GREAT HEIGHTS ACADEMY TRUST

Supporting Pupils with Medical Needs Policy

January 2019

Statement of intent

Great Heights Academy Trust wishes to ensure that pupils with medical conditions receive appropriate care and support at school. This policy has been developed in line with the DfE's guidance released in Sept 2014: Supporting pupils at school with medical conditions.

Ofsted places a clear emphasis on meeting the needs of pupils with special educational needs and disabilities (SEND), and this includes children with medical conditions.

The Trust strives to always provide an inspirational, positive and welcoming environment where there is a sense of pride and fun and where everyone works together with confidence, enthusiasm and mutual respect. We aim to nurture academic, personal, spiritual and social development in a caring and professional manner so that all achieve their full potential and all can reach great heights.

1. Key roles and responsibilities

1.1. The local authority (LA) is responsible for:

1.1.1. Promoting cooperation between relevant partners and stakeholders regarding supporting pupils with medical conditions.

1.1.2. Providing support, advice and guidance to schools and their staff.

1.1.3. Making alternative arrangements for the education of pupils who need to be out of school for 15 days or more due to a medical condition.

1.2. The Trust is responsible for:

1.2.1. The overall implementation of the Supporting Pupils with Medical Conditions Policy and procedures of The Trust

1.2.2. Ensuring that the Supporting Pupils with Medical Conditions Policy, as written, does not discriminate on any grounds including, but not limited to: ethnicity/national origin, culture, religion, gender, disability or sexual orientation.

1.2.3. Handling complaints regarding this policy as outlined in the school's Complaints Policy.

1.2.4. Ensuring that all pupils with medical conditions are able to participate fully in all aspects of school life.

1.2.5. Ensuring that relevant training is delivered to staff members who take on responsibility to support children with medical conditions.

1.2.6. Guaranteeing that information and teaching support materials regarding supporting pupils with medical conditions are available to members of staff with responsibilities under this policy.

1.2.7. Keeping written records of any and all medicines administered to individual pupils and across the school population.

1.2.8. Ensuring the level of insurance in place reflects the level of risk.

1.3. The Principal (or a delegated representative) is responsible for:

1.3.1. The day-to-day implementation and management of the Supporting Pupils with Medical Conditions Policy and procedures of each Academy

1.3.2. Ensuring the policy is developed effectively with partner agencies.

1.3.3. Making staff aware of this policy.

1.3.4. Liaising with healthcare professionals regarding the training required for staff.

1.3.5. Making staff who need to know aware of a child’s medical condition.

1.3.6. Developing IHCPs.

1.3.7. Ensuring a sufficient number of trained members of staff are available to implement the policy and deliver IHCPs in normal, contingency and emergency situations.

1.3.8. If necessary, facilitating the recruitment of a member of staff for the purpose of delivering the promises made in this policy.

1.3.9. Ensuring the correct level of insurance is in place for teachers who support pupils in line with this policy.

1.3.10. Contacting the school nursing service in the case of any child who has a medical condition.

1.3.11. Organising first-aid training.

1.4. Staff members are responsible for:

1.4.1. Taking appropriate steps to support children with medical conditions.

1.4.2. Where necessary, making reasonable adjustments to include pupils with medical conditions into lessons.

1.4.3. Administering medication, if they have agreed to undertake that responsibility.

1.4.4. Undertaking training to achieve the necessary competency for supporting pupils with medical conditions, if they have agreed to undertake that responsibility.

1.4.5. Familiarising themselves with procedures detailing how to respond when they become aware that a pupil with a medical condition needs help.

1.4.6. If a child requires an injection a named staff member will be assigned and trained to become the person responsible for administering injections.

1.4.7. Ensuring that if they take children on an educational visit and/or sporting activity they are aware of all medical needs and are responsible for ensuring prescribed medication is taken with them.

1.5. School nurses are responsible for:

1.5.1. Notifying the school when a child has been identified with requiring support in school due to a medical condition.

