Northern Lights
LEARNING TRUST

Venerable Bede CE Academy
Supporting pupils with Medical Conditions

Review Date: Spring Term 2024
Next Review Due: Spring Term 2025
Person in Charge: Sally Holt
Governance: Mark Thompson

Northern Lights Learning Trust

Signed off by: Chair of Local Governing Board

Date from: Spring Term 2024

Review Date: Autumn Term 2025

The quality of relationships between all members of school staff and pupils, and the relationship with parents and carers is the area that is most commonly associated with the ethos of the schools in our Trust. It is expressed in the terms of sharing and caring. In the Church schools in our Trust, we follow the teachings of:

'Love your neighbour as yourself' – Matthew 22:39.

'This is my commandment: love each other' – John 15:17.

In our schools we believe every pupil is an individual who is valued for who they are.

We have a series of overlapping networks of relationships, which includes governors, staff, children, parents, church members, and members of the community which the school seeks to serve. Our pastoral work will strive to meet the significant challenge to create and maintain such networks including in our Church schools in ways which reflect the Gospel. Those who are in leadership roles, which includes all who have a particular responsibility, ensure that by their personal example they set the highest standards expected.

It is from this premise that both Christian and spiritual love will pervade all aspects of life at Northern Lights Learning Trust. It will influence how we reward and teach discipline. It will affect how we value work and the achievements of pupils and staff. It will be seen in the way in which the school environments are created and cared for, in the way in which the needs of pupils, parents, and community are met, and in the way in which teaching and non-teaching staff work together effectively as a team. Pastoral care pervades all aspects of school life and therefore will be reflected in the way the schools are organised and the policies are written and implemented.

Relevant staff applicable to this policy

Venerable Bede CE Academy	
Head of School	Mrs T. Burgess Email: Tracey.burgess@nllt.co.uk
Medication co-ordinator	Mrs J Chipp Email: Jackie.chipp@nllt.co.uk
SENDCo	Mrs S Holt Email: sally.holt@nllt.co.uk
Inhaler and spacer disposal	Mrs J Chipp Email: Jackie.chipp@nllt.co.uk

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Introduction

Children and young people with medical conditions are entitled to a full education and have the samerights of admission to school as other children. All reasonable arrangements for a child's medical condition will be made so that wherever possible no child with a medical condition should be denied admission or prevented from taking up a place in school (Supporting pupils at school with medical conditions).

This policy sets out the procedures to be followed when:

- a pupil with a medical condition is admitted
- the pupil's medical needs change
- a pupil is re-integrated following a diagnosed medical condition
- a pupil is returning following treatment/long period of absence

Supporting a pupil with a medical condition is not the sole responsibility of one person. Partnership between academy staff, healthcare professionals, local authorities, parents, carers andpupils is critical.

This policy sets out the roles and responsibilities of all those involved in the arrangements made tosupport pupils in the academy with medical conditions.

Roles and Responsibilities

Responsibility of Parents/Carers

Parents/carers have the principal responsibility for the administration of medication to their children,who have the right to be educated with their peers, regardless of any short or long-term needs for medication whilst at the academy.

It is preferable that medication be given at home whenever possible. If prescribed medicines are to be taken three or more times per day, parents/carers should ask the prescribing doctor if the administration of the medication can occur outside normal academy hours. Non-prescription medication (such as cough medicines) should not be administered in the academy. However, in certain circumstances, analgesics can be given (see page 4).

Parents/carers have a duty to inform the academy of their children's medical conditions and to makea request for the Head of school to make arrangements for medication to be administered in the academy. This can occur if the child:

- has been newly diagnosed
- is due to return after a long absence and has a chronic illness or long-termcomplaints, such as asthma, diabetes, epilepsy or another condition

- is recovering from a short-term illness and is well enough to return to theacademy whilst still receiving a course of antibiotics or other medication.

- has needs that have changed

Responsibility of Health Care Professionals

In situations where the condition requires a detailed individual healthcare plan or specific specialisttraining is required for academy staff, this will often require direct input from Healthcare Professionals with clinical responsibility for the child. Examples include community or specialist nurses and, in the case of children with mobility needs, occupational therapists or physiotherapists.

Often the specific details in an individual healthcare plan can only be provided by professionals who have access to the confidential notes that the Consultants and other healthcare professionals workingwith the child in question have prepared.

The Academy Nursing Team is able to provide training on anaphylaxis and can provide a 'signposting role' should the academy have difficulty accessing professional medical assistance or ifthere is uncertainty about which consultant to contact.

Responsibility of Academy Staff

Each request for medicine to be administered to a pupil in the academy will be considered on its merits. The Head of school will give consideration to the best interests of the pupil and the implicationsfor the academy.

It is generally accepted that academy staff may administer prescribed medication whilst acting in locoparentis. However, it is important to note that this does not imply that there is a duty upon academy staff to administer medication and the following should be taken into account:

- No member of staff will be compelled to administer medication to a pupil.

- No medication can be administered in the academy without the agreement of the Head of schoolor her/his nominated representative.

- The Head of school has nominated a member of staff to assume the role of Medication Coordinator, who will have overall responsibility for the implementation of this policy. The named person is listed at the front of this policy. Where the named member of staff is absentfrom the academy, another member of staff will be assigned this responsibility.

- Staff who administer medication will receive appropriate guidance and training from LocalAuthorities, Specialist Nurses or Chemists including, but not limited to 'Administration of Medications Training/refreshers', Epipen/Auto injector training, Diabetes Awareness/ Epilepsy Awareness training, First Aid training etc.

- Although administering medicines is not part of a teacher's professional duties, they shouldtake into account the needs of the pupils with medical conditions they teach. Parents/

carers

requesting administration of medication for their children should be referred to the academy'swebpage where they can access a copy of this document. They should be asked to complete Part 1 of the form 'Administration of Medication to Pupils – Agreement between Parents/carers and School', a copy of which can be found in Appendix 1. Completion of this form safeguards staff by allowing only **prescribed** medication to be administered. For administration of 'over the counter' medicines, please see section below.

- Academy staff may consult with the prescriber to ascertain whether medication can be givenoutside of academy hours.

Responsibility of Pupils

Pupils with medical conditions are often best placed to provide information about how their medicalcondition affects them. They should be fully involved in discussions about their medical needs and contribute as much as possible to their individual healthcare plan.

General Procedures

1. If medication cannot be given outside of academy hours, parents/carers should fill in theaforementioned request form (Appendix 1) giving the dose to be taken, the method of administration, the time and frequency of administration, other treatment, any special precautions and signed consent.

2. The parent/carer (not the pupil) should bring all essential medication to the academy. It should be delivered personally to the medication co-ordinator listed at the front of this policy.Only the smallest practicable amount should be kept in the academy.

3. All medication taken in the academy will be kept in a clearly labelled pharmacy bottle, preferably with a child safety top, which must give the owner's name, the contents and thedosage to be administered.

4. Whilst medication is in the academy, it will be kept in a locked cupboard/fridge within a locked room. The exceptions to this are inhalers, adrenaline auto-injectors and insulin. These medications should be carried by the child or may be kept in the classroom, depending on thechild's age and developing independence. Emergency school Epi-pen and Inhalers are stored in the School Office and are clearly marked.

5. Medication to be taken orally should be supplied with an individual measuring spoon or syringe. Eye drops and ear drops should be supplied with a dropper. A dropper or spoon must only be used to administer medicine to the owner of that implement.

