



APRIL 2013

**THE ADMINISTRATION OF
MEDICINES AND ASSOCIATED COMPLEX
HEALTH PROCEDURES FOR CHILDREN
ADVICE & GUIDANCE FOR CHILDREN'S SERVICES IN
DERBYSHIRE**

1. Approval and Authorisation

Completion of the following section signifies the review and approval of this process:- *(this section **must** be completed for new policies)*

Name	Job Title	Date
Authored by:-	Michael Upsall	February 2013
Approved by:-	Sally Savage	May 2013
Authorised by:-	Ian Johnson	May 2013

2. Change History *(this section **must** be completed each time the policy is amended)*

Version	Date	Reason	Name
Version			

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Based on DFES Guidance for schools and early years settings

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APPENDIX TWO

Procedures that can be carried out by staff who have received appropriate training and whose competency has been established

1 Introduction

This document provides guidance for those who provide, commission and who use children's services in Derbyshire. It reflects the most recent national guidance and replaces earlier Derbyshire guidance published separately for schools/early years settings and for children's social care. It does not replace the main national guidance documents to which services will need to refer.¹

In producing this guidance there has been concern to recognise the reality that not only do children access different services and settings but also that staff, carers and consenting staff members who work with them, may also work across different settings – schools, community, short breaks and children's own homes etc. – and separate, setting-specific guidance can sometimes be unhelpful and inconsistent. Parents too, and persons they engage under individual budgets or direct payments arrangements are key partners who need to know that guidance has been produced with them in mind and to which they have access. Furthermore, Aiming High for Disabled Children has promoted both greater access to universal services by disabled children and their families and the development of more individualised approaches and families employing their own workers.

National guidance has not always kept up with these developments – this document aims to bridge the gap and:

- offers common advice across settings and services;
- includes codes of practice which can be easily updated and extended and which provide stand-alone advice;
- includes templates for recording or evidencing compliance with standards and/or regulations – these can be adapted for any service or setting; and above all,
- reinforces the need for regular, accurate communication between all who are involved in the delivery of health care to children across different settings to ensure safe handover with the minimum risk of error.

This document retains a dual focus on the key areas for which national guidance is provided, namely schools/education/early years' settings and social care/short breaks. It does not differentiate between different types of school, although it is recognised that some will have nurses as part of the staff team and this will clearly affect the way they implement the guidance. It encompasses both universal and specialist services – "specialist" includes those for children who are disabled, or

¹ The main documents are:

Managing Medicines in Schools and Early Years Settings:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108489aging-medicines-in-schools

The Handling of Medicines in Social Care: Royal Pharmaceutical Society

<http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf>

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who have additional needs, and those who are in care where the parental responsibility may be shared with the Local Authority.

- Children’s and foster homes and boarding schools have additional responsibilities by virtue of the full-time care they provide.

Scope of Policy Guidance

Schools and services need to set out their policies and procedures for the administration of medicines with particular reference to the following:

- children with medical needs;
- the respective responsibilities of schools/services and parents;
- working in partnership;
- parental responsibility and consent;
- young people giving their own consent;
- eight core principles of safe and appropriate handling of medicines;
- receipt, storage and disposal of medicines;
- administration of medicines;
- record keeping;
- the individual treatment plan;
- children with complex health needs;
- assessing and managing risk;
- staff training.

Terminology

Throughout this document the following terms have been used:

- *headteachers and managers* are used to refer to persons in charge of schools and other services respectively;
- *schools* includes special and enhanced resource schools and pupil support centres - any specialised or complex procedures will be addressed in individual treatment plans for pupils.
- *children* is used inclusively for all children under the age of 18 (19 if disabled) and more specifically for younger children;
- *young person/people* is used to refer to children typically aged 14+;
- *parents* includes guardians and others who have parental responsibility but not foster carers nor private foster carers;
- *carers* includes staff in residential homes and schools and foster carers.
- *Individual treatment plans* has been used where some national guidance refers to “individual health care plans” – this is to avoid possible confusion with children in care who have statutory health care plans

This document has been prepared in consultation with health professionals in Derbyshire, along with teacher associations and recognised trade unions. It supersedes all previous guidance on administration of medicines.

