



Supporting Pupils with Medical Conditions Policy

Last Review Date:	15 June 2022
This Review Date:	June 2022
Approved by Governors:	11 July 2022
Next Review Date:	June 2024
Reviewer:	N Craig (Medical Lead)

Signed.....

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1. Aims

This policy aims to ensure that:

- › Pupils, staff and parents understand how our school will support pupils with medical conditions
- › Pupils with medical conditions are properly supported to allow them to access the same education as other pupils, including school trips and sporting activities

The governing board will implement this policy by:

- › Making sure sufficient staff are suitably trained
- › Making staff aware of pupils' conditions, where appropriate
- › Making sure there are cover arrangements to ensure someone is always available to support pupils with medical conditions
- › Providing supply teachers with appropriate information about the policy and relevant pupils
- › Developing and monitoring individual healthcare plans (IHPs)

2. Legislation and statutory responsibilities

This policy meets the requirements under [Section 100 of the Children and Families Act 2014](#), which places a duty on governing boards to make arrangements for supporting pupils at their school with medical conditions.

It is also based on the Department for Education's statutory guidance on [supporting pupils with medical conditions at school](#).

3. Roles and responsibilities

3.1 The governing board

The governing board has ultimate responsibility to make arrangements to support pupils with medical conditions. The governing board will ensure that sufficient staff have received suitable training and are competent before they are responsible for supporting children with medical conditions, ensuring they access the same opportunities as their peers.

3.2 The headteacher

The headteacher will:

- › Make sure all staff are aware of this policy and understand their role in its implementation
- › Ensure that there is a sufficient number of trained staff available to implement this policy and deliver against all individual healthcare plans (IHPs), including in contingency and emergency situations
- › Ensure that all staff who need to know are aware of a child's condition
- › Take overall responsibility for the development of IHPs with external professional support.
- › Make sure that school staff are appropriately insured and aware that they are insured to support pupils in this way
- › Contact the school nursing service in the case of any pupil 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
- › Ensure that systems are in place for obtaining information about a child's medical needs and that this information is kept up to date

3.3 Staff

Supporting pupils with medical conditions during school hours is not the sole responsibility of one person. Any member of staff may be asked to provide support to pupils with medical conditions, although they will not be required to do so. This includes the administration of medicines.

Those staff who take on the responsibility to support pupils with medical conditions will receive sufficient and suitable training, and will achieve the necessary level of competency before doing so.

Teachers will consider the needs of pupils with medical conditions that they teach. All staff will know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help.

3.4 Parents

Parents will:

- › Provide the school with sufficient and up-to-date information about their child's medical needs
- › Be involved in the development and review of their child's IHP and may be involved in its drafting
- › Carry out any action they have agreed to as part of the implementation of the IHP, e.g. provide medicines and equipment, and ensure they or another nominated adult are contactable at all times
- › Notify the school as quickly as possible of any changes to medical need or care plan.
- › Take responsibility for ensuring all necessary medicines are accessible in school and in date.

3.5 Pupils

Pupils with medical conditions will often be best placed to provide information about how their condition affects them. Pupils should be fully involved in discussions about their medical support needs and contribute as much as possible to the development of their IHPs. They are also expected to comply with their IHPs.

3.6 School nurses and other healthcare professionals

Our school nursing service will notify the school when a pupil has been identified as having a medical condition that will require support in school. This will be before the pupil starts school, wherever possible. They may also support staff to implement a child's IHP.

Healthcare professionals, such as GPs and ,paediatrician will liaise with the school's nurses and notify them of any pupils identified as having a medical condition. They may also provide advice on developing IHPs.

4. Equal opportunities

Our school is clear about the need to actively support pupils with medical conditions to participate in school trips and visits, or in sporting activities, and not prevent them from doing so.

The school will consider what reasonable adjustments need to be made to enable these pupils to participate fully and safely on school trips, visits and sporting activities.

Risk assessments will be carried out so that planning arrangements take account of any steps needed to ensure that pupils with medical conditions are included. In doing so, pupils, their parents and any relevant healthcare professionals will be consulted.

5. Being notified that a child has a medical condition

When the school is notified that a pupil has a medical condition, the process outlined below will be followed to decide whether the pupil requires an IHP.

