develops. If there is doubt about the stages and symptoms, the administration of medication is safe and should not be withheld. **Even if it is given through misdiagnosis, it will do no harm.**

2.0 Main Symptoms

Mild	**Moderate**	**Severe**
Skin rash	Difficulty in breathing	Severe difficulty in breathing
Mild swelling of face	Tightness in throat	Abdominal cramps, nausea
Generalised itching	Metallic taste	Pale and floppy
		Unconscious

Reactions may vary in severity on different occasions.

3.0 Trigger Substances

3.1 Nuts, especially peanuts, bee and wasp stings, fish, eggs, milk proteins, some drugs (e.g. penicillin), some fruits.

3.2 The reaction can be caused by unbelievably small amounts of the substance – some children will react just sitting next to someone with a peanut butter sandwich.

4.0 Prevention

4.1 Prevention is the mainstay of management. The sufferer should avoid all contact with the substance (if peanuts, it is wise to avoid all nuts as there may be cross-reactions).

4.2 If the child has school dinners, kitchen staff need to be aware that nuts should be avoided, including food where peanut oil is used in preparation (also known as groundnut oil or arachis oil). Many manufacturers will supply a list of nut-free products on request, and the community dieticians will also help.

4.3 In cookery/home economics classes, every effort should be made to avoid the offending substance. If unavoidable, the sufferer should probably not attend the lesson when the substance is used, as a reaction may be caused by other people using it.

4.4 Some children may not need quite such stringent avoidance, and will be able to participate using a different recipe. Seek advice from parents and from your school nurse or doctor.

4.5 If nuts are the problem, avoid using them in collage work.

4.6 Discuss with parents whether or not the rest of the class should know about the allergy – they can be very helpful in spotting the early stages of a reaction, but if they are to be told, they must also be told on no account to 'test' the child with the substance.

5.0 Treatment comes into play if prevention fails.

5.1 Even if treatment is successful, the child should be checked at hospital, both to make sure that he/she is all right, and in case symptoms recur when the medication wears off. Therefore, whenever the treatment programme is started, someone should also call an ambulance (saying anaphylactic reaction and emergency). It is also important to inform parents, but do not delay starting treatment in order to contact them.

5.2 It is important that as many people as possible know the emergency instructions for each child and know where the medication is kept. This should be somewhere where it is safe, but can be obtained quickly. Even people who do not wish to learn to administer the treatment should know where it is kept, so that they can fetch it for someone else if necessary.

5.3 Always take the medication to the child, not the child to the medication.

5.4 For some children the first line is an antihistamine (e.g. Piriton) in tablet or syrup form. This needs to be taken at the first sign of a reaction as it is fairly slow acting.

5.5 Some children have adrenaline injections. The Epipen has a concealed spring-loaded needle, and is very easy to administer (even through clothing). The Anapen is similar. No other adrenaline injections are appropriate for use in schools.

5.6 Should an incident occur, replacement medication/equipment should be arranged immediately. It is essential that only adrenaline prescribed for the named person is used. A follow up meeting with relevant school staff, school nurse and parents should take place to evaluate the emergency instructions and provide additional support for staff is required.

Appendix G

Sample chart of Emergency Instructions for Allergic Reaction attached.

www.anaphylaxis.org.uk This site provides general information about anaphylaxis, links to further information and frequently asked questions.

PHOTO

CHILD'S NAME ……

DOB

……

EMERGENCY INSTRUCTIONS FOR AN ALLERGIC REACTION

_____has had an allergic reaction to_____

All foods containing nuts should be avoided. A severe reaction can cause swelling of the mouth, tongue and throat leading to difficulty breathing and collapse (known as anaphylactic shock).

IT IS IMPORTANT TO REALISE THAT THE STAGES DESCRIBED BELOW MAY MERGE INTO EACH OTHER RAPIDLY AS A REACTION DEVELOPS.