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It will be regularly updated and added to as new guidance documents are published and local practice develops. A review will meet at regular intervals to refresh this document. The most up to date version can be found at.....*DCC website address to be inserted*

2 Indemnity

The Council fully indemnifies its staff against claims for alleged negligence, providing they are acting within the scope of their employment, have been provided with adequate training, and are following the Local Authority's guidelines. For the purposes of indemnity, the administration of medicines falls within this definition and hence staff can be reassured about the protection their employer provides. The indemnity would cover the consequences that might arise where an incorrect dose is inadvertently given or where the administration is overlooked. In practice, indemnity means the Council and not the employee will meet the cost of damages should a claim for alleged negligence be successful.

For this indemnity to be available certain procedures must be approved by the Risk and Insurance Manager before they are commenced. Please refer to Appendix 2 for procedures which must be notified.

If the procedure requires the confirmation of the Risk and Insurance Manager the following information and documentation must be provided to obtain approval of commencement of the procedure:

1. Copy of the Care Plan.
2. Full details of the training undertaken and copy of the competency sign-off from the qualified trainer.
3. Parental Consent Form.
4. Staff Member Consent form – confirming that they are happy to undertake the task.

The Authority's current insurance policy does not cover some of the listed procedures and this information is required to seek Insurer approval or to agree to accept the risk within the Council's Insurance Fund.

NOTE:

Academies, non-maintained schools, contracted and other services outside of the Derbyshire County Council are not covered by the indemnity set out here and they are advised to seek advice from their insurers.

3 Access to Education and Services - The Equalities Act 2010

The Equality Act 2010 provides a single, consolidated source of anti-discrimination law, covering all the types of discrimination that are unlawful. It simplifies the law by removing anomalies and inconsistencies that had developed over time under previous legislation. It also introduces a single combined duty to eliminate discrimination and advance equality of opportunity and replaces the former race, disability and gender equality duties. As far as schools and general children's services are concerned, the effect of the new law for the most part is the same as it has been in the past namely to prohibit unlawful discrimination against children/pupils because of their sex, race, disability, religion or belief and sexual orientation other than in relation to the content of the curriculum, collective worship and admissions to single-sex schools and schools of a religious character.

Under the new act it is unlawful to offer/provide a lesser standard of service to a child with a disability and there is a new reasonable adjustment duty requiring schools and services to provide auxiliary aids and services to disabled pupils. An important principle underlying how schools respond to the specific duties is **proportionality**. This means that, for example, more is expected from a large secondary school than from a small primary. A second important principle is **flexibility**. This means that each individual school is permitted, and indeed expected, to interpret the legislation in ways which are appropriate to its own context, neighbourhood, history and circumstances.

The Equalities Act and Disabled Children

The overriding principle of equality legislation is generally one of equal treatment and includes protection against discrimination that may arise in the provision of services and public functions, premises and in education. It does so by making discrimination unlawful in a number of ways, and by providing legal remedies to individuals who experience discrimination. However, the provisions relating to disability discrimination are different in that schools/services may, and often must, treat a disabled person more favourably than a person who is not disabled and may have to make changes to practices to ensure, as far as is reasonably possible, that a disabled child can benefit from what is on offer to the same extent that a child without that disability can.

In general, therefore, disabled children can expect services to be provided to them on the same terms and to the same standards as other members of the public, and can also expect steps to be taken to help overcome particular difficulties that a particular disabled person may face. This is an ongoing duty and service providers are expected to review the way they provide services and make changes to avoid discriminating. Sometimes, a service-provider may be able to make reasonable alternative arrangements and would not be obliged to take steps that would

fundamentally alter the nature of the service or to take a step which it has no power to take. (Schedule 2)

Definition of Disability Section 6 (1) and (2)

The Equality Act prohibits discrimination on the basis of any “protected characteristic” which includes disability. It defines disability as when a person has a “physical or mental impairment which has a substantial and long term adverse effect on that person’s ability to carry out normal day to day activities.” Some specified medical conditions such as HIV, multiple sclerosis and cancer are all considered as disabilities, regardless of their effect. This also has relevance for children with ongoing needs for medication. The key elements in the definition remain as before:

- the individual has a physical or mental impairment; and
- that impairment has a **substantial** and **long-term** adverse effect on the individual’s ability to carry out normal day-to-day activities.