The school will make every effort to ensure that arrangements are put into place within 2 weeks, or by the beginning of the relevant term for pupils who are new to our school.

6. Individual healthcare plans

The headteacher has overall responsibility for the development of IHPs for pupils with medical conditions. This has been delegated to our medical lead.

Plans will be reviewed at least annually, or earlier if there is evidence that the pupil's needs have changed.

Plans will be developed with the pupil's best interests in mind and will set out:

- › What needs to be done
- › When
- › By whom

Not all pupils with a medical condition will require an IHP. It will be agreed with a healthcare professional and the parents when an IHP would be inappropriate or disproportionate. This will be based on evidence. If there is no consensus, the headteacher will make the final decision.

Plans will be drawn up in partnership with the school, parents and a relevant healthcare professional, such as the school nurse, specialist or paediatrician, who can best advise on the pupil's specific needs. The pupil will be involved wherever appropriate.

IHPs will be linked to, or become part of, any education, health and care (EHC) plan. If a pupil has SEN but does not have an EHC plan, the SEN will be mentioned in the IHP.

The level of detail in the plan will depend on the complexity of the child's condition and how much support is needed. The medical lead, will consider the following when deciding what information to record on IHPs:

- › The medical condition, it's triggers, signs, symptoms and treatments
- › The pupil's resulting needs, including medication (dose, side effects and storage) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage their condition, dietary requirements and environmental issues, e.g. 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 complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions

- › The level of support needed, including in emergencies. If a pupil is self-managing their medication, this will be clearly stated with appropriate arrangements for monitoring
- › Who will provide this support, their training needs, expectations of their role and confirmation of proficiency to provide support for the pupil's medical condition from a healthcare professional, and cover arrangements for when they are unavailable
- › Who in the school needs to be aware of the pupil's condition and the support required
- › Arrangements for written permission from parents and the headteacher for medication to be administered by a member of staff, or self-administered by the pupil during school hours
- › Separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the pupil can participate, e.g. risk assessments
- › Where confidentiality issues are raised by the parent/pupil, the designated individuals to be entrusted with information about the pupil's condition
- › What to do in an emergency, including who to contact, and contingency arrangements

7. Managing medicines

Prescription and non-prescription medicines will only be administered at school:

- › When it would be detrimental to the pupil's health or school attendance not to do so **and**
- › Where we have parents' written consent

The only exception to this is where the medicine has been prescribed to the pupil without the knowledge of the parents.

Pupils under 16 will not be given medicine containing aspirin unless prescribed by a doctor.

Anyone giving a pupil any medication (for example, for pain relief) will first check maximum dosages and when the previous dosage was taken. Parents will always be informed.

The school will only accept prescribed medicines that are:

- › In-date
- › Labelled
- › Provided in the original container, as dispensed by the pharmacist, and include instructions for administration, dosage and storage

The school will accept insulin that is inside an insulin pen or pump rather than its original container, but it must be in date.

All medicines will be stored safely in the first aid office behind reception. Pupils will be informed about where their medicines are at all times and be able to access them immediately. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens will always be readily available to pupils and not locked away.

Medicines will be returned to parents to arrange for safe disposal when no longer required.

7.1 Controlled drugs

[Controlled drugs](#) are prescription medicines that are controlled under the [Misuse of Drugs Regulations 2001](#) and subsequent amendments, such as morphine or methadone.

A pupil who has been prescribed a controlled drug may have it in their possession if they are competent to do so, but they must not pass it to another pupil to use. All other controlled drugs are kept in a secure cupboard in the school office.

Controlled drugs will be easily accessible in an emergency and a record of any doses used and the amount held will be kept.

7.2 Pupils managing their own needs

Pupils who are competent will be encouraged to take responsibility for managing their own medicines and procedures. This will be discussed with parents and it will be reflected in their IHPs.

Pupils will be allowed to carry their own medicines and relevant devices wherever possible. Staff will not force a pupil to take a medicine or carry out a necessary procedure if they refuse, but will follow the procedure agreed in the IHP and inform parents so that an alternative option can be considered, if necessary.