1.5.2. Liaising locally with lead clinicians on appropriate support.

1.6. Parents and carers are responsible for:

1.6.1. Keeping the school informed about any changes to their child/children's health.

1.6.2. Completing a "Parental agreement for school to administer medicine" form before bringing medication into school.

1.6.3. Providing the school with the medication their child requires and keeping it up-to-date.

1.6.4. Collecting any leftover medicine at the end of the course or year.

1.6.5. Discussing medications with their child/children prior to requesting that a staff member administers the medication.

1.6.6. Where necessary, developing an IHCP for their child in collaboration with the Principal (or the person they delegate this responsibility to), other staff members and healthcare professionals.

2. Definitions

2.1. "Medication" is defined as any prescribed or over the counter medicine.

2.2. "Prescription medication" is defined as any drug or device prescribed by a doctor.

2.3. A "staff member" is defined as any member of staff employed at Great Heights Academy Trust including teachers.

3. Training of staff

3.1. Teachers and support staff will receive training on the Supporting Pupils with Medical Conditions Policy as part of their new starter induction.

3.2. Teachers and support staff will receive regular and ongoing training as part of their development as required.

3.3. Teachers who undertake responsibilities under this policy will receive appropriate training.

3.4. No staff member will be required to administer prescription medicines or undertake any healthcare procedures without undergoing training specific to the responsibility, including administering medication. Staff members who administer prescription medicines will have undertaken basic first aid training.

3.5. No staff member may administer drugs by injection unless they have received training in this responsibility.

3.6. The Chief Operations Officer will keep a record of training undertaken and a list of staff members qualified to undertake responsibilities under this policy.

3.7. Staff trained to carry out medical procedures specific to a pupils needs will be identified in their IHCP.

4. The role of the child

4.1. Children who are competent will be encouraged to take responsibility for managing their own medicines and procedures.

4.2. Where possible, pupils will be allowed to carry their own medicines and devices. Where this is not possible, their medicines will be located in an easily accessible location.

4.3. If pupils refuse to take medication or to carry out a necessary procedure, parents will be informed so that alternative options can be explored.

4.4. Where appropriate, pupils will be encouraged to take their own medication under the supervision of a teacher.

5. Individual Healthcare Plans (IHCPs)

5.1. Where necessary, an IHCP will be developed in collaboration with the pupil, parents/carers, Principal (or their named representative), special educational needs coordinator (SENCO) and medical professionals.

5.2. IHCPs will be displayed in the pupils classroom and the staffroom for all staff members, copies will be held in the school office on all sites. Parents will be notified of this to comply with GDPR.

5.3. IHCPs will be reviewed at least annually or when a child’s medical circumstances change, whichever is sooner.

5.4. Where a pupil has an Education, Health and Care (EHC) plan or special needs statement, the IHCP will be linked to it or become part of it.

5.5. Where a child is returning from a period of hospital education or alternative provision or home tuition, we will work with the LA and education provider to ensure that the IHCP identifies the support the child needs to reintegrate.

6. Medicines

6.1. Where possible, it is preferable for medicines to be prescribed in frequencies that allow the pupil to take them outside of school hours.

6.2. No child will be given any prescription or non-prescription medicines without written parental consent except in exceptional circumstances.

6.3. No pupil will be given medication containing aspirin without a doctor’s prescription.

6.4. Medicines MUST be in date, labelled, and provided in the original container (except in the case of insulin which may come in a pen or pump) with dosage instructions. Medicines which do not meet these criteria will not be administered.

6.5. A maximum of four weeks supply of the medication may be provided to the school at one time.

6.6. Medications will be stored in the school office on each site or in the case of emergency medication (ie inhalers) in the class teachers desk if necessary. Medication that needs to be kept in a refrigerator will be stored in the staffroom fridge at West Vale and KS1 and in the main office fridge at KS2.

6.7. Any medications left over at the end of the course will be returned to the child’s parents.

6.8. Pupils will never be prevented from accessing their medication.

6.9. Great Heights Academy Trust cannot be held responsible for side effects that occur when medication is taken correctly.