An effect is **substantial** where it is more than minor or trivial (but not necessarily much more than that). **Long term** includes an effect that has lasted for at least 12 months, or is likely to last at least 12 months or for the rest of a child’s life. The definition also acknowledges that mental health conditions in particular can fluctuate over time, by making clear that if a child is no longer experiencing significant adverse effects then he or she may still be classed as having a disability if there is evidence that the effect is likely to recur (that the effect could well happen again).

Also, where someone is being helped to get on with day-to-day activities by taking medication or because they are having some other treatment, they are still to be treated as having a disability if there is evidence that they could well be affected in a significant way once again if they stop taking the medication or if they were no longer having the treatment.

The duty to make reasonable adjustments – Section 20

Under the DDA the law recognised a need to help disabled people that may not apply in other areas, by making adjustments to help them. The new act recognises the need for positive action and that more favourable provisions may need to be put in place in relation to the protected characteristic of disability.

Where it has been identified that there is a practice or arrangement that is putting a disabled person at a substantial disadvantage when compared with a non-disabled child, then there is a requirement to make reasonable adjustments that would help a disabled person to overcome that substantial disadvantage. The duty also extends to ensuring that physical features that put a disabled person at a disadvantage are dealt with and, if auxiliary aids are needed to assist the disabled person, that they should be provided.

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Much of the legislation and guidance addresses schools but it also has relevance for other children's services and settings.

Schools are also under a duty to plan strategically to increase access, over time, to schools. This should include planning in anticipation of the admission of a disabled pupil with medical needs, so that they can access the school premises, the curriculum and the provision of written materials in alternative formats to ensure accessibility. Early years and child care settings not constituted as schools should also be making reasonable adjustments for disabled children including those with medical needs. However, unlike schools, the reasonable adjustments by early year's settings will not include alterations to the physical environment as they are not covered by the Part 4 planning duties. All early years and child care settings should have copies of the DfES guidance and briefing documentation to accompany it.

The National Curriculum Inclusion Statement 2000 emphasises the importance of providing effective learning opportunities for all pupils and offers three key principles for inclusion:

- responding to pupils diverse needs;
- setting suitable learning challenges;
- overcoming potential barriers to learning.

Further information on The Equality Act

The regulations concerning the specific duties came into force on 10 September 2011 and are known as [*The Equality Act 2010 \(Specific Duties\) Regulations 2011.*](#)

For a fuller explanation of the duties in general terms, and of the principles and case law underlying them, it is worth consulting a succinct and clear document issued in October 2011 by the TUC:
http://www.tuc.org.uk/extras/EQUALITY_TOOLKIT.pdf

There is a quick-start guide issued by the Government Equalities Office on 21 October 2011 ([*Equality Act 2010: the specific duties – what do I need to know?*](#));

Non-statutory advice updated by the Department for Education on 21 December 2011 can be found at ([*Equality Act 2010: advice for school leaders, school staff, governing bodies and local authorities*](#));

Updated guidance published by the Equality and Human Rights Commission (EHRC) on 19 December 2011 ([*Guidance on the Equality Duty*](#), a set of five booklets).

Advice for schools can be found at:
<http://media.education.gov.uk/assets/files/pdf/e/equality%20act%202010%20advice%20for%20school%20leaders.pdf>

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Further guidance on this and all other areas of disability in schools is available in the “Implementing Disability Discrimination Act in Schools and Early Years Settings” pack, which although it refers to the repealed DDA, contains helpful advice for schools in the area of disability and is available at:

<http://publications.education.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DFES%200160%202006&>

The Government Office for Disability Issues has published guidance on how to define disability which can be found at: <http://odi.dwp.gov.uk/docs/law/ea/ea-guide-2.pdf>

Guidance on producing a Policy on the Administration of Medicines

The purpose of any policy should be to enable a child to achieve regular attendance at school or any service they attend, or wish to attend. To achieve this it must be drawn up in partnership with children, their parents, employers, governing bodies, the Local Authority and it must always have in mind the welfare of children for whom it is intended.

- It needs to be clear to all parents, staff and children.
- It can be included as part of any prospectus, brochure or other information written with them in mind.

Most services – schools, early years, short breaks, activities etc. - are for children who are well and able to attend. Their medicines policies should therefore, reflect this and be clear that they are *not for children who are unwell* (except where illness arises whilst the child is in school/attending a service) who should not be sent to school/ services. They are therefore, for children who are:

- suffering from chronic illness or allergy; or
- recovering from a short-term illness and are undergoing or completing a course of treatment using prescribed medicines and are fit to attend.