7.3 Unacceptable practice

School staff should use their discretion and judge each case individually with reference to the pupil's IHP, but it is generally not acceptable to:

- › Prevent pupils from easily accessing their inhalers and medication, and administering their medication when and where necessary
- › Assume that every pupil with the same condition requires the same treatment
- › Ignore the views of the pupil or their parents
- › Ignore medical evidence or opinion (although this may be challenged)
- › Send children with medical conditions home frequently for reasons associated with their medical condition or prevent them from staying for normal school activities, including lunch, unless this is specified in their IHPs
- › If the pupil becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable
- › Penalise pupils for their attendance record if their absences are related to their medical condition, e.g. hospital appointments
- › Prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- › Require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their pupil, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs
- › Prevent pupils from participating, or create unnecessary barriers to pupils participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany their child
- › Administer, or ask pupils to administer, medicine in school toilets

8. Emergency procedures

Staff will follow the school's normal emergency procedures (for example, calling 999). All pupils' IHPs will clearly set out what constitutes an emergency and will explain what to do.

If a pupil needs to be taken to hospital, staff will stay with the pupil until the parent arrives, or accompany the pupil to hospital by ambulance.

9. Training

Staff who are responsible for supporting pupils with medical needs will receive suitable and sufficient training to do so.

The training will be identified during the development or review of IHPs. Staff who provide support to pupils with medical conditions will be included in meetings where this is discussed.

The relevant healthcare professionals will lead on identifying the type and level of training required and will agree this with the Medical Lead. Training will be kept up to date.

Training will:

- › Be sufficient to ensure that staff are competent and have confidence in their ability to support the pupils

- › Fulfil the requirements in the IHPs
- › Help staff to have an understanding of the specific medical conditions they are being asked to deal with, their implications and preventative measures

Healthcare professionals will provide confirmation of the proficiency of staff in a medical procedure, or in providing medication.

All staff will receive training so that they are aware of this policy and understand their role in implementing it, for example, with preventative and emergency measures so they can recognise and act quickly when a problem occurs. This will be provided for new staff during their induction.

10. Record keeping

The governing board will ensure that written records are kept of all medicine administered to pupils for as long as these pupils are at the school. Parents will be informed if their pupil has been unwell at school.

IHPs are kept in a readily accessible place which all staff are aware of.

11. Liability and indemnity

The governing board will ensure that the appropriate level of insurance is in place and appropriately reflects the school's level of risk.

12. Complaints

Parents with a complaint about their child's medical condition should discuss these directly with the Medical Lead in the first instance. If the Medical Lead cannot resolve the matter, they will direct parents to the school's complaints procedure.

13. Monitoring arrangements

This policy will be reviewed and approved by the governing board every two years.

14. Links to other policies

This policy links to the following policies:

- › Complaints
- › Equality and diversity
- › First aid
- › Health and safety
- › Safeguarding
- › Special educational needs information report and policy
- › Intimate care policy

Appendix A: Good practice

Good Practice Points for Asthma Care

People with asthma have airways which narrow as a reaction to various triggers. The narrowing or obstruction of the airways causes difficulty in breathing and can usually be alleviated with medication taken via an inhaler.

Schools can hold salbutamol inhalers for emergency use but if a child diagnosed with asthma may need to use the school's emergency inhaler, this possibility should be explained in their Care Plan and schools should have asked for parent's consent at the same time. For further information and guidance, please see Guidance on the use of emergency salbutamol inhalers in schools, Department for Health, March 2015.

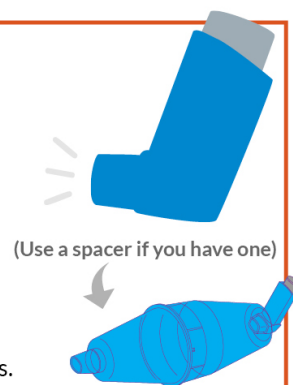
Schools should also consider:

1. Keeping a register of children in school diagnosed with asthma together with copies of their parental consent forms enabling them to take medication, i.e. inhalers;
2. Preparing Care Plans for pupils whose asthma is so severe that it may result in a medical emergency;
3. Where to keep inhalers, including during offsite visits, so that they are stored safely but are readily available for children who need them, which may mean encouraging pupils of year 5 and above to carry their own inhalers. Arrangements should be considered on a case by case basis. If the pupil is too young or immature to take responsibility for their inhaler, it should be stored in a readily accessible safe place.
4. In special school all inhalers should be kept in classrooms, but accessible immediately, and should be administered by staff who have received training.
5. Asking parents to supply schools with a spare inhaler and spacer device for pupils who carry their own inhalers to store safely at school in case the original inhaler is accidentally left at home or the pupil loses it. This inhaler should have an expiry date beyond the end of the school year and parents should be asked to replace it if it does not. Schools should dispose of out of date inhalers regularly, either by returning them to parents or to the pharmacist.
6. How they will ensure that all inhalers are labelled with the following information: -
 - Pharmacist's original label;
 - Child's name and date of birth;
 - Name and strength of medication;
 - Dose;
 - Dispensing date; and
 - Expiry date.

7. Labelling children's spacer device, which is used with an inhaler often by younger children, and making arrangement with parents to ensure that it is sent home to be cleaned regularly, e.g. at the end of each term.
8. Taking appropriate disciplinary action, in line with their school's Behaviour and, if they have one, Managing Substance Related Incidents policies, if inhalers are misused by pupils or others. Inhalers are generally safe and, if a pupil took another pupil's inhaler, it is unlikely that that pupil would be adversely affected; however medical advice should be sought.
9. The arrangements for monitoring inhaler use, and how parents will be notified if their child is using the inhaler excessively
10. How to ensure that staff running PE lessons and sports activities are aware that physical activity will benefit pupils with asthma, but that these pupils may need to use their inhaler 10 minutes before exertion. The inhaler **MUST** be available during PE and games. If pupils are unwell they should not participate.
11. How they will ensure that pupils who have a particular trigger for their asthma, such as animal fur, glue, nuts etc. can avoid those substances

What to do if a child is having an asthma attack

- 1 Help them sit up straight and keep calm.
- 2 Help them take one puff of their reliever inhaler (usually blue) every 30-60 seconds, up to a maximum of 10 puffs.
- 3 **Call 999 for an ambulance if:**
 - their symptoms get worse while they're using their inhaler – this could be a cough, breathlessness, wheeze, tight chest or sometimes a child will say they have a 'tummy ache'
 - they don't feel better after 10 puffs
 - you're worried at any time.
- 4 You can repeat step 2 if the ambulance is taking longer than 15 minutes.



IMPORTANT! This asthma attack information is not designed for children using a SMART or MART regime. If they do not have a reliever inhaler, call an ambulance. Then speak to their GP or asthma nurse to get the correct asthma attack information for the future.

Further source of information:

Asthma UK

Tel: 0300 222 5800

Email: info@asthma.org.uk

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

Good Practice Points for the Administration of Auto Adrenaline Injectors

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to the allergen, which may be a certain food or other substance, but may occur after a few hours. Auto adrenaline injectors should only be administered by staff who have volunteered and been trained by the appropriate health professional. Schools should have obtained parental consent and prepared a Care Plan for the child on becoming aware that the child has been prescribed this medication.

An auto adrenaline injector (AAI) is a preloaded pen device, which contains a single measured dose of adrenaline for administration in cases of anaphylaxis. It is not possible to give too large a dose from one device used correctly in accordance with the child's Care Plan, so even if it is given inadvertently it is unlikely to do any harm. However medical advice should be obtained as soon as possible after the medication is administered. Auto adrenaline injectors should only be used for the person for whom it is prescribed.

National guidance on AAI's within school was released by the DfE in September 2017 and this should be considered as a supplement to this guidance. The DfE Guidance can be found at: <https://www.gov.uk/government/publications/using-emergency-adrenaline-auto-injectors-in-schools>

Schools should consider:

1. Where to safely store the AAI, in the original box, at room temperature and protected from heat and light, so that it is readily available. If the Care Plan records that the pupil is competent then the AAI can be carried on their person
2. What systems can be put in place to check, termly, the AAI expiry dates and discolouration of contents so that parents can be asked to dispose of and replace medication.
3. Ensuring that all staff know that **immediately after the AAI is administered, a 999-ambulance call must be made and parents notified**. If two adults are present, the 999 call should be made at the same time as the administration of the AAI. The used AAI must be given to the ambulance personnel.
4. The use of the AAI must be recorded on the School Record of Medication Administered, with time, date, and full signature of the person who administered it.
5. Reminding parents that, if the AAI has been administered, they must renew it before the child returns to school.
6. Ensuring that the pupil is accompanied by an adult, who has been trained to administer the AAI on off-site visits, and that the AAI is available and safely stored at all times during the visit.