6. When medication is given, the name of the drug, the dose, the mode of administration, the time that treatment is required to be given and date of expiry should be checked. A written record should be kept of the time it was given and by whom to avoid more than one person

ever giving more than the recommended dose. This should be kept with the parental consent form. See form in Appendix 1.

7. Where any change of medication or dosage occurs, clear written instructions from the parent/carer should be provided. If a pupil brings any medication to the academy for which consent has not been given, academy staff can refuse to administer it. In such circumstances the Head of school or his representative should contact the parent/carer as soon as possible.

8. Renewal of medication which has passed its expiry date is the responsibility of the parent/carer. Nevertheless, if parents/carers are unable to collect expired medication then academy staff will take it to the local pharmacy so that it can be disposed of safely. The medication will not be disposed of in any other way.

9. In all cases where, following the administration of medication, there are concerns regarding the reaction of the pupil, medical advice will be sought immediately (by contacting 111) andthe parents/carers informed.

10. Where a pupil transfers to another school, all records relating to their medical condition willbe transferred to the new school. Any existing medication will be handed back to the parent/carer.

Refusal or Forgetting to Take Medication

If pupils refuse medication or forget to take it, the academy will inform the child's parent/carer as a matter of urgency. If necessary, the academy will call the emergency services (contact 111). Refusal to take medication is recorded on a pupil medication record.

Non-prescribed Medication

At the discretion of the Head of school, non-prescribed medication will **not** be administered in schoolduring the 2022-23 academic year.

If you feel strongly that your child requires Paracetamol frequently during school hours, we ask that you speak with your GP and then contact Mrs L Cockburn, Trust Chief Operating Officer to arrangea meeting to discuss this further. Circumstances whereby paracetamol can be administered in schoolinclude:

- GP has provided Paracetamol on prescription due to a medical condition.
- GP has provided doctor's note/letter explaining that in their medical opinion,the pupil in question requires regular (day time) use of Paracetamol.

Once Paracetamol is presented as above a formal agreement should be made between the academy and the parents/carers (see Appendix 1 below). In order to monitor and prevent the danger of any individuals overdosing on the medication the member of staff dispensing the paracetamol will keep a

record of when it was issued, giving such information as name of the pupil and the time and the dosewhich was administered (see Appendix 5). Before administering the medication members of staff should always ask the child whether any side effects or allergic reactions have been experienced andcheck when they last took medication to ensure they are not 'over dosing'.

500mg paracetamol tablets are recommended for such problems as migraine and period pain.Paracetamol will not be kept in first-aid boxes.

On no account will aspirin or preparations that contain aspirin be given to pupils unless a doctor hasprescribed such medication.

Individual Healthcare Plan

This section of the policy covers the role of individual healthcare plans in supporting pupils at academy who have long-term, severe or complex medical conditions. The new statutory guidance imposes a requirement to identify the member of staff who is responsible for the development of these plans. In this academy it is the SENDCO, listed at the front of this policy (Special educationalneeds and disability code of practice: 0 to 25 years).

Healthcare plans will be developed with the child's best interests in mind and the academy will ensure that it assesses and manages risks to the child's education, health and social well-being andminimises disruption.

Personalised risk assessments, moving and handling risk assessments, emergency procedures andother such documents will be used to supplement the individual healthcare plan, as appropriate.

A model healthcare plan is given in Appendix 3. To ensure compliance with the new statutory guidance, the following issues have been taken into account:

- the medical condition, its triggers, signs, symptoms and treatments.
- the pupil's resulting needs, including medication (with details of dose, side-effectsand storage arrangements) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage his/her condition, dietary requirements and environmental issues such as crowded corridors, travel time between lessons.
- specific support for the pupil's educational, social and emotional needs – for example, how absences will be managed, requirements for extra time to completeexams, use of rest periods or additional support in catching up with lessons, counselling sessions.
- the level of support needed, (some children will be able to take responsibility for their own health needs), including in emergencies. If a child is self-managing their medication, this should be clearly stated with appropriate arrangements for monitoring.

- who will provide this support, their training needs, expectations of their role andconfirmation of their proficiency to provide support for the child's medical condition from a healthcare professional, together with an indication of the arrangements for cover that will be available when those supporting are unavailable.

- who in the academy needs to be aware of the child's condition and the supportrequired.

- the need to establish arrangements which enable written permission from parents/carers and the Head of school to be drawn up, thus authorising a member ofstaff to administer medication or allowing the pupil to self-administer during academy hours.

- the designated individuals to be entrusted with information about the child'scondition where the parent/carer or child has raised confidentiality issues.

- what to do in an emergency, including whom to contact, and contingency arrangements. Some children may have an emergency healthcare plan prepared by their lead clinician that could be used to inform development of their individual healthcare plan.

- the separate arrangements or procedures required for academy trips, educational visits or other extra-curricular activities. In practice, these should be logged on the EVOLVE system, together with supporting information, such as personalised risk assessments. These arrangements enable the child to participate fully in such activities and ensure social inclusion, as recommended by the Outdoor Education Advisory Board's National guidance 3.2e 'Inclusion'.

Practical Advice for Common Conditions

A small number of children need medication to be given by injection, auto-injectors or other routes. The most appropriate arrangements for managing these situations effectively will be determined by agreement between the academy, parent/carer, school nurse (where there is one) and the doctor whoprescribed the medication.

Members who have this in their job description or are willing to administer medication will be made fully aware of the procedures and will receive appropriate training from competent healthcare staff. More information on training requirements is given below in the sections of this policy covering common medical conditions. The majority of parents/carers will be aware of the contact details for their child's specialist nurse. The academy will contact them directly in the first instance. The school nursing team will be contacted for advice and is able to direct inquirers to other health agencies, where necessary. An individual healthcare plan for each pupil with a medical need will be completed and conform to the procedures described on pages 6 and 7. Information in the appendicesshould prove helpful.

The medical conditions in children that most commonly cause concern in academy are asthma, epilepsy, diabetes and anaphylaxis. Essential information about these conditions is provided within this policy. More detailed information can be obtained from the following organisations:

- Asthma UK
- Epilepsy Society (formerly The National Society for Epilepsy)
- Epilepsy Action (formerly the British Epilepsy Association)
- Diabetes UK
- Anaphylaxis Campaign
- National Electronic Library for Medicines (NHS)
- Resuscitation Council (UK)

Anaphylaxis

What is Anaphylaxis?

Anaphylaxis is an extreme allergic reaction that occurs rarely in people who have an extreme sensitivity to a particular substance known as an allergen. It can affect the whole body, including the airways and circulation. Often it occurs within minutes of exposure to the allergen, though sometimes it does not arise until many hours later.

What Causes It?

Common causes of anaphylaxis include:

- Edible triggers, such as peanuts, tree nuts, fish, shellfish, dairy products and eggs.
- Other triggers, such as natural latex, the venom of stinging insects (for examplewasps, bees and hornets), penicillin and any other drugs or injections.
- Anaphylactic shock is the most severe form of allergic reaction. This occurs when the blood pressure falls dramatically and the patient loses consciousness.

What are the Signs of the Condition?

Common signs of anaphylaxis in children include:

- swelling in the throat, which can restrict the air supply thus causing breathingdifficulties.
- severe asthma.
- dizziness.
- itchy skin, generalised flushing of the skin, tingling or itching in the mouth orhives anywhere on the body.
- swelling of the lips, hands and feet.
- abdominal cramps, nausea and vomiting.

What is the Treatment for the Condition?