Where services are full-time/24 hour however, their policies will also need to provide for children who are unwell. For example, for children who are in care, receiving overnight short breaks or are boarding school.

Sections 4 – 18 provide guidance for headteachers and managers on how to produce their own policies and procedures on the administration of medicines and associated matters.

Advice on a range of specific areas is contained in the Codes of Practice that follow.

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Forms for recording a range of essential information are fundamental to the safe administration of medicines and a range of templates that can be adapted to meet the specific requirements of different settings can be found in Appendix One.

- Templates 1-7 are taken from “Managing Medicines in Schools and Early Years Settings”.
- Templates 8 onwards have been drafted with social care and short break services in mind.

GUIDANCE ON PRODUCING A POLICY ON THE ADMINISTRATION OF MEDICINES

4 Assessing Needs and Managing Risks

Medicines, whilst not hazardous if used and administered in the correct manner, present a risk if not used and administered correctly. The main risks associated with settings storing, managing and administering medicines are:

- Medicines given to wrong child;
- Medicines not given to child at appropriate time;
- Medicines not given at all;
- Wrong dose of medicine given to children;
- Medicines not available when required (particularly rescue medication);
- Medicines being lost;
- Medicines stored incorrectly;
- Medicines not in correct containers and not labelled correctly;
- Young people giving medicines to other young people;
- Needlestick injuries.

Organisations should have their own guidance and procedures on assessing and managing risk. Services and settings should produce a **general risk assessment** for the storage and administration of medicines indicating how the above risk is being controlled using this guidance to inform the control measures.

- Derbyshire County Council staff who are unfamiliar with the concept of risk assessment should ensure they have also read the Children and Younger Adult's Department's guidance on Risk Assessment which can be found at: http://dnet/working_for_us/your_wellbeing/caya/caya_health_safety/policy_guidance/default.asp
- Workers in other agencies should take advice from their own organisations.

For young people with complex medical needs who have an individual treatment plan a separate risk assessment is not required as the **general risk assessment** will deal with issues such as storage and labelling of medicines and the **treatment plan** will provide detail on the administration of the medicines.

5 Children with Medical Needs

Children with short term medical needs

Many children will need to take medicines during the day at some time during their time in school and/or any services they use. This will usually be for a short period only, perhaps to finish a course of antibiotics or to apply a lotion. To allow children to do this will minimise the time that they need to be absent.

- However, such medicines should only be taken to school or a service where it would be detrimental to a child's health if it were not administered during the school day/ duration of the service.

Children with long term medical needs

It is important that schools and services have sufficient information about the medical condition of any child with long-term medical needs. If a child's medical needs are inadequately supported this may have a significant impact on a child's experiences and the way they function in or out of school or a service. The impact may be *direct* in that the condition could affect cognitive or physical abilities, behaviour or emotional state. Some medicines may also affect learning leading to poor concentration or difficulties in remembering. The impact could also be *indirect*, perhaps disrupting access to education through unwanted effects of treatments or through the psychological effects that serious or chronic illness or disability may have on a child and their family.

- The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that **must** be considered.
- Some specified medical conditions such as HIV, multiple sclerosis and cancer are all considered as disabilities, regardless of their effect.
- Also, where someone is being helped to get on with day-to-day activities by taking medication, or because they are having some other treatment, they are still to be treated as having a disability.

Schools and services need to know about any such needs before a child is admitted or when s/he first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. For such children, it is often helpful to have a written individual treatment plan drawn up by relevant health professionals in consultation with the parents. This can include:

- details of a child's condition;
- special requirement e.g. dietary needs, pre-activity precautions;
- what constitutes an emergency;

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- what action to take;
- what **not** to do;
- who to contact – including when parents expect to be contacted.
- the role the staff can play.

The overriding duty is to ensure good communication that will ensure a child receives the right medicine at the right time with the minimum risk of error.

Further details on individual treatment plans can be found in Section 13

Further details on children with complex health needs can be found in Section 14

6 The Respective Responsibilities of Schools, Services & Parents

Head teachers and managers of services have a shared responsibility with parents to ensure good communication and information sharing to ensure a child receives the right medicine at the right time and, furthermore, that when a child is “handed over”, parents/carers and staff know what medicines have been given and when the next doses are due. They also have separate responsibilities.