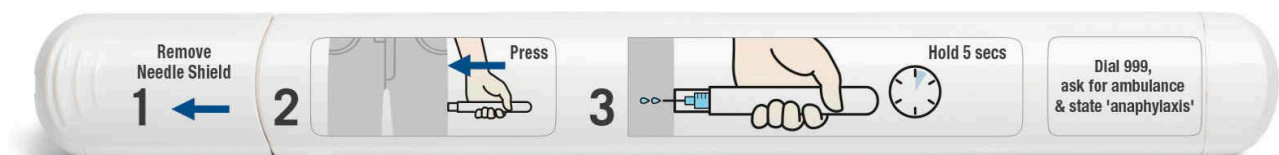
Administering EpiPen



Administering Jext



Administering emerade



Further source of information

The Anaphylaxis Campaign

Helpline: 01252 542029

Website: <https://www.anaphylaxis.org.uk>

Email: info@anaphylaxis.org.uk

Good Practice Points for the Management of Diabetes

Diabetes is a condition where the person's normal hormonal mechanisms do not control their blood sugar levels because the pancreas does not make any or enough insulin, because the insulin does not work properly, or both. There are two main types of diabetes:

Type 1 Diabetes develops when the pancreas is unable to make insulin. The majority of children and young people will have Type 1 diabetes and need to replace their missing insulin either through multiple injections or an insulin pump therapy.

Type 2 Diabetes is most common in adults, but the number of children with Type 2 diabetes is increasing, largely due to lifestyle issues and an increase in childhood obesity. It develops when the pancreas can still produce insulin but there is not enough, or it does not work properly.

Treating Diabetes

Children with Type 1 diabetes manage their condition by the following:-

- Regular monitoring of their blood glucose levels
- Insulin injections or use of insulin pump
- Eating a healthy diet
- Exercise

The aim of treatment is to keep the blood glucose levels within normal limits. Blood glucose levels need to be monitored several times a day and a pupil may need to do this at least once while at school.

Insulin therapy

Children who have Type 1 diabetes may be prescribed a fixed dose of insulin; other children may need to adjust their insulin dose according to their blood glucose readings, food intake, and activity levels. Children may use a pen-like device to inject insulin several times a day; others may receive continuous insulin through a pump.

Insulin pens

The insulin pen should be kept at room temperature but any spare insulin should be kept in the fridge. Once opened it should be dated and discarded after 1 month. Parents should ensure enough insulin is available at school and on school trips at all times.

Older pupils will probably be able to independently administer their insulin; however, younger pupils may need supervision or adult assistance. The pupil's individual Care Plan will provide details regarding their insulin requirements.

Insulin pumps

Insulin pumps are usually worn all the time but can be disconnected for periods during PE or swimming etc. The pumps can be discretely worn attached to a belt or in a pouch. They continually

deliver insulin and many pumps can calculate how much insulin needs to be delivered when programmed with the pupil's blood glucose and food intake. Some pupils may be able to manage their pump independently, while others may require supervision or assistance. The child's individual Health Care Plan should provide details regarding their insulin therapy requirements.

Medication for Type 2 Diabetes

Although Type 2 Diabetes is mainly treated with lifestyle changes e.g. healthy diet, losing weight, increased exercise, tablets or insulin may be required to achieve normal blood glucose levels.

Administration of Insulin injections

If a child requires insulin injections during the day, individual guidance/training will be provided to appropriate school staff by specialist hospital paediatric diabetic nurses, as treatment is individually tailored. A Care Plan should be prepared.

Best Practice Points for Managing Hypoglycaemia (hypo or low blood sugar) in Children Who Have Diabetes

Schools should offer all staff diabetes awareness training which will be provided by the paediatric diabetic nurses, if a child in the school has diabetes. Training should include how to prevent the occurrence of hypoglycaemia which occurs when the blood-sugar level falls. Staff who volunteer can also be trained in administering treatment for hypoglycaemic episodes.