7. Administering medication

7.1. Teachers and support staff will receive training on the Medical Policy and administering medication as part of their new starter induction and will receive regular ongoing training as part of their development as required.

7.2. Medications will only be administered at school if it would be detrimental to the child not to do so.

7.3. Prior to staff members administering any medication, the parents/carers of the child must complete and sign the “Parental agreement for school to administer medicine” form.

7.4. Staff members may refuse to administer medication. If a class teacher refuses to administer medication, the Principal (or their representative) will delegate the responsibility to another staff member.

7.5. Where appropriate, pupils will be encouraged to take their own medication under the supervision of a teacher.

7.6. Written records will be kept of any medication administered to children.

8. Emergencies

8.1. Medical emergencies will be dealt with under the school's emergency procedures.

8.2. Where an IHCP is in place, it should detail:

- What constitutes an emergency?
- What to do in an emergency.

8.3. Pupils will be informed in general terms of what to do in an emergency, such as telling a teacher.

8.4. If a pupil needs to be taken to hospital, a member of staff will remain with the child until their parents arrive.

9. Asthma

9.1. Pupils with asthma or who have been prescribed an inhaler as a reliever will be identified, their condition recorded and their medication monitored using the asthma register.

9.2. The parents of pupils with asthma or who have been prescribed an inhaler as a reliever will complete an asthma care plan for their child and ensure school have in date medication.

9.3. Asthma information including relevant care plans and a copy of the asthma register will be available to all staff in each staffroom, school office and classroom.

9.4. From 1st October 2014 the Human Medicines Regulations 2014 will allow schools to keep a salbutamol inhaler for use in emergencies.

9.5. The nominated first aiders at each site, Zoe Marsden (Key Stage 2) and Bev Chamberlain (Key Stage One) and Jane Gravenor at West Vale will;

- be available to support in an emergency situation
- ensure inhalers are checked monthly
- ordering replacement inhalers are obtained before the expiry date
- ordering replacement spacers are re-ordered and replaced after use
- ensure empty/out of date inhalers are disposed of at the local Pharmacy

9.6. The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

9.7. The inhaler can only be used if the pupils inhaler is not available (for example, because it is empty or broken)

9.8. School First aid staff will be responsible for ensuring the protocol for the use of the emergency inhaler is followed and that all usages are recorded appropriately as per the administering medicines guidance.

10. First aid

10.1. The Greetland Academy accepts its responsibilities under the Health and Safety (First Aid) Regulations 1981.

10.2. The Principal (or a representative with delegated responsibility) will ensure that all policies are reviewed regularly, appropriate to the circumstances of the Great Heights Academy Trust and the supporting of pupils with medical conditions.

10.3. The Principal (or a representative with delegated responsibility) is responsible for organising first aid training.

10.4. All staff members are offered First Aid Training every 3 years annually. Unless first aid cover is part of a staff member's contract of employment, people who agree to become first aiders should do so on a voluntary basis.

10.5. The school staffroom is the academy's designated medical room and meets the DfE guidance specifically to:

- Be large enough to hold the necessary equipment
- Have washable surfaces and adequate heating, ventilation and lighting.
- Be kept clean and tidy at all times.
- Be positioned as near as possible to a point of access for transport to hospital.
- Have a sink with hot and cold water, if possible.
- Have drinking water and disposable cups.
- Have soap and paper towels.
- Have a suitable container with disposable waste bags.

10.6. The Greetland Academy first aid locations can be found in the Key Stage One conservatory, Key Stage Two office and in both kitchens. At West Vale first aid boxes are kept in each classroom, KS1/2 cloakroom school office, staffroom and kitchen. These locations contain a sufficient number of suitable provisions to enable the administration of first-aid.