The Responsibilities of Headteachers/Managers

It is the responsibility of the Head teacher/manager to ensure that schools and services have a clear medicines policy which is understood and accepted by staff, parents and children. The policy should be readily accessible and ideally be included as part of the school prospectus or service information/brochure. The policy should set out clearly what is expected of parents and children, including how working together will ensure that children with medical needs are not disadvantaged.²

- Head teachers and managers are advised not to allow children to bring medication into school/services except as covered by this document and the relevant codes of practice.
- They should advise parents that schools/services (other than full-time care) do not keep any medication for distribution to children, e.g. paracetamol. They will, of course, have a first aid kit.³
- They should have particular regard to the section dealing with consent below.

This does not imply a duty on Head teachers/managers or staff to administer medication. The Local Authority wishes to point out to school staff, governors, parents and staff in other services that participation in the administration of medication is on a voluntary basis unless staff have accepted job descriptions that include duties in relation to the administration of medicines.

- **Individual decisions on involvement must be respected.**
- **Punitive action must not be taken against those who choose not to consent.**

When employing care and support staff, schools and services will need to consider including the management and administration of medicines and associated tasks within their job descriptions to ensure a sufficient number of staff are employed to carry out this role.

² See section 2 - Access to education and services - the Equalities Act 2010

³ See Code of Practice 13

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All staff are advised to consult their trade union branch or regional officer or representative for further advice if needed.

The advice contained here sets out the principle requirements from statutory guidance, where it exists, and from other sources as necessary.

- Schools and services are advised to adopt, and where necessary adapt, the guidance in this document to form their own policy, which should be regularly reviewed and updated as necessary.
- It also includes templates which can be used without change or adapted as appropriate to meet the individual needs of specific services.

Notifiable Diseases

Head teachers and managers should also be aware of and make available the document “Guidance on infection control in schools and nurseries” available from the Health Protection Agency website. www.hpa.org.uk/infections/topics_az/schools/default.htm. If they are unsure of any issue relating to notifiable diseases they should seek advice from the Health Protection Team (0844 225 4524).

The Responsibilities of Parents

The responsibility for ensuring that children with medication needs receive the correct “treatment” rests ultimately with their parents/guardians, or with a young person capable of self-administering his or her own medication. Parents and doctors should decide how best to meet each child’s requirements. Carefully designed prescribing can sometimes reduce the need for medicine to be taken during school hours or when they are attending services. To help avoid unnecessary taking of medicines at school/ services, parents should:

- be aware that a three times daily dosage can usually be spaced evenly throughout the day and taken in the morning, after school hours and at bedtime;
- ask the prescriber if it is possible to adjust the medication to enable it to be taken outside the school day.

Where this cannot be arranged, parents should consider whether or not, the child could return home for this, or the parent should come to school/service to administer the medicine. If this is not possible, the recommended procedure for administration of medicines should be adopted.

- The parents should be informed that they will need to ask the pharmacist for duplicate labelled bottles in order to send medicines to school.
- It should be noted that duplicate containers may not be supplied free of charge – charges will be at the discretion of individual pharmacists.
- Alternatively, parents can ask the prescriber for two prescriptions, one to cover home and the other to cover school.

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- Parents must not ask staff to administer doses other than as prescribed in the written instructions. Similarly, staff must not accede to any such request.

Consent

Before administering medicine to a child, there needs to be written evidence of consent. This may be given by a young person who is competent to do so but, in all other circumstances, by a parent or person with parental responsibility

See section 7.

See form templates 2, 3, 6 & 8

7 Working in Partnership

Introduction

When children are in school or using services, whether for a few hours, overnight or for longer, parents need to know that arrangements are in place to provide for any health care need that might arise. This advice sets out the requirements for parents and others with parental responsibility, staff/carers and health professionals to work together to ensure that such arrangements are in place. Although the main emphasis is properly on parental consents, children of all ages should be engaged in the decision-making and older children capable of giving their own consents should be encouraged to do so.

- Whether or not the main focus is parental consent or a young person's consent, the principles of working in partnership remain the same.

Working in partnership is about a shared duty of care and is the key to ensuring that all of a child's health care needs are met.

- Many children have no particular needs but may fall ill or have an accident whilst at school or receiving services.
- Most children, at some point during their childhood, will have a temporary need.
- Some will have on-going needs requiring regular medication or procedures that must be followed and for which staff and carers must be trained.
- A small number may occasionally have urgent, including life-threatening, needs which must be met without delay.