ASSESS THE SITUATION
Send someone to get the emergency kit, which is kept in:

_____

MILD REACTION

-
-

ACTION

- **Give antihistamine immediately.**
- **Monitor child until you are happy he/she has returned to normal.**
- **If symptoms worsen see –**

SEVERE REACTION

- Difficulty Breathing/choking/coughing
- Severe swelling of lips/eyes/face
- Pale/floppy
- Collapsed/unconscious

ACTION

- Send someone to telephone 999 for an ambulance – as set out in **emergency telephone procedure** overleaf.

Lie the child down and remove their trousers if they are made of thick material.

Take Epipen – remove grey cap

Restrain child's leg firmly. Push black tip of Epipen firmly into outer aspect of mid-thigh.

MAKE SURE A CLICK IS HEARD.

Hold Epipen in place for 10 seconds.

Remain with child until ambulance arrives.

NB Give used Epipen to ambulance staff – do not touch the needle. If you do prick yourself, wash the wound under running water and contact your GP.

EMERGENCY
TELEPHONE PROCEDURE

1. **DIAL 999.** Tell the operator you need an ambulance Immediately. Tell them you have a case of anphylaxix (ana-fil-ac-sis) and that a child is having difficulty breathing and is losing consciousness.

2. Phone …….Surgery on ……. Tell them you have an emergency with a child having an anaphylactic reaction.

3. Family contact numbers:

   Mother:

   Father:

   Other:

Health 0 -19 Team

Kempston Clinic
Halsey Road
Kempston

01234 310 336

Appendix H: Individual healthcare planning meeting invitation

Dear parent/carer,

Developing an individual healthcare plan for your child

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupil at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, which will set out what support your child needs, and how this will be provided. The plan will be developed in partnership between yourselves, your child, the school and the relevant healthcare professional, who will be able to advise us on your child's case. The aim of this partnership is that the school are aware of how to support your child effectively, and provide clarity about what needs to be done, when and by whom. The level of detail within the plan will depend on the complexity of your child's medical condition and the degree of support needed.

It may be that decision is made that your child will not need an individual healthcare plan, but we will need to make judgements about how your child's medical condition will impact on their ability to participate fully in school life, and whether an individual healthcare plan is required to facilitate this.

A meeting to discuss the development of your child's individual healthcare plan has been arranged for _____. I hope that this is convenient for you, and would be grateful if you could confirm if you are able to attend. The meeting will involve the following people: _____. Please let me know if you would like is to invite any other medical practitioners, healthcare professional or specialist that would be able to provide us with any other evidence which would need to be considered when developing the plan.