10.7. The Trust has travelling first aid containers for use during school trips and off-site visits, which are stored in the KS2 staffroom first aid filing cabinet, the Key Stage One medicines cabinet and in the classrooms at West Vale

10.8. Inventories are kept of all first aid supplies including expiry dates. Full lists can be found in each first aid container.

10.9. First aiders will be made aware of any pupils with medical conditions and treat them accordingly, should the need for first aid arise.

10.10. The main duties of the first aiders are to give immediate help to casualties with common injuries and those arising from specific hazards or medical conditions at the The Trust, and ensure that an ambulance or other professional medical help is called where appropriate.

10.11. The Principal will ensure that procedures are in place to report any major or fatal injuries without delay (e.g. by telephone), as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Other reportable injuries will be reported within 10 days.

11. Reasonable adjustments

11.1. The Trust will meet its duties under the Equality Act 2010.

11.2. The Trust will make reasonable adjustments for pupils with medical conditions, including the provision of auxiliary aids.

12. Avoiding unacceptable practice

12.1. The Trust understands that the following behaviour is unacceptable:

- Assuming that pupils with the same condition require the same treatment.
- Ignoring the views of the pupil and/or their parents.
- Ignoring medical evidence or opinion.
- Sending pupils home frequently or preventing them from taking part in activities at school.
- Sending the pupil to the medical room or school office alone if they become ill.
- Penalising pupils with medical conditions for their attendance record where the absences relate to their condition.
- Making parents feel obliged or forcing parents to attend school to administer medication or provide medical support, including toilet issues.
- Creating barriers to children participating in school life, including school trips.
- Refusing to allow pupils to eat, drink or use the toilet when they need to in order to manage their condition.

13. Insurance

13.1. Staff who undertake responsibilities within this policy are covered by the Trust's insurance, this includes administering both prescription and non-prescription medication.

14. Complaints

14.1. The details of how to make a complaint can be found in the Complaints Policy:

14.1.1. Stage 1 - Complaint Heard by Staff Member

14.1.2. Stage 2 – Teacher (Or Principal if immediately involved)

14.1.3. Stage 2 - Complaint Heard by Principal or CEO

14.1.4. Stage 3 – Complaint Heard by Trust Board or Independent Appeal Committee Complaints Appeal Panel (CAP)

Appendix 1

Common conditions

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

ASTHMA

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have asthma in the UK.

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

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

Medicine and Control

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

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child’s name.

Inhalers should always be available during physical education, sports activities and educational visits.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:
- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:
- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

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

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.
Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

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

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

What to do in an asthma attack

It is essential for people who work with children and young people with asthma to know how to recognise the signs of an asthma attack and what to do if they have an asthma attack.

What do do

- Keep calm
- Encourage the child or young person to sit up and slightly forward – do not hug or lie them down
- Make sure the child or young person takes two puffs of reliever inhaler (usually blue) immediately – preferably through a spacer
- Ensure tight clothing is loosened
- Reassure the child

If there is no immediate improvement

Continue to make sure the child or young person takes one puff of reliever inhaler every minute for five minutes or until their symptoms improve.

Call 999 or a doctor urgently if:

- The child or young person's symptoms do not improve in 5-10 minutes
- The child or young person is too breathless or exhausted to talk
- The child or young person's lips are blue
- You are in doubt

Ensure the child or young person takes one puff of their reliever inhaler every minute until the ambulance or doctor arrives.

Common signs of an asthma attack are:

- coughing
- shortness of breath
- wheezing
- tightness in the chest
- being unusually quiet
- difficulty speaking in full sentences
- sometimes younger children express feeling tight in the chest as a tummy ache

After a minor asthma attack

- Minor attacks should not interrupt the involvement of a pupil with asthma in school. When the pupil feels better they can return to school activities.
- The parents/carers must always be told if their child has had an asthma attack.