Good planning and communication is fundamental to effective partnership working:

- this begins with a clear statement about a child's health needs and how they are to be met;
- it also includes essential information about any allergies or health conditions such as diabetes and any other information which staff/carers need to know about;
- it must ensure clarity about who needs to do what and when and provide a written record to confirm it has been carried out.

These are the building blocks that ensure the "five rights" are upheld - ***the right child, the right drug, the right dose, the right route, the right time.***

- The longer a child is away from home, the more comprehensive the arrangements will need to be.

Regulation and inspection of schools and services

Schools and other services are subject to independent inspection by one of the government's regulatory bodies. A key function of inspection is to ensure that there is compliance with minimum standards for safe care. This means that schools and services:

- must be able to provide inspectors with evidence of their good practice – this includes the procedures for staff/carers to follow, written records that show compliance with them and other evidence that they understand the needs and wishes of parents and children and take them into account;
- will ask for parental cooperation to help them meet these requirements.

The basic information that is required

Most children do not have medical conditions that require specific care. However, there may be things that staff/carers need to know about, for example a child may:

- have an allergy to certain foods or other substances;
- be taking medication that needs to be administered when they are in school/using services;
- have a condition that means routine or urgent medical treatment by a doctor or nurse could possibly be required, for example epilepsy

Staff/carers will want to discuss what needs to happen in these circumstances and will ask for written consent to provide both planned and routine care and seek urgent medical treatment should the need arise. They will also ask parents to give consent for staff/carers to have contact with health professionals and for those health professionals to share medical information with the staff/carers as necessary. They will also ask for contact details in order that a parent – or someone named by a parent - can be contacted in an emergency

Extra help for children with additional health care needs

Children who have additional needs arising from a medical condition, disability or illness will be under the care of their GP and perhaps also a Paediatrician and/or other health professional. They will have an individual treatment plan which is regularly reviewed and which needs to be implemented across all services and settings – home, school, short break care and in the community.

- Parents and workers/carers alike need to understand what the plan entails and what is required to comply with it.
- This needs to be written down so that it can be shared with all who have the care of a child and to minimise the risk of error.
- Parents will need to supply staff/carers with sufficient medication for the duration of the school day, service or short break.

- This should be in its original container with the original pharmacy label – *this is the only way that staff/carers can evidence that they are acting in accordance with a medical practitioner’s instructions.*
- Staff/carers need to keep records to show that they have complied with these requirements and returned any unused medication.

See also Sections 13 The individual treatment plan & 14 Children with complex health needs

Specialised help for children requiring medical interventions or procedures

Some children need their parents and staff/carers to carry out medical interventions or procedures for which specific training is required – for example, catheter care or gastrostomy care.

- The expectations of staff/carers are essentially the same as those made of the child’s parents.
- Staff/carers need the same training they have received from health professionals

A service will only be provided where these conditions can be satisfied and where parental consent has been given for an essential procedure to be carried out by staff/carers and they have been trained to provide it.

8 Parental Responsibility and Consent

Parental Responsibility

Who has parental responsibility?

A mother automatically has parental responsibility for her child from birth. However, the conditions for fathers gaining parental responsibility vary throughout the UK. In England and Wales, if the parents of a child are married to each other at the time of the birth, or if they have jointly adopted a child, then they both have parental responsibility.

- Parents do not lose parental responsibility if they divorce, and this applies to both the resident and the non-resident parent.

This is not automatically the case for unmarried parents. According to current law, a mother always has parental responsibility for her child. A father however, has this responsibility only if he is married to the mother when the child is born or has acquired legal responsibility for his child through one of the following 3 routes:

- by jointly registering the birth of the child with the mother;
- by a parental responsibility agreement with the mother; or,
- by a parental responsibility order, made by a court

Orders under the Children Act 1989

Parental responsibility is also obtained through the making of a residence order, a special guardianship order and through the act of adoption.

- Where a child is the subject of a care order (Section 31) in favour of a Local Authority, it shares parental responsibility with the mother or both parents.
- Where a child is in care on the basis of a voluntary agreement with a parent (Section 20), parental responsibility remains with the parents.
- Persons who may have day to day responsibility for children such as teachers and childminders do not have parental responsibility but are under a duty of care to act as a reasonable parent would do to ensure the child's safety and in emergency circumstances may take reasonable steps to promote a child's welfare.