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine)into the muscle of the upper outer thigh via a pre-loaded injection device, such as an epiPen, anapenor jext. An injection should be given as soon as a reaction is suspected.

Anaphylaxis should always be regarded as a medical emergency which requires that an ambulance becalled immediately.

Arrangements in Place at our

AcademyHealthcare Plan

Anaphylaxis is manageable. With sound precautionary measures, the development of a suitable healthcare plan and support from members of staff, academy life may continue as normal for allconcerned.

Our procedures to manage the use of adrenaline auto-injectors are:

- awareness among all members of staff that the child has this particular medicalcondition
- awareness of the symptoms associated with anaphylactic shock
- knowledge of the type of injector to be used
- labelling of injectors for the child concerned, for example adrenaline, anti-histamine
- knowledge of the locations where the injector is stored, preferably in an easilyaccessible place such as a medication box

- the provision of appropriate instruction and training to nominated members of staff
- familiarity with the names of those trained to administer treatment
- an understanding of the need to keep records of the dates of issue
- knowledge of emergency contacts

This information is displayed in the areas where the medication is to be kept. This information includes the name of the child and, ideally, a photograph. Care must be given to ensure confidentiality. The information will be accessible but not publicly displayed – this will be by way of photograph in the staffroom. The information required will accompany the medication on school trips. The arrangements for swimming and other sporting activities will also be considered as part ofthe risk assessment for the trip/visit/event.

Collectively, it is for the Head of school, the child's parents/carers and the medical staff involved todecide how many adrenaline devices the academy should hold, and where they should be stored.

Where children are deemed sufficiently responsible for carrying their own emergency treatment withthem, it is nevertheless important that a spare set should always be kept safely on site in the school office. This should be accessible to all staff and stored in a secure place. In large academy or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location. In an emergency situation it is important to avoid any delay.

Food Management

Where a pupil has a food allergy, the catering team and Food Technology staff will be informed and measures put into place for food management. A healthcare plan is prepared and shared with parents/carers and all staff.

Although not always feasible, where possible, food to which pupils may be allergic to will be excluded from the menu and premises. Where exclusion is not possible, appropriate steps will betaken to minimise any risks to allergic pupils.

Please note that nuts, or nut products of any kind are **not** allowed in the academy.

Training

Where members of staff are either willing (or have this in their job description) to inject adrenaline inan emergency, the academy will contact the school nurse to arrange for them to deliver an appropriate training session in the use of the auto-injectors.

Asthma

What is Asthma?

People with asthma have airways which narrow as a reaction to various triggers. The narrowing or obstruction of the airways causes breathing difficulties.

What Causes It?

There are many things that can trigger an asthma attack. Common examples include:

- viral infections
- house dust mites
- pollen
- smoke
- fur
- feathers
- pollution
- laughter
- excitement ▪ stress

What are the Signs of the Condition?

The most common symptoms of an asthma attack include:

- coughing
- wheezing
- difficulty breathing
- nasal flaring
- a tight feeling in the chest (younger children may express this as ‘tummy ache’ orfeeling like someone is sitting on their chest)
- Inability to talk or complete sentences (some children will go very quiet).

What is the Treatment for the Condition?

The main types of medicines used to treat asthma are discussed briefly below:

Relievers

Usually it is a reliever that a child will need during the school day. Relievers (usually blue inhalers) are medicines that are taken immediately to relieve the symptoms of asthma during an attack. They quickly relax the muscles surrounding the narrowed airways thus allowing them to open wider, making it easier for the child to breathe. They are sometimes taken before exercise.

Preventers

Preventer inhalers can be brown, red or orange in colour and can sometimes be in the form of tablets.Preventers are usually used out of academy hours and it is rare for them to be needed during the school day.

Preventers protect the lining of the airways, help to calm the swelling and stop the tubes in the lungsfrom being so sensitive.

Spacers

Both kinds of inhalers are often used in combination with spacers which help deliver medicine to thelungs more effectively. Where prescribed, the spacer will be individually labelled with the child's name and kept with the inhaler.

Nebulisers

A nebuliser is a machine that creates a mist of medicine that is then breathed through a mask or mouthpiece. They are becoming increasingly less common. Pupils with asthma should not normally need to use a nebuliser in the academy. However, if they do have to use one, then members of the academy staff will receive appropriate training from a healthcare professional.

Training

Since emergency treatments vary in each case, the parents/carers will often be best placed to inform the academy of the child's treatment regime. There may be a specialist nurse from the local NHS Trust who can deliver training and will have access to the medical advice that has informed the healthcare plan. This is carried out annually, either in person or virtually, or sooner if a pupil joins the school with a different healthcare need.

Children with asthma will often be looked after solely by their GP or Asthma Nurse. Although the GP would be unable to provide training it is likely that they will provide the information that wouldhelp academy staff to complete the healthcare plans. Children with complex conditions may have access to a specialist nurse with expert knowledge in oncology, nephrology, gastroenterology, urology or cystic fibrosis, who may be able to assist.

Designated Members of Staff

Designated members of staff will be trained in:

- recognising asthma attacks (and distinguishing them from other conditions withsimilar symptoms)
- responding appropriately to a request for help from another member of staff
- recognising when emergency action is necessary
- administering salbutamol inhalers through a spacer
- keeping appropriate records of asthma attacks

ALL Members of Staff

In additional to this, **ALL** members of staff will be:

- briefed on how to recognise the symptoms of an asthma attack and, ideally, how todistinguish them from other conditions with similar symptoms. This will usually be carried out during staff inset at the start of a new academic year.
- aware of this policy, usually as part of their induction process.
- aware of how to check if a child is on the asthma register.
- aware of how to access the emergency inhaler and who the designated members ofstaff are, and the policy on how to access their help.

Asthma UK has produced demonstration films on using a metered-dose inhaler and spacerssuitable for staff and children.

http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

Arrangements in Place at our

AcademyHealthcare Plan

Pupils with asthma have an individual healthcare plan, details about which are given on page 6 and inAppendix 3.

Asthma Register

A register of pupils who have been diagnosed with asthma or prescribed a reliever inhaler will be kept. This is particularly important where there may be many pupils with asthma, and it will not be feasible for individual members of staff to be aware of which children these are. Medical needs (including allergies such as asthma) are shared with all staff so that they may be considered for specific teaching departments. For example, DT/PE or Food Technology.

The asthmas register is located in the school office and is available to all staff via secure shared folder to allow for a quick check to establish if a pupil is recorded as having asthma and that consentfor an emergency inhaler to be administered has been obtained.

Carrying the Medication

Pupils with asthma need to keep their reliever inhalers with them at all times

If pupils are not able to do so then inhalers will be stored safely away and members of staff will issuethem when the pupil needs the medication.

All asthma medicine will be clearly labelled with the pupil's name. The expiry date of the medicines will be checked every six months by the medication co-ordinator.

Emergency Salbutamol Inhalers in Schools

As indicated above, the academy is now permitted to keep a supply of salbutamol inhalers on site foruse in an emergency. This is a sensible contingency arrangement in the event that children lose, forget or break their inhalers.

The emergency salbutamol inhaler should only be used by children:

- who have been diagnosed with asthma, and prescribed a reliever inhaler
- who have been prescribed a reliever inhaler
- for whom written parental consent for use of the emergency inhaler has beengiven.

Information on the use of the emergency inhaler will be recorded in a child's individual healthcareplan.

Academies are not required to hold an inhaler – this is a discretionary power enabling them to do soif they wish. Those which choose to keep an emergency inhaler should use the guidance below to establish a protocol for its use.

Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital and, potentially, save the child's life. Having a protocol that sets out how and when the inhaler should be used will also protect members of staff by ensuring they know what to do in the event of a child having an asthma attack; this should include:

- Establishing arrangements for the supply, storage, care and disposal of theinhaler and spacers. Assigning these responsibilities to at least two staff members who are listed at the front of this policy.

- Maintaining a register of pupils who have been diagnosed with asthma or prescribed a reliever inhaler. The register should confirm that parental consent has been obtained for use of the emergency inhaler and a copy of it should be kept with the emergency inhaler. The responsibility for this is the medication co-ordinator.

- Having written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan. This consent can either be secured by amending the School/Parental Agreement Form (Appendix 1) to include this permission or by using the specific consent form for use of the emergencyinhaler (Appendix 6) which should be updated regularly, ideally annually, to take account of changes to a child's condition.

- Arranging for appropriate support and training for staff in the use of theemergency inhaler in line with this policy.

- Keeping a record of use of the inhaler (including when and where the attack took place, how much medication was given and by whom) and informing parents or carers that their child has used the emergency inhaler (this should bein writing so the parent/carer can pass the information onto the child's GP – a sample letter is attached as Appendix 7)

The medication co-ordinator will monitor the protocol to ensure compliance with it.

Supply

The academy can buy inhalers and spacers from a pharmaceutical supplier, such as a local pharmacy,without a prescription, provided the general advice relating to these transactions are observed. The academy can buy inhalers in small quantities provided it is done on an occasional basis and is not forprofit.

A supplier will need a request signed by the Head of school (ideally on appropriately headed paper)stating:

- the name of the academy for which the product is required;
- the purpose for which that product is required, and
- the total quantity required.

The academy may wish to discuss with their community pharmacist the different plastic spacers that are available and what is most appropriate for the age-group in the academy. They can also provideadvice on use of the inhaler. The academy should be aware that pharmacies cannot provide inhalersand spacers for free and will, therefore, charge for them.

The Emergency Kit

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler
- at least two single-use plastic spacers compatible with the inhaler
- instructions on using the inhaler and spacer
- instructions on cleaning and storing the inhaler
- manufacturer's information
- a checklist of inhalers, identified by their batch number and expiry date, with monthly checksrecorded
- a note of the arrangements for replacing the inhaler and spacers
- a register of children permitted to use the emergency inhaler as detailed in their individualhealthcare plans
- a record of when the inhaler has been used
- a copy of the academy protocol on the use of the emergency salbutamol inhaler

The academy will consider keeping more than one emergency asthma kit, to ensure that all childrenwithin the academy environment are close to such equipment. Although the Department of Health

suggests a stock of five spacers would be adequate for a typical academy, parental consent will besought initially.

Salbutamol

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild, temporary and not likely to cause serious harm. The child may feel a bit shaky or may tremble, or may say that they feel their heart is beating faster. The main risk of allowing academies to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential, therefore, that academies follow the advice on page 14 in relation to whom the emergency inhaler can be used by.

Children may be prescribed inhalers for their asthma which contain an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhalers are not accessible – it will still help to relieve their asthma andcould save a life.

Storage and Care of the Inhaler

The academy will ensure that the inhaler and spacers are kept in a safe central location, such as the school office and medical room, which is known to all members of staff, and to which they have access to at all times. However, the inhaler must be stored out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with the manufacturer's guidelines), usually below 30^{o}C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any individual child's inhaler; the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler. An inhaler should be primed when first used (for example, spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by the member of staff administering it, byspraying two puffs.

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use. The inhaler itself, however, can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place.The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place.

However, if there is any risk of contamination with blood (for example if the inhaler has been usedwithout a spacer), it should also not be re-used but disposed of.

The two named volunteers listed at the front of this policy should have responsibility for ensuringthat:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhalerhas sufficient number of doses available

- replacement inhalers are obtained when expiry dates approach
- replacement spacers are available following use
- the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned tostorage following use, or replacements are available if necessary.

Disposal

Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled. Academies should be aware that to do this legally, they will need to 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 infuture years. The hyperlink to enable schools to register is provided below:

https://www.gov.uk/waste-carrier-or-broker-registration

As a general rule however, the academy will dispose of spent inhalers via its recycling and rubbishbins.

PE and Off-site Activities

Children with asthma should participate in all aspects of academy life, including physical activities. They need to take their reliever inhaler with them on all off-site activities and these should also be available during physical education and sports activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work may need to 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.

The emergency inhaler kit should be easily accessible should the child's primary inhaler not beavailable.

Action During an Attack

When a child has an attack they should be treated according to their individual healthcare plan orasthma card, as previously agreed. If the child does not have his/her prescribed reliever inhaler available, then the academy's emergency inhaler can be used in the circumstances described previously.

An ambulance should be called if:

- the symptoms do not improve sufficiently after 10 puffs on the inhaler
- the child is too breathless to speak
- the child is becoming exhausted
- the child has a blue/white tinge around the lips
- the child has collapsed

Because asthma varies from child to child, it is impossible to provide emergency guidance that will apply uniformly in every single case. However, the guidelines given in Appendix 8 may be helpful. Academies may wish to copy the information and display it as emergency guidance.

Diabetes

What is Diabetes?

Diabetes is a condition where the amount of glucose in the blood is too high because the body cannotuse it properly.

What Causes It?

Diabetes is a disorder caused when the pancreas produces an insufficient amount of the hormoneinsulin or when insulin production is absent. There are two main types of diabetes which are discussed briefly below:

Type 1 Diabetes

Type 1 diabetes develops when the insulin-producing cells have been destroyed and the body is unable to generate any of the substance. It is treated with insulin either by injection or pump, a healthy diet and regular physical activity. The majority of affected children have Type 1 diabetes.

Type 2 Diabetes

Type 2 diabetes develops when the body does not produce enough insulin or the insulin that isproduced does not work properly.

This type of diabetes is treated with a healthy diet and regular physical activity, though medication(and/or insulin) is often required.

In both instances, each child may experience different symptoms and these should be discussed whendrawing up the healthcare plan.

What is the Treatment for the Condition?

For most children diabetes is controlled by injections of insulin each day. Some children may require multiple injections, though it is unlikely that they will need to be given injections during academy hours.

In some cases, the child's condition may be controlled by an insulin pump. Most children can manage their own injections, however, if doses are required at the academy then supervision may berequired and a suitable, private place to inject will need to be identified.

It has become increasingly common for older children to be taught to count their carbohydrate intakeand adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin athome, usually at bedtime and then insulin with breakfast, lunch and 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. The child is then responsible for administering injections and the regime to be followed would be detailed in the individual healthcare plan.

It is essential that children with diabetes make sure that their blood glucose levels remain stable. They 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 academy lunch break, before PE or more regularly if their insulin needs to be adjusted. The majority of older children will be able to undertake this task without assistance and will simply need a suitable place to do it. However, younger children may need adult supervision to carry out the test and/or interpret the results.

When members of staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional, usually a specialist nurse with clinical responsibility forthe treatment of the particular child.

What Arrangements are in Place at our Academy?

Training

Since emergency treatments vary in each case, the parents/carers will often be best placed to inform the academy of the child's treatment regime. A specialist nurse from the local NHS Trust delivers training and will have access to the medical advice that has informed the healthcare plan. This training is carried out annually, either in person or virtually, or sooner if a pupil joins the school with a specific healthcare need.