EPILEPSY:

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual. Auditory stimulation, emotion (anxiety, upset).
- any unusual 'feelings' reported by the child prior to seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

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

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected, a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumblings sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan. During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

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

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal diazepam. Instructions for use **must** come from the prescribing doctor.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?
Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed
when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control
The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

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

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a **hypoglycaemic reaction** (hypo) in a child with diabetes:
- ♦ hunger
- ♦ sweating

- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

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

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

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

Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to
draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures and relate specifically to the child's individual health care plan.

Hypo – a *quick* guide

What causes a hypo

- too much insulin
- not enough food to fuel an activity
- too little food at any stage of the day
- a missed or delayed meal or snack
- cold weather
- vomiting.

Watch out for

- sweating
- trembling or shakiness
- drowsiness
- headache
- lack of concentration
- hunger
- pallor
- glazed eyes
- mood change, especially angry or aggressive behaviour.

What to do

Immediately give something **sugary**, eg:

- Lucozade
- fresh fruit juice
- glucose tablets
- fizzy drinks (non-diet).

The exact amount needed will vary from person to person and will depend on circumstances.

Hypostop, honey or jam can be massaged into the child's cheek if they are too drowsy to take anything themselves.

Follow this with some **starchy** food to prevent the blood glucose from dropping again:

- roll/sandwich
- muffin
- one individual mini pack of dried fruit
- cereal bar
- portion of fruit
- two biscuits, eg garibaldi, ginger nuts.

If the child still feels hypo afer 15 minutes, some more sugary food should be given. When the child has recovered, give some starchy food, as above.

If the child is **unconscious do not give them anything to eat or drink** and **call for an ambulance.**

The charity for people with diabetes

Diabetes UK Careline 020 7424 1030 **Website** www.diabetes.org.uk

Hypoglycaemia advice for schools

Calderdale and Huddersfield NHS Trust

Children with Diabetes
the management of
HYPOGLYCAEMIA

Blood Glucose below 4 mmols
But still able to take diet and fluids

Administer x2 dextrose tablets or ½ glass of sugary drink
Check blood level again in 15 minutes

If blood glucose still below
4 mmols
Repeat the above and then
Check blood level again in another 15 minutes

Once child returns to normal functioning
and
blood level above 4 mmols
Offer long acting carbohydrates
Biscuits/ milk or a sandwich

Return to lessons

Blood Glucose below
3.5 mmols
but will not take diet or fluids

Administer glucogel as instructed.
Check blood level again in 10-15 minutes if over 4 mmols offer digestive biscuits/milk or sandwich

When back to normal functioning
return to lessons

If the child is found unresponsive or unconscious DIAL 999
Ask ambulance crew to take the child direct to the children's ward at Calderdale Royal Hospital

Diabetes contact – Nancy Harrison
Children's Diabetes Nurse
Phone 01422 224126 or 07775538923

ANAPHYLAXIS

What is anaphylaxis?
Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish,
certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

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

Medicine and Control
The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

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

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using
this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an
individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:
- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

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

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel
different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with
medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

Anaphylactic shock

Allergic Reactions

MINOR SYMPTOMS

- Urticarial rash – pink, raised, very itchy (HIVES, NETTLE RASH);
- Flushed face and neck
- Child otherwise unwell