Symptoms of diabetes can vary from person to person, therefore it will always be necessary for schools to prepare a Care Plan for children who have the condition and obtain parental consent to administer treatment. Often, this will be done when the nurse attends the staff training session if the parent is also able to attend to give their views

To prevent a hypo

1. Children must be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. Meals should not be unduly delayed due to extracurricular activities at lunchtimes, or detention sessions;
2. Offsite activities e.g. visits, overnight stays, will require additional planning and liaison with parent; and
3. Schools should ask parents to ensure that they provide the school with sufficient, in-date, quantities of the treatment that their child may require.

To treat a hypo

1. Staff should be familiar with pupil's individual symptoms of a "hypo" so that steps to treat the pupil can be taken at the earliest possible stage. Symptoms may include confrontational behaviour, inability to follow instructions, sweating, pale skin, confusion, and slurred speech;

2. If a meal or snack is missed, or after strenuous activity, or sometimes even for no apparent reason, the child may experience a “hypo”. Treatment might be different for each child, and will be set out in their Care Plan, but will usually be either dextrose tablets, or sugary drink, or Glucogel/Hypostop (dextrose gel) which should be readily available, not locked away and may be carried by the pupil. Expiry dates must be checked each term by the parent/carer.
3. Glucogel/Hypostop is used by squeezing it into the side of the mouth and rubbing it into the gums, where it will be absorbed by the bloodstream.
4. Once the child has started to recover a slower acting starchy food such as biscuits and milk should be given.
5. If the child is or becomes very drowsy, unconscious, or fitting, a 999 call must be made and the child put in the recovery position. Due to the risk of choking the caregiver should not attempt to give the child an oral treatment, i.e. a drink, tablets or food.
6. Parents should be notified that their child has experienced a hypo, informed of the treatment provided and asked to provide new stocks of medication.

Once the child has recovered the School Record of Medication Administered should be completed

Best Practice Guidance for Blood Glucose Monitoring for Children

The Care Plan will explain how frequently the pupil needs to check their blood glucose levels and will set out the method that should be used.

It is recommended that all staff use a fully disposable Unistik 3 Comfort Lancets device if they are undertaking patient blood glucose testing on a pupil. This is a single use device and the lancet remains covered once it has been used.

If a child has an insulin pump, individual arrangements will be made with a specialist nurse and parents to ensure school staff are fully trained in the management and use of the pump.

For children who self-test the use of Unistiks is not necessary and he/she will be taught to use a finger pricker device in which a disposable lancet will be inserted. This device can be purchased at a local chemist or in some cases may be provided by the Paediatric Diabetes Specialist nurse. The disposable lancet can be ordered on prescription via the pupil's GP.

Whenever possible, staff will encourage pupils to undertake their own finger prick blood glucose testing and management of their diabetes, encouraging good hand hygiene. However, in exceptional circumstances such as a pupil having a hypoglycaemic attack, it may be necessary for a member of staff to undertake the test.

How to use the Unistik lancet:

- Prior to the test wash hands
- Encourage pupil to wash their hands wherever possible
- Ensure all equipment is together on a tray including a small sharps box
- Where possible explain the procedure to the pupil
- Apply gloves before testing
- Use a meter which has a low risk for contamination then blood is applied to the strip such as an optium exceed or one touch ultra

- Ensure meter is coded correctly for the strips in use and that the strips are in date.
- Place the strip into the meter
- Prick the side of the finger using a Unistik comfort 3
- Apply blood to the test strip according to the manufacturer's instructions
- Once the test is completed put the used test strip and lancet directly into the sharps box
- Return the tray to a safe area/room
- Wash hands following the removal of gloves avoiding any possible contact with blood; use alcohol rub
- Record the blood glucose reading in the pupil's care plan/diary
- Parents are responsible for supplying all necessary equipment and medication
- Provision and disposal of a sharps box should be discussed individually with the Paediatric Diabetes Specialist Nurse

Further notes:

The Care Plan will document what action to take if the blood glucose result is higher or lower than expected.

Further sources of information:

Diabetes UK, Tel: 020 7424 1000, Email: info@diabetes.org.uk

Website: <https://www.diabetes.org.uk/>

Good Practice Points for Managing Eczema

Eczema (also known as dermatitis) is a non-contagious dry skin condition which affects people of all ages, including one in five children in the UK. It is a highly individual condition which varies from person to person and comes in many different forms.