Consent

What is “informed” consent?

It is really important that parents do not feel they are being asked to give their consent to something they do not understand or may not agree with. It is also important that they do not feel that once a parent has given consent, they cannot later change their mind. Consent cannot be generalised, it must be specific.

- A parent will be asked to give consent separately to each individual requirement of meeting a child’s needs.
- Staff should also give parents the opportunity to ask for further information/clarification before they sign a consent form.

What consents are needed?

The level of consent will vary with a child’s needs, the service or setting and the length of time s/he is away from home. Staff/carers may need a parent’s agreement to some or all of the following to allow them:

- to approach the family GP (or other health professional) for further advice and information about a child’s health care needs;
- to share this with those who are planning for a child’s education or care needs;
- to administer a medicine should this be necessary;
- to seek routine advice or treatment from a medical practitioner should the need arise;
- to seek urgent medical treatment should this be necessary;
- to contact a named person if they are not available.

Consents to planned or urgent medical treatment

Staff/carers will usually carry out routine procedures for which a parent has given consent without contacting them. They will always attempt to contact a parent to discuss any significant health concern that affects their child whilst s/he is attending school or services.

- What is *significant* will vary from child to child and with age but parental consent for any specialist assessment, operation or medical procedure will normally be sought.

In urgent circumstances, it may not be possible to obtain consent but every effort will be made to contact a parent and the urgent consent that has been given will only be used where a medical assessment indicates the need for immediate action.

- A doctor will always act in the best interests of a child’s health, including in emergency situations.

What if a parent/person with parental responsibility feels unable to give consent?

The aim is always to work in partnership and on the basis of agreements. If the school or service feels it needs parental consent to a specific procedure and the parent/ person with parental responsibility is unable to give it, the service will take further advice and try to resolve the dilemma without, in its opinion, compromising a child's wellbeing.

- Where s/he is competent, it is the consent of a competent older that will be sought – see below.
- The parent's views will be respected.
- This *may* mean that a service cannot be provided or *may* be restricted in some way.
- However, the consent of only one person with parental responsibility is required - this is true even where it is known that the other parent may not give his or her consent.

Confidentiality

Similarly, in some circumstances, parents or a young person may ask for sensitive information to be confidential.

- This should be respected so long as it does not place the child, or anyone else, at risk of significant harm - the “**need** to know” is a key consideration.

Keeping up to date with changing needs

Whether a child is a frequent, or just an occasional user, of services, staff/carers need to know that the medication instructions are up to date. The individual treatment plan will be regularly reviewed and any new requirements must be communicated to all involved in the plan for the child.

- Parents must always provide current instructions – this means ensuring that the child's GP, paediatrician or the pharmacist is aware of the need to pass on *written* instructions to a school or service provider.

9 Young People Giving Their Own Consent

Children under 16, competence and consent

Children under 16 are **not automatically** presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16's *will* be competent to give valid consent to a particular intervention if they have sufficient comprehension and intelligence to understand fully what is proposed.

- In other words, there is no specific age when a child becomes competent to consent to treatment - it depends both on the child and on the seriousness and complexity of the treatment being proposed.
- 'Competence' is not a simple attribute that children either possess or do not - it is nurtured from an early age by involving them in decisions and about their health care.

The extent to which a child may be deemed competent in any given situation may depend to a great extent on the quality of relationships with adults and the extent to which they can help the child to give an informed opinion.

- It would be **exceptional** for a child under the age of 14 to be judged to be competent to give his or her own consent.

Confidentiality

Where a young person who is judged to be competent asks for their confidence to be maintained, this must be respected, except where disclosure is required on the grounds of *reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm*.

- Wherever possible, their agreement to the involvement of their parents should be sought, unless it is believed to be against their best interests to do so.
- There may be a good reason why a young person has accessed health services confidentially and no good reason why that confidence should be breached.

Young people aged 16/17

Once a young person has reached the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care.

- This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.
- However, it is still best practice to encourage competent children to involve their parents in decision-making.

Some young people aged 16 and 17 may sometimes **not** be competent to take particular decisions. To be competent to take a particular decision, they must be able to:

- comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and
- use and weigh this information in the decision-making process.