Children with Diabetes will often be looked after solely by their GP or Diabetes Nurse. Although the GP would be unable to provide training it is likely that they will provide the information that would help academy staff to complete the healthcare plans.

Designated Members of Staff

Designated members of staff will be trained in:

- recognising signs of diabetes symptoms
- responding appropriately to a request for help from another member of staff
- recognising when emergency action is necessary and what that action is

- keeping appropriate records of medical treatment

ALL Members of Staff

In additional to this, **ALL** members of staff will be:

- briefed on how to recognise the symptoms of diabetes. This will usually be carriedout during staff inset at the start of a new academic year by a member of the Diabetic Nursing Team. This is either virtually or face to face.

- aware of this policy, usually as part of their induction process.

- aware of how to check if a child is on the medical register.

- aware of how to access the emergency plan for diabetic pupils, who the designatedmembers of staff are, and the policy on how to access their help.

Healthcare Plan

A healthcare plan will be needed for pupils with diabetes. Information about these plans is given on page 6 and Appendix 2.

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. The academy may need to make special arrangements for pupils with diabetes if the academy has staggered lunchtimes. Members of staff need to be made aware that if a child should miss a meal or snack he/she could experience a hypoglycaemic episode (commonly known as a 'hypo') during which the blood glucose level falls too low. It is, therefore, important that staff should be aware of the need for children with diabetes to have glucose tablets or asugary drink to hand. After strenuous activity a child may experience similar symptoms, in which case the teacher in charge of physical education or other sessions involving physical activity should be aware of the need to take appropriate action.

What are the Signs of a Hypoglycaemic Episode?

Staff should be aware that the following symptoms, either individually or in combination, may be anindicator of low blood sugar:

- 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 upindividual healthcare plans.

Emergency Action

If a child experiences a 'hypo', it is very important that he/she is not left alone and that a fast actingsugar, 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. Emergency stock of food/glucose is stored in the Lead Practitioner's office, the school kitchen and the main office 'emergency box'.

An ambulance should be called if:

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

Hyperglycaemia

Some children may experience hyperglycaemia, which is a high glucose level.

The underlying cause of hyperglycaemia will usually be from loss of insulin producing cells in thepancreas or if the body develops resistance to insulin.

More immediate reasons for it include:

- Missing a dose of diabetic medication, tablets or insulin
- Eating more carbohydrates than the body and/or medication can manage
- Being mentally or emotionally stressed
- Contracting an infection

The symptoms of hyperglycaemia include thirst and the passing of large amounts of urine. Tiredness and weight loss may indicate poor diabetic control. If these symptoms are observed, members of staff should draw these signs to the attention of parents/carers. If the child is unwell, is 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 he/she will require urgent medical attention.

Further information on this condition can be found on the Diabetes UK website.

Epilepsy

What is Epilepsy?

Since emergency treatments vary in each case, the parents/carers will often be best placed to informthe academy of the child's treatment regime. A specialist nurse from the local NHS Trust delivers training and will have access to the medical advice that has informed the healthcare plan. This training is carried out annually in September, either in person or virtually, or sooner if a pupil joins the school with a specific healthcare need.

Children with Epilepsy will often be looked after solely by their GP or Epilepsy Nurse Specialist.Although the GP would be unable to provide training it is likely that they will provide the information that would help academy staff to complete the healthcare plans.

Designated Members of Staff

Designated members of staff will be trained in:

- recognising signs of diabetes symptoms
- responding appropriately to a request for help from another member of staff
- recognising when emergency action is necessary and what that action is
- keeping appropriate records of medical treatment

ALL Members of Staff

In additional to this, **ALL** members of staff will be:

- briefed on how to recognise the symptoms of epilepsy and if a child is having a seizure. This will usually be carried out during staff inset at the start of a new academic year by a member of the Epilepsy Nursing Team. This is either virtuallyor face to face.
- aware of this policy, usually as part of their induction process.
- aware of how to check if a child is on the medical register.
- aware of how to access the emergency plan for epileptic pupils, how to support them, who the designated members of staff are, and the policy on how to accesstheir help.

Epilepsy is characterised by a tendency for someone to experience recurrent seizures or a temporaryalteration in one or more brain functions.

What Causes It?

An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time.Seizures can happen for many reasons and can result from a wide variety of disease or injury.

Triggers such as anxiety, stress, tiredness and illness may increase the likelihood that a child will have a seizure. Flashing or flickering lights and some geometric shapes or patterns can also triggerseizures. The latter is called photosensitivity and is very rare. Most children with epilepsy can usecomputers and watch television without any problem.

What are the Signs of the Condition?

Seizures can take many different forms and a wide range of terms may be used to describe theparticular seizure pattern that individual children experience.

What the child experiences depends on whether all of the brain is affected or the part of the organ that is involved in the seizure. 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 display unusual habits, 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.

Most seizures last for a few seconds or minutes, and stop of their own accord. In some cases, 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', and sometimes there will be 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.

What is the Treatment for the Condition?

The great majority of seizures can be controlled by anti-epileptic medication. It should not be necessary to take regular medicine during school hours.

What Arrangements are in Place at our Academy?

Healthcare Plan

An individual healthcare plan is needed when a pupil has epilepsy.

Parents/carers and health care professionals should provide information to the SENDCO at the academy so that it can be incorporated into the individual healthcare plan, detailing the particularpattern of an individual child's epilepsy. If a child experiences a seizure whilst at the academy, details should be recorded and communicated to parents/carers including:

- any factors which might possibly have acted as a trigger to the seizure – for examplevisual/auditory stimulation, anxiety or upset.
- any unusual 'feelings' which the child reported prior to the seizure
- the parts of the body demonstrating seizure activity, such as limbs or facial muscles
- the time when the seizure happened and its duration
- whether the child lost consciousness
- whether the child was incontinent

The above information will help parents/carers to give the child's specialist more accurate information about seizures and their frequency. In addition, it should form an integral part of the academy's emergency procedures and relate specifically to the child's individual healthcare plan. The healthcare plan should clearly identify the type or types of seizures, including descriptions of the seizure, possible triggers and whether emergency intervention may be required.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or participating in science lessons. The Medication Coordinator should discuss any safety issues with the child and parents/carers as part of the healthcare plan, and these concernsshould be communicated to members of staff.

Emergency Action

Information regarding emergency management is given in Appendices 9 and 10. Appendix 9 covers the procedures to be followed with regard to first aid for all seizures, whilst Appendix 10 covers procedures to be followed if the casualty is known to have epilepsy and has been prescribed buccal midazolam or rectal diazepam.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured him/herself badly
- the child has problems breathing after a seizure
- a seizure lasts longer than the period identified in the child's healthcare plan
- a seizure lasts for five minutes and members of staff do not know how long the seizuresusually last for a particular child
- there are repeated seizures, unless this is usual for the child, as described in the child's healthcare 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. Putting something soft under the child's head during a convulsive seizure will help to protect it from injury.

Nothing should be placed in the child's mouth. After a convulsive seizure has stopped, the pupil should be placed in the recovery position and a member of staff should stay with him/her until thechild has fully recovered.

Status Epilepticus

Status epilepticus is a condition described as one continuous, unremitting seizure lasting longer than five minutes or recurrent seizures without regaining consciousness between them for greater than fiveminutes. It must always be considered a medical emergency.

A five minute seizure does not in itself constitute an episode of status and it may subsequently stop naturally without treatment. However, applying emergency precautions after the five minute mark has passed will ensure that prompt attention will be available if a seizure does continue. Such precautions are especially important if the child's medical history shows a previous episode of statusepilepticus.