In mild cases of eczema, the skin is dry, scaly, red, and itchy but in more severe cases the child's skin may experience weeping, crusting, and bleeding which can be exacerbated by constant scratching causing the skin to split and bleed and leaving it open to infection. In severe cases, it may be helpful and reassuring for all concerned if a Care Plan is completed. . If whole body or significant creaming is required, factors that will need to be taken into account might include:

- Who will do the creaming? (Including taking into account how much the child can do for him/herself depending on age, maturity etc., Permission needed from parents)
- How often does this need to happen? (How can this be planned around curriculum time etc.?)
- Where will the creaming take place? (Considering the need to ensure both privacy and safeguarding of the pupil and the safety of staff.)
- What medication and/or equipment will the parents provide and what may school need to provide (e.g. gloves etc.)?

These details would all need to be provided on the pupil's care plan.

Atopic eczema is the most common form. We still do not know exactly why atopic eczema develops in some people. Research shows a combination of factors play a part including genetics (hereditary) and the environment. Atopic eczema can flare up and then calm down for a time, but the skin tends to remain dry and itchy between flare ups. The skin is dry and reddened and may be very itchy, scaly and cracked. The itchiness of eczema can be unbearable, leading to sleep loss, frustration, poor concentration, stress, and depression.

There is currently no cure for eczema but maintaining a good skin care routine and learning what triggers a pupil's eczema can help maintain the condition successfully, although there will be times when the trigger is not clear. Keeping skin moisturised using emollients (medical moisturisers) is key to managing all types of eczema, with topical steroids commonly used to bring flare ups under control.

Good practice point for managing epilepsy

Epilepsy is a neurological condition that causes recurrent seizures. This is caused by abnormal electrical activity in the brain. Seizures can happen anytime anywhere. 60% of people with epilepsy there is no known reason for them to have developed epilepsy. The other 40% there is an underlying cause or brain trauma. About 1 in 133 people suffer from epilepsy.

Epilepsy is diagnosed through a good medical history and an eye witness account of the seizure. When it is suspected that a child has epilepsy the child is sent for tests such as EEG's and MRI to help support the diagnosis and to look for any structural abnormalities in the brain. There is a big problem with misdiagnosis, as some things that look like epilepsy are not epilepsy such as migraine and fainting.

There are two main types of seizures: focal and generalised.

- Generalized seizure is where the whole of the brain is affected and the electrical activity is coming from all over. These seizures are when the muscles relax and the person falls to the floor, they can become stiff and have generalized jerking of all four limbs. These are also the absence types of epilepsy.
- Focal seizures are when the electrical activity is localized to one part of the brain, these seizures can present with twitching in their face, hands, arms and legs. They can feel strong emotions, make unusual noises and have unusual behavior such as lip smacking, head turning to one side.

When you suspect a child to have a seizure, make sure you try and time the seizure, record what happened before, during and afterwards. If you have permission from parents a video is very helpful to make a diagnosis.

General first aid advice

- Managing a Tonic Clonic Seizure

If a child has a generalized tonic clonic seizure (jerking or all four limbs) it is important to stay as calm as possible. Reassure the other children in the classroom. Ensure that the child having the seizure cannot harm themselves

1. Check safety of the area
2. Move any potential dangerous object which the child could hurt themselves on
3. Cushion head with something soft – such as a small jumper (especially if on concrete to avoid injury)
4. Stay with the child throughout the seizure
5. After the seizure is over put into recovery position until completely recovered
6. Check the child for injury and maintain privacy and dignity throughout

DO NOT

1. Restrain the child
2. Do not move the child unless they are in direct danger
3. Put anything in their mouth
4. Do not give any food or drink

When to call for an AMBULANCE

1. If the seizure is going on for longer than 5 minutes
2. If it is the child's first seizure
3. If the child is injured
4. If you are concerned at any point

REMEMBER

- Keep a record of the seizure
- Time the seizure
- Description of the event if possible - how it started, what happened, how it finished
- Did anything happen before the seizure? i.e. bump to the head, argument, sleepy, do they have a fever.
- What happened during? i.e. were they stiff, floppy, jerking, eyes rolled, head turned etc.- were they incontinent
- What happened after? i.e. how long it took to recover, were they sleepy after, did they go back to normal and do they remember it.