SEVERE SYMPTOMS

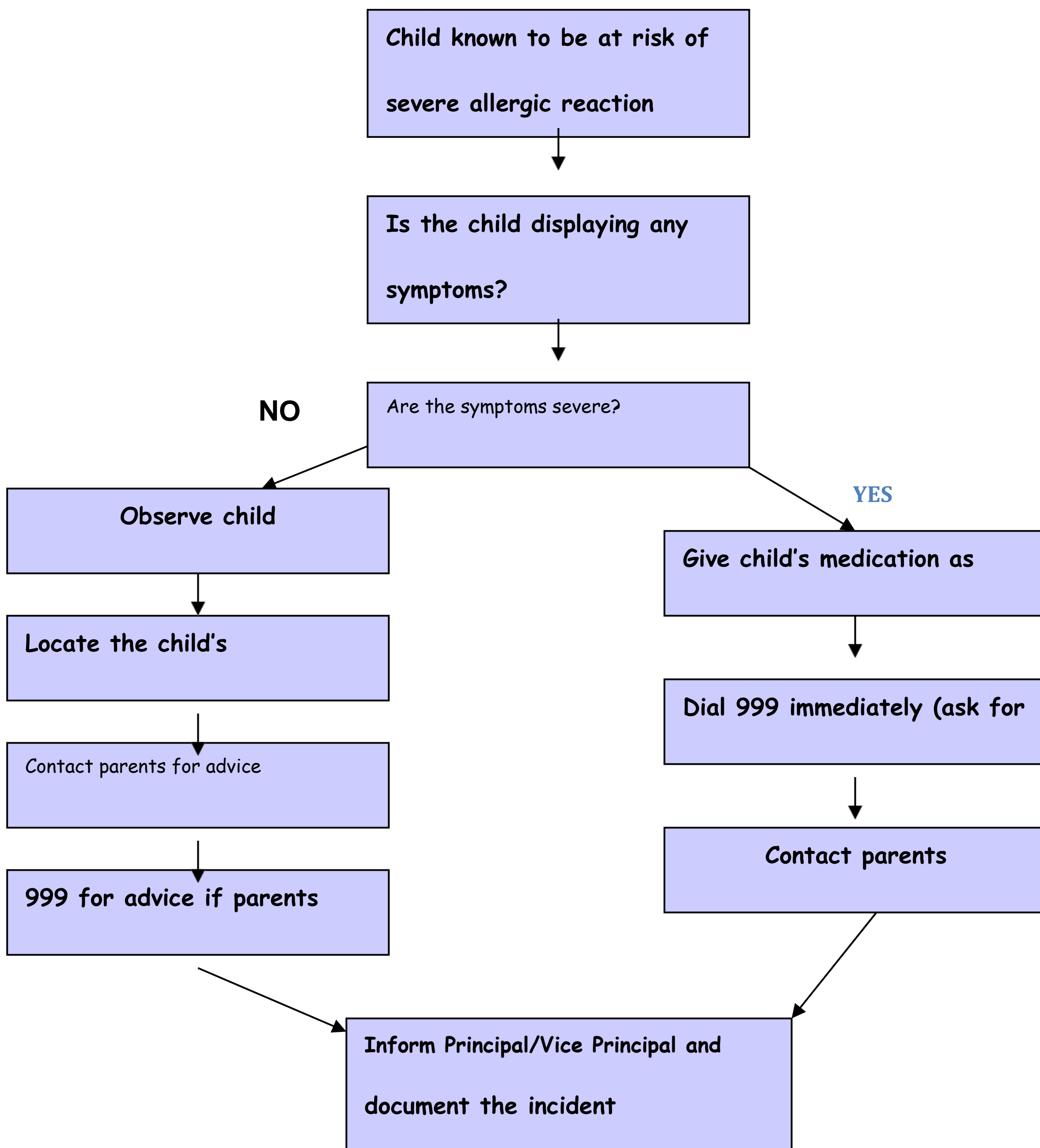
- Facial tingling leading to swelling of face, lips, tongue and eyes
- Hoarse voice and/or feeling of a lump in the throat
- Cough and/or noisy breathing
- Difficult breathing and/or swelling
- Feeling of faintness and/or fear
- Abdominal pain and nausea/vomiting

LEADING TO:-

- Loss of consciousness
- Rapid weak pulse
- Very laboured breathing
- Blue lips

Not All Symptoms Will Necessarily Be Experienced

IF IN ANY DOUBT DIAL 999 EVEN IF ONLY FOR ADVICE


ANAPHYLACTIC SHOCK
Child known to be at risk of severe allergic reaction
Is the child displaying any symptoms?
Are the symptoms severe?
NO
Observe child
Locate the child's
Contact parents for advice
999 for advice if parents
YES
Give child's medication as
Dial 999 immediately (ask for
Contact parents
Inform Principal/Vice Principal and document the incident