Any child not known to have had a previous seizure should receive medical assessment as soon aspossible. Both medical staff and parents/carers need to be informed of any events of this nature.

Emergency Medication

Two types of emergency medication are prescribed to counteract status, namely:

- Rectal diazepam, which is given rectally (into the bottom). This is an effective emergency treatment for prolonged seizures.

- Buccal (oromucosal) midazolam. This is a new authorised treatment for prolonged acute convulsive seizures, which is placed via syringe into the buccal cavity (the side of the mouth between the cheek and the gum). It may be considered as an alternative to rectal diazepam for this purpose.

These drugs are sedatives which have a calming effect on the brain and are able to stop a seizure. In very rare cases, these emergency drugs can cause breathing difficulties so the person must be closelywatched until they have fully recovered.

Training in the administration of buccal midolazam and rectal diazepam is essential and is providedby the specialist nurse with clinical responsibility for the treatment of the particular child. Special training should be updated annually.

Administration of Buccal Midazolam and Rectal Diazepam

Any child requiring rectal buccal midolazam or diazepam should have his/her medication reviewedevery year. As an additional safeguard, each child requiring buccal midolazam or rectal diazepam should have his/her own specific healthcare plan that will focus exclusively on this issue.

All

interested parties should be signatories to this document. An example is reproduced in Appendix 11 below.

Buccal midolazam and rectal diazepam can only be administered in an emergency if an accredited first-aider, trained in mouth to nose/mouth resuscitation, is easily accessible (that is only one or twominutes away). At least one other member of staff must be present as well.

Arrangements should be made for two adults to be present for such treatment, at least one of whom isthe same sex as the child; this minimises the potential for accusations of abuse. The presence of two adults can also make it much easier to administer treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

Staying with the child afterwards is important as buccal midolazam and diazepam may cause drowsiness. Moreover, those who administer buccal midolazam and rectal diazepam should be aware that there could be a respiratory arrest: if breathing does stop, a shake and a sharp voice should usually start the child breathing again; if this does not work, it will be necessary to give mouth to mouth resuscitation.

Functional Neurological Disorder (Functional/Non-epileptic seizures)What is Functional Neurological Disorder?

Functional Neurological Disorder (FND) is the diagnosis given when there is a problem with how thebrain/nervous system is functioning, rather than a disease. Symptoms may appear similar to neurological conditions such as Multiple Sclerosis, Parkinson's disease and Epilepsy, and are associated with similar levels of disability and distress.

Other diagnostic names may be given which come under the same diagnostic umbrella. Such as Functional Movement Disorder, Functional Seizure Disorder (may be referred to as Non-Epileptic Attack Disorder or dissociative seizures), Functional Dystonia, Functional Cognitive Disorder, and others relating to bodily functions. These diagnostic names may be used if a person is experiencingspecific/isolated symptoms.

Designated Members of Staff

Designated members of staff will be trained in:

- recognising symptoms of Functional Neurological Disorder
- responding appropriately to a request for help from another member of staff

- recognising when emergency action is necessary and what that action is

- keeping appropriate records of medical treatment

ALL Members of Staff

In additional to this, **ALL** members of staff will be:

- briefed on how to recognise the symptoms of FND and if a child is experiencing symptoms. This will usually be carried out during staff inset at the start of a new academic year by a trained member of staff or School Nursing Team. This is eithervirtually or face to face.

- aware of this policy, usually as part of their induction process.

- aware of how to check if a child is on the medical register.

- aware of how to access the emergency plan for FND pupils, how to support them,who the designated members of staff are, and the policy on how to access their help.

What Causes It?

It is currently believed that the seizures are the brain's response to overwhelming stress, but there may be other causes. For some people they may have been triggered by a traumatic incident (such as abuse, an accident, or death of a loved one), and for others an accumulation of stress over time. Stresstriggers can be both physical (e.g. pain, trauma to the body following an accident or operation, or illness) or emotional. Many people can be confused by the diagnosis as they do not feel particularly stressed prior to a seizure. Triggering factors, such as physical injury and comorbid disease, may alsobe important.

What are the Signs of the Condition?

Symptoms may include:

- Fatigue
- Cognitive difficulties
- Memory loss
- Confusion when coming around from the seizure
- Temporary paralysis of parts of the body
- Movement and motor symptoms such as tremors, limb weakness, episodes of paralysis,altered gait, muscle spasms or fixed joints.
- Sensory symptoms such as altered sensation or visual disturbances.
- Seizures which resemble those associated with Epilepsy or syncope.

What is the Treatment for the Condition?

Successful, early diagnosis and treatment helps the person understand what is going on and how it can be treated. It is recognised that the sooner treatment is started, the better chance a person has ofrecovery/symptom management.

Treatment plans must be tailored to an individual pupil's need, and it is important that collaborativecare is accessible. This may include treatment from neuro-physiotherapy (specific evidence-based physiotherapy which is tailored around retraining the brain), neuro-psychotherapy (such as CBT to help manage symptoms and possible triggers), occupational therapy, and other associated therapies dependant on symptoms.

Treatment outcomes are variable. Not all people can improve, but evidence from randomised trialsindicate that appropriate treatment can be highly effective for some.

Treatment in school depends largely on the medical advice and the specific symptoms displayed by an individual pupil. Medications such as antidepressants or neuropathic painkillers are sometimes helpful in treating FND however medication rarely fixes the symptoms on its own. It can be useful inpromoting sleep, improving pain, improving low mood and reducing worry.

Treatment will be outlined in the pupil individual healthcare plan.

What Arrangements are in Place at our Academy?

Healthcare Plan

An individual healthcare plan is needed when a pupil has FND .

Parents/carers and health care professionals should provide information to the SENDCO at the academy so that it can be incorporated into the individual healthcare plan, detailing the particularpattern of an individual child's symptoms and diagnosis.

If a child experiences a seizure whilst at the academy, details should be recorded and communicatedto parents/carers including:

- any factors which might possibly have acted as a trigger to the seizure – for examplevisual/auditory stimulation, anxiety or upset.
- any unusual 'feelings' which the child reported prior to the seizure
- the parts of the body demonstrating seizure activity, such as limbs or facial muscles
- the time when the seizure happened and its duration
- whether the child lost consciousness

- whether the child was incontinent

The above information will help parents/carers to give the child's specialist more accurate information about seizures and their frequency. In addition, it should form an integral part of the academy's emergency procedures and relate specifically to the child's individual healthcare plan. The healthcare plan should clearly identify the type or types of seizures, including descriptions of the seizure, possible triggers and whether emergency intervention may be required.

Children with FND should be included in all activities. Extra care may be needed in some areas such as participating in DT or science lessons. The Lead Medical Practitioner should discuss any safety issues with the child and parents/carers as part of the healthcare plan, and these concerns should be communicated to members of staff.

Emergency Action

An ambulance should be called during a seizure if:

- it is the child's first seizure
- the child has injured him/herself badly
- the child has problems breathing after a seizure
- a seizure lasts longer than the period identified in the child's healthcare plan
- a seizure lasts for five minutes and members of staff do not know how long the seizuresusually last for a particular child
- there are repeated seizures, unless this is usual for the child, as described in the child's healthcare 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. Putting something soft under the child's head during a convulsive seizure will help to protect it from injury.

Nothing should be placed in the child's mouth. After a convulsive seizure has stopped, the pupil should be placed in the recovery position and a member of staff should stay with him/her until thechild has fully recovered.