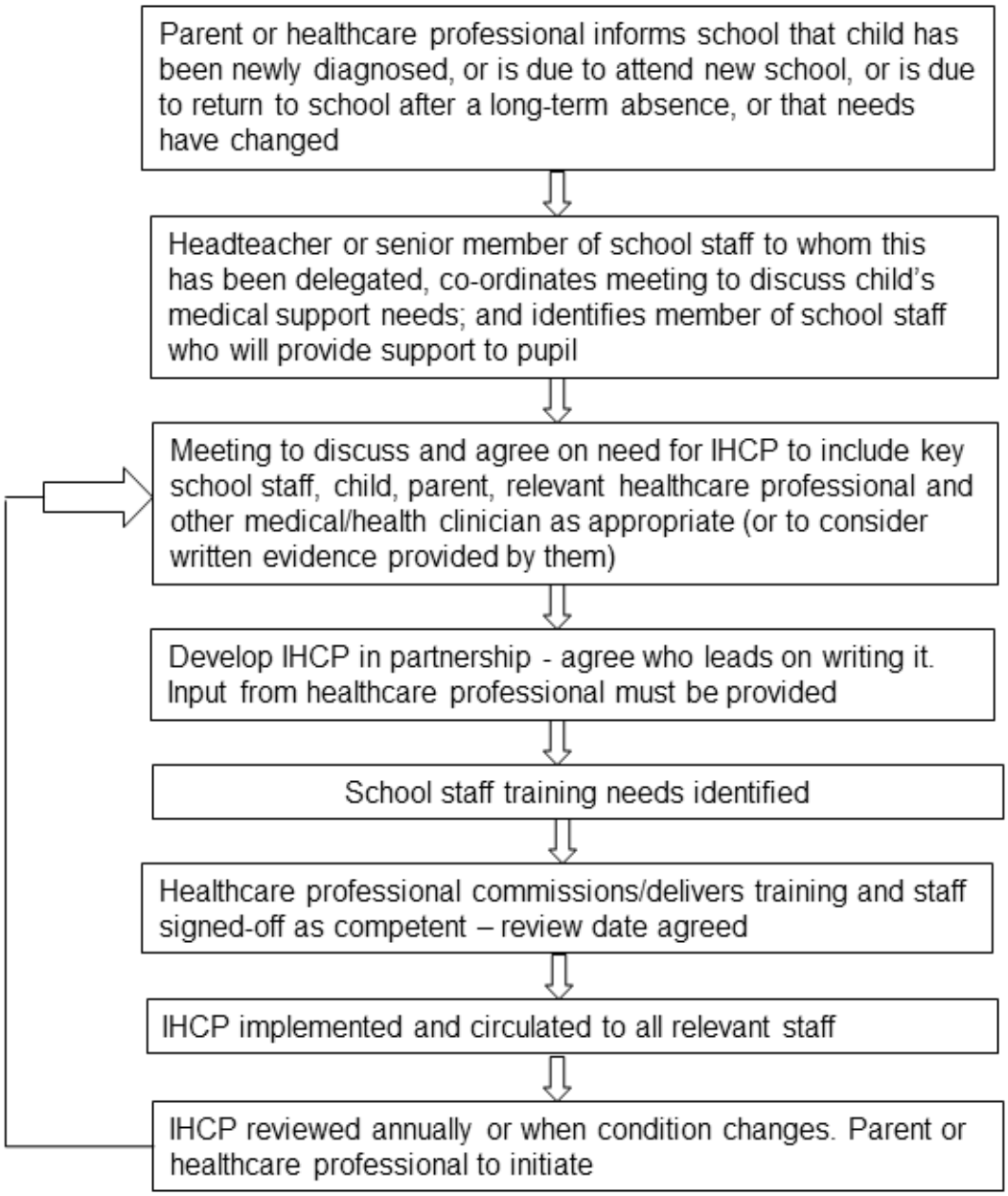
If you are unable to attend, please could you complete the attached individual healthcare template and return it, with any relevant evidence, for consideration at the meeting.

If you would like to discuss this further, or would like to speak to me directly, please feel free to contact me on the number below.

Yours sincerely,

Mrs S Sears
SENDCo/Inclusion Lead

Appendix I: Individual healthcare template flow chart



Appendix J: Individual healthcare template

Name of School/setting/academy

Pupil's name	
Group/class/form	
Date of birth	
Pupil's address	
Medical diagnosis or condition	
Date	
Review date	

Family contact information

First contact name	
Relationship to pupil	
Phone no (mobile)	
Phone no (home)	
Phone no (work)	
Second contact name	
Relationship to pupil	
Phone no (mobile)	
Phone no (home)	
Phone no (work)	

Clinic/Hospital contact

Name	

Phone no	

GP

Name	
Phone no	
Person(s) responsible for providing support in school	

Describe the medical needs of the pupil

Give details of the pupil's symptoms

What are the triggers and signs?

What treatment is required?

Name of medication and storage instructions (if applicable)

Can pupil administer their own medication: YES/NO

Does pupil require supervision when taking their medication: YES/NO

Arrangements for monitoring taking of medication

Dose, when to be taken, and method of administration

Describe any side effects

Describe any other facilities, equipment, devices etc. that might be required to manage the condition

Describe any environmental issues that might need to be considered

Daily care requirements

Specific support for the pupil's educational needs

Specific support for the pupil's social needs

Specific support for the pupil's emotional needs

Arrangements for school visits/trips/out of school activities required

Any other relevant information

Describe what constitutes an emergency and the action to be taken when this occurs

Named person responsible in case of an emergency

In school:

For off-site activities:

Does pupil have emergency healthcare plan? YES/NO

Staff training required/undertaken

Who:

What:

When

Cover arrangements

(see separate staff training form)

People involved in development of plan

Form to be copied to