Epilepsy can be controlled with regular medications, emergency medications, Ketogenic diet, surgery and VNS. The medications that we use to control epilepsy are strong and important to take regularly. When a child is prescribed an anti-epileptic medication, they are usually given a plan with how and when to take the medication. Usually they only take the medication twice a day however, there are some children who need a third dose in the day time. If the child was to vomit after the administration of the medication, unless it was a tablet and you can see it, we would advise not to repeat the dose as you are not sure how much has been absorbed.

If a dose is missed, a catch up dose may be given within 4 hours of the designated time. After the 4 hours, do not give the dose and carry on with the next dose. If a child was to miss a dose of medication, be aware that they may have more seizures as a result.

Epilepsy can have a significant impact on a child's achievement; they can experience problems with the visual/verbal learning process, reading, writing, speech language, numeracy, memory, psychosocial problems, concentration and behavior. We can help improve this through group work, providing written information as a prompt, making sure that the student has not missed anything, encourage note taking, cue cards, highlighting important information, rhymes, repetition and revision.

Every child with a diagnosis of epilepsy should have a health care plan in school with details on how to manage that child's seizure. Children with emergency medication also need an up-to-date care plan with details of when to give the medication. Most of the time the child will be prescribed Buccolam (midazolam), however if the child cannot take this, they will be prescribed a rectal emergency medication.

Guidelines for the administration of Bucolic (midazolam)

Bucolic (midazolam) is an emergency treatment for epilepsy, for prolonged convulsions and clusters of seizure activity. It is administered via the mouth in the Bucolic cavity (between the gum and the cheek)

Bucolic (midazolam) can only be administered by a member of the school staff, ideally someone who spends the most time with the student, who has been assessed and has been signed to say they have received the training and know what to do. Training of the designated staff will be provided by the school nurse and a record of the training undertaken will be kept by the head teacher for the schools records. Training must be updated annually. The training must be child specific, general Bucolic (midazolam) training can be done but each child who requires it must have their care plan reviewed and understood by the staff members who would be administering the Bucolic (midazolam).

Bucolic (midazolam) care plans should reflect the specific requirements of each case and further advice should be sought from the specialist nurse/consultant/GP

1. Buccolam (midazolam) can only be administered in accordance with an up-to-date written care plan with medical and parental input. If the dose changes it is the responsibility of the parent to have the care plan updates. Old care plans should be filed in the pupils records.
2. The Buccolam (midazolam) care plan should be renewed yearly. The school nurse will check with the parent/ carer that the dose remains the same
3. The care plan must be available each time the Buccolam (midazolam) is administered: if practical to be kept with the Buccolam (midazolam)
4. Buccolam (midazolam) can only be administered by designated staff, who has received training from the school nurse. A list of appropriately training staff will be kept.
5. The consent form and care plan must always be checked before the Buccolam (midazolam) is administered
6. It is recommended that the administration is witnessed by a second adult
7. The child should not be left alone until fully recovered
8. The amount of Buccolam (midazolam) that is administered must be recorded on the pupil's Buccolam (midazolam) record card. The record card must be signed with a full signature of the person who has administered the Buccolam (midazolam), timed and dated. Parents should be informed if the dose has been given in an emergency situation

9. Each dose of Buccolam (midazolam) must be labelled with the individual pupil's name and stored in a locked cupboard, yet readily available. The keys should be readily available to all designated staff
10. School staff must check expiry date of Buccolam (midazolam) each term. In special schools, where nurses are based on site, the school nurse may carry out this responsibility. It should be replaced by the parent/ carer at the request of the school or health staff. Please inform parents within a month of expiry to give them time to replace it.
11. All school staff designated to administer Buccolam (midazolam) should have access to a list of pupils who may require emergency Buccolam (midazolam). The list should be updated annually, and amended at other times as necessary.
12. All Buccolam (midazolam) training needs to be child specific. General training can be done but each individual care plan needs to be reviewed.
13. A Buccolam authorisation form should be completed by a consultant paediatrician outlining the dosage, and administration guidance from the doctor and signed parental consent confirming the dose. Within special schools best practice would be that parents are contacted before buccolam administration to establish if an earlier dose has been administered.

Appendix B: Process for developing individual care plans