Further guidance

The following website has a wealth of information about FND including symptoms, causes,treatment, FAQ and fact sheets.

https://www.neurosymptoms.org/en/

Unacceptable Practice

The DfE's statutory guidance makes it very clear that governing bodies and/or Trust boards should ensure that the academy's 'Policy on Supporting Pupils with Medical Conditions' is explicit about what practice is not acceptable. Though most schools have for many years implemented exemplary practice to ensure that children with medical needs are fully supported, it is, nevertheless,

recommended that they retain the information listed below which is taken from the DfE document. If nothing else, it will enable governors to demonstrate unequivocally to a scrutinising authority that they are not adhering to or advocating practices that are deemed unacceptable, prejudicial or which promote social exclusion.

Although academy staff should use their discretion and judge each case on its merits whilst referencing the child's individual healthcare plan, it is **NOT** considered acceptable practice to:

- prevent children from easily accessing their inhalers and medication and administering theirmedication when and where necessary
- assume that every child with the same condition requires the same treatment
- ignore the views of the child or their parents/carers; or ignore medical evidence or opinion(although this may be challenged)
- 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 healthcareplans
- if the child becomes ill, send them to the school office or medical room unaccompanied orwith someone unsuitable
- penalise children for their attendance record if their absences are related to their medicalcondition, such as hospital appointments
- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to inorder to manage their medical condition effectively
- require parents/carers, or otherwise make them feel obliged, to attend the academy to administer medication or provide medical support to their child, including assisting withtoileting issues. No parent/carer should have to give up working because the academy isfailing to support their child's medical needs
- prevent children from participating, or create unnecessary barriers which would hinder their participation in any aspect of academy life, including school trips by, for example, requiringparents/carers to accompany the child

Complaints

Similarly, to the stance adopted above, the DfE's statutory guidance requires that governing bodies ensure that the academy's policy is crystal clear. It needs to set out how complaints concerning the support provided to pupils with medical conditions may be made and how they will be handled.

Should parents/carers or pupils be dissatisfied with the support provided, they should discuss their concerns directly with the academy. If, for whatever reason, this does not resolve the issue, they may make a formal complaint via the academy's existing complaints procedure which can be found on theacademy's website.

Administration of Medication to Pupils (Appendix 1)
Agreement between Parents and Academy (Including paracetamol)

In order to keep the administration of medication to a minimum, the Head of school should consider requesting that parents administer the daily doses out of school hours. However, if this is not possible, it will be necessaryfor the academy and parents to make a formal agreement to enable members of staff to administer medicationto pupils during the school day by completing the form below.

In most cases only medication that the child's doctor has prescribed can be administered, hence school staff should not administer 'over-the-counter' medication. However, at the discretion of the Head of school, it is permissible for paracetamol to be administered provided that the practice is strictly controlled in the same way as is prescribed medication. Further information is given on page 6.

Note: Medicines must be kept in the original container as dispensed by the pharmacy.

Part 1 – To be Completed by Parent/Carer	
To the Head of school: *(addname)*	**Academy name:**
My child *(name)* _____ Date of birth:_____ Class_____has the following medical condition _____ I wish for him/her to have the following medicine administered by school staff, as indicated below:	
Name of Medication:	
Dose/Amount to be given:	
Time(s) at which to be given:	
Means of administration:	
How long will the child require this medication to be administered?	

Known side effects and any special precautions (please attach details)
Procedures to take in case of emergency (please attach details)

Emergency Contact 1	***Emergency Contact 2***
Name:_____	Name:_____
Tel: Work: _____	Tel: *Work*: _____
Tel: Home: _____	*Tel: Home*: _____
Relationship: _____	Relationship: _____

I undertake to deliver the medicine personally to the Head of school or Medication Coordinator and to replace it whenever necessary. I also undertake to inform the school immediately of any change of treatment that the doctor or hospital has prescribed.

Name:_____Signature:_____

Relationship to child: _____ Date: _____

Part 2 - To be completed by Head of school/Medication Coordinator

Confirmation of agreement to administer medicine

It is agreed that *(child)*_____will receive (*quantity and name of medicine)* _____every day at (*time medicine to be administered, for example,lunchtime or afternoon break)*_____.

*(Child)*_____ will be given medication or supervised whilst he/she takes it by (*name ofmember of staff)* _____.

This arrangement will continue until_____*(either the end date for thecourse of medicine or until the parents instruct otherwise).*

Name: _____ Signature: _____
Head of school/Medication Coordinator

School _____

Parental Request for Child to Carry andSelf-administer Medicine (Appendix 2)

This form must be completed by a parent/carer

To: Head of school: *(add name)*	
School: *(add school name)*	
Name of child:	Class:
Address:	
Name of Medication:	
Procedures to be taken in an emergency:	
Contact Information	

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

Name:_____Signature: _____

Daytime Tel no(s):_____Date:_____

Relationship to child:_____

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

Healthcare Plan for a Pupil with Medical Needs

(Appendix 3)

Details of Child and Condition	
Name of child:	*Add photo here*
Date of birth:	
Class/Form:	
Medical Diagnosis/Condition:	
Triggers:	
Signs/Symptoms:	

Treatments:
Has the Parental Consent Form been completed? *Yes/No* *(Medication cannot be administered without parental approval)*

Date:	Review Date:

Medication Needs of Child
Medication:
Dose:
Specify if any other treatments are required:
Can the pupil self-manage his/her medication? *Yes/No* If *Yes*, specify the arrangements in place to monitor this: Indicate the level of support needed, including in emergencies: *(some children will be able to takeresponsibility for their own health needs)*

Known side-effects of medication:
Storage requirements:
What facilities and equipment are required? *(such as changing table or hoist)*
What testing is needed? *(such as blood glucose levels):*
Is access to food and drink necessary? *(where used to manage the condition):* Yes/No Describe what food and drink needs to be accessed

Identify any dietary requirements:
Identify any environmental considerations *(such as crowded corridors, travel time between lessons):*

Action to be taken in an emergency *(If one exists, attach an emergency healthcare plan prepared by the child'slead clinician):*
Staff Providing Support
Give the names of staff members providing support *(State if different for off-site activities):*
Describe what this role entails:
Have members of staff received training? *Yes/No* (*details of training should be recorded on the Individual Staff Training Record, Appendix 4)*
Where the parent or child have raised confidentiality issues, specify the designated individuals who areto be entrusted with information about the child's condition:

Detail the contingency arrangements in the event that members of staff are absent:
Indicate the persons (or groups of staff) in school who need to be aware of the child's condition and thesupport required:
Other Requirements

Detail any specific support for the pupil's educational, social and emotional needs *(for example, how absences will be managed; requirements for extra time to complete exams; use of rest periods;additional support in catching up with lessons or counselling sessions)*

Emergency Contacts

Family Contact 1 Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____	***Family Contact 1*** Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____
Clinic or Hospital Contact Name:_____ Telephone: *Work*:_____	***GP*** Name:_____ Telephone: *Work*:_____
Signatures	
Signed *(Head of* *school)*	*Signed* _____ *(Medication Coordinator)*

Individual Staff Training Record – Administration of Medication (Appendix 4)

Name:_____Job:_____School: ___

Type of training received	**Date completed**	**Training Provided by**	***Trainer's Signature*** *I confirm that this employee has received the training detailed and is*	**Employee's Signature confirming receipt of training**	**Suggested review**

Record of Medication Administered in School (Appendix 5)

School: _____

Date	Pupil's Name	Time	Name of Medication	Dose Given	Any Reactions	Signature of Staff	Print Name

Parental Consent: Use of Emergency Salbutamol Inhaler Appendix 6

School Name:	
Name of child:	
Date of birth:	Class/Form:

Child showing symptoms of asthma/having an asthma attack

1. I can confirm that my child has been diagnosed with asthma/has been prescribed an inhaler *[delete as appropriate].*

2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring withthem to school every day.