This may arise in relation to mental health needs such as eating disorders or depression

- In such circumstances, where consent is being unreasonably withheld and is not in a young person's best interests, it may be necessary to ask a court to consider the matter.

It **must not be** assumed that a young person with a learning disability/ difficulty is **not competent** to take his or her own decisions:

- many will be competent if information is presented in an appropriate way and they are supported through the decision-making process.

If a young person aged 16 or 17 is not competent to take a particular decision, then a parent/person with parental responsibility can take that decision for them, although the young person will still be involved as much as possible and his or her views will always be properly considered in the decision-making process.

Young people aged 18

Once a young person has reached the age of 18, no-one else can take decisions on his/her behalf. However, if a young person aged 18 is deemed *not competent* to take their own decisions, clinicians can provide treatment and care that is in their "best interests".

- More information on this is given in the Department of Health's *Reference guide to consent for examination or treatment*.

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FURTHER INFORMATION ON CONSENT CAN BE FOUND IN:

Reference guide to consent for examination or treatment second edition

Department of Health, April 2009

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalassets/dh_103653.pdf

Consent – what you have a right to expect - A guide for children and young people Department of Health July 2001

http://ethics.grad.ucl.ac.uk/forms/DH_GuideForChildrenAndYoungPeople.pdf

12 key points on consent: the law in England Department of Health, August 2001

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006131

Seeking consent: working with children Department of Health, November 2001

http://www.health.wa.gov.au/mhareview/resources/documents/UK_DoH_Consent_children.pdf

0 – 18 years: guidance for all doctors, General Medical Council, 2008

http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

Promoting the health and wellbeing of looked after children - revised statutory guidance Department of Health, November 2009

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108501

10 Eight Core Principles of Safe and Appropriate Handling of Medicines

The following principles have been adapted for application across all schools, settings and children's services from advice in "The Handling of Medicines in Social Care, Chapter 1." Whilst they have been drawn up with full time care very much in mind, they also have relevance for all settings.

1. Young people in long term care have a choice in relation to their provider of pharmaceutical care and services, including dispensed medicines

This means:

- they can choose to look after and take their own medicines with help and support from staff;
- they are included in decisions about their own treatment;
- those of sufficient age and understanding have a say about which pharmacy (or dispensing doctor) supplies their medicines;
- they receive only medicines for which their own or their parent's consent has been given;
- they have their personal and cultural preferences respected.

2. Staff know which medicines each child has and the school/service keeps a complete account of medicines.

Medicine records are essential in every service/setting and especially those providing full-time care. All staff should know which children need someone to administer, or oversee the self-administration of, medicines. Those who help children with their medicines should:

- know what the medicines are and how they should be taken and what conditions the medicines are intended to treat;
- be able to identify the medicines prescribed for each person and how much they have left;
- have access to a complete record of all medicines - what comes in, what is used, what goes out - the 'audit trail';
- schools and services are dependent upon the cooperation of parents to enable them to meet this requirement.

3. Staff who help people with their medicines are competent

Head teachers and managers need to ensure that new members of staff understand that there are policies and procedures to be followed when administering medicines to children. The arrangements for inducting and supervising new staff should also identify the training and skills that each new

staff member has and what training they will need in order to ensure that are adequately trained and knowledgeable to give medicines to children with specific medication needs identified within an individual treatment plan.

- Some services, including those who provide full-time care, will need to ensure that job descriptions include duties relating to the administration of medication – others such as schools and early years will need to ensure that they have sufficient consenting staff members to enable them to discharge their responsibilities.
- Where specific training is needed to administer a medicine or carry out a procedure, only staff who have been given appropriate training *and* have demonstrated their competence, should be permitted to do this.
- Headteachers and managers are responsible for assessing a worker's competence to give medicines to the children for whom they care.
- Evidence of competence needs to be confirmed by a health professional – *see also Appendix Two*

4. Medicines are given safely and correctly, and staff preserve the dignity and privacy of individuals when they give medicines to them

Safe administration of medicines means that they are given in a way that avoids causing harm to a child.

- They should only be given to the person for whom they were prescribed.
- Children should receive the right medicine at the right time and in the right way.
- Every effort should be made to preserve the dignity and privacy of individuals in relation to medicine-taking.
- It also means keeping personal medical information confidential, for example, a person's medicines administration record (MAR) should not be