3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or isunusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Name:_____Signature: _____

Date:_____Relationship to child:_____

Address:_____

_____

Daytime Tel no(s):_____

Specimen letter to inform parents that the emergency salbutamol inhaler was used (Appendix 7)

Child's name: _____

Class: _____

Date of Incident: _____

Dear *[enter name of parent(s)]*

I thought I would drop you a line to let you know that *[enter child's first name]* experienced problems with *his/her breathing today. This happened when *[enter details]*

*A member of staff helped *[enter child's first name]* to use *his/her asthma inhaler.

*Unfortunately, *[enter child's first name]* did not have *his/her own asthma inhaler with *him/her, so a member of staff helped *him/her to use the school's emergency asthma inhaler, which contains salbutamol. *[Enter child's first name]* took *[enter number]* puffs on the inhaler.

* Unfortunately, *[enter child's first name]* own asthma inhaler was not working, so a member of staff helped *him/her to use the school's emergency asthma inhaler which contains salbutamol. *[Enter child's first name]* took *[enter number]* puffs on the inhaler.

Although *[enter child's first name]* soon felt a lot better, I think it might be a good idea if you were to take *him/her to see the family doctor for a check-up.

Yours sincerely

[Enter signature]

*Head of school/Medication Coordinator

[**Delete as appropriate*]

Emergency Action in the Event of an Asthma Attack

(Appendix 8)

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of salbutamol via the spacer
- If there is no immediate improvement, continue to give twopuffs at a time every two minutes, up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until he/she feels better. The child can return to school activitieswhen he/she feels better
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE
- If an ambulance does not arrive in 10 minutes give another10 puffs in the same way

Emergency Action: Epilepsy - First Aid for allSeizures (Appendix 9)

▫ Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course

- Check the time the child starts to fit
- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements
- Do not try to put anything at all between the teeth
- Do not give anything to drink
- Loosen tight clothing around the neck, remembering that this could frighten a semiconscious childand should be done with care
- Arrange for other children to be escorted from the area, if possible
- Call for an ambulance if:
    - a seizure shows no sign of stopping after a few minutes
    - a series of seizures take place without the individual properly regaining consciousness
- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/ unconscious) position, to aid breathing and general recovery. Wipe away salivafrom around the mouth
- Be reassuring and supportive during the confused period which often follows this type of seizure.If rest is required, arrangements should be made for this purpose
- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrangeto keep spare clothes at school if this is a regular occurrence

If a child is known to have epilepsy:

- It is not usually necessary for the child to be sent home following a seizure, but each child is different. If the Head of school feels that the period of disorientation is prolonged, it might be wise to contact the parents. Ideally, a decision will be taken in consultation with the parents when thechild's condition is first discussed, and a Healthcare Plan drawn up
- If the child is not known to have had a previous seizure medical attention should be sought
- If the child is known to have diabetes this seizure may be due to low blood sugar (a hypoglycaemicattack) in which case an ambulance should be summoned immediately

Emergency Action: First Aid for Children Known to HaveEpilepsy and Prescribed Rectal Diazepam

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course.
- Check the time the child starts to fit
- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements
- Do not try to put anything at all between the teeth
- Do not give anything to drink
- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care
- Arrange for other children to be escorted from the area, if possible
- Rectal diazepam must only be given to a child with a prescription that a Consultant Paediatrician hasendorsed and updated annually
- Rectal diazepam must only be administered in an emergency by an appropriately trained member of staff in the presence of at least one other member of staff
- Rectal diazepam must only be administered if a trained First Aider is on site
- If the child has been convulsing for five minutes and there is no suggestion of the convulsion abating,the first dose of rectal diazepam should be given. The medication should indicate the name of child, the date of birth, date of expiry, contents and the dosage to be administered
- If after a further five minutes

  (a) a seizure shows no sign of stopping or
  (b) a series of seizures takes place without the individual properly regaining consciousness, then call an ambulance

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) positionto aid breathing and general recovery. Wipe away saliva from around the mouth
- Be reassuring and supportive during the confused period which often follows this type of seizure. Many children sleep afterwards and if rest is required, arrangements could be made for this purpose
- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence
- A child should be taken home after a fit if he/she feels ill

Individual Care Plan for the Administration of RectalDiazepam (Appendix 11)

This care plan should be completed by or in consultation with the medical practitioner

(Please use language appropriate to the lay person)

Details of Child and Condition	
Name:	Class:
Date of birth:	
Identify the seizure classification and/or description of seizures which may require rectal diazepam *(Record all details of seizures, for example goes stiff, falls, convulses down both sides of body,convulsions last 3 minutes etc. Include information re: triggers, recovery time etc. If in status epileptics, note whether it is convulsive, partial or absence)*	
Usual duration of seizure?	
Other useful information:	
Diazepam Treatment Plan	

When should rectal diazepam be administered? *(Note here should include whether it is after a certainlength of time or number of seizures)*

Initial dosage: how much rectal diazepam is given initially? *(Note recommended number of milligrams for this person*)

What are the usual reactions to rectal diazepam?

What action should be taken if there are difficulties in the administration of rectal diazepam *such as constipation/diarrhoea?*

Can a second dose of rectal diazepam be given? *Yes/No*

If ***Yes***, after how long can a second dose of rectal diazepam be given? (*state the time to have elapsed before re-administration takes place)*

How much rectal diazepam is given as a second dose? *(state the number of milligrams to be given and how many times this can be done after how long)*

When should the person's usual doctor be consulted?

When should 999 be dialled for emergency help?

▫ if the full prescribed dose of rectal diazepam fails to control the seizure *Yes/No* ·

Other (Please give details)

Who Should:

- administer the rectal diazepam? *(ideally someone should be trained in at least 'EmergencyAid,' preferably 'First Aid at Work'):*

- witness the administration of rectal diazepam? *(this should normally be another member ofstaff of the same sex):*

Who/where needs to be informed?

Parent_____Tel: _____
Prescribing Doctor:_____Tel:_____

Other:_____Tel: _____

Precautions: under what circumstances should rectal diazepam not be used?
(forexample, Oral Diazepam already administered within the last .....minutes)

All occasions when rectal diazepam is administered must be recorded on the "Record ofUse of Rectal Diazepam" log sheet (Appendix 12)

This plan has been agreed by the following:

Prescribing Doctor

Name_____Signature_____Date_____

Authorised person(s) trained to administer rectal diazepam

Name_____Signature_____Date_____

Name_____Signature_____Date_____

Parent

Name_____Signature_____Date_____

Head of school/Medical Coordinator

Name_____Signature_____Date_____

This form should be available at every medical review of the patient and copies held by the GP and the school.

Expiry date of this form:_____

Copy holders to be notified of any changes by: _____

Record of Use of Rectal Diazepam (Appendix 12)

Name of Child:_____Class:_____

Date:					
Recorded by:					
Type of seizure:					
Length and/or number of seizures:					
Initial dosage:					
Outcome:					
Second dosage (if any):					
Outcome:					
Observations:					
Parent informed:					
Prescribing doctor informed:					
Other information:					
Witness:					
Name of Parent supplying dosage:					
Date delivered to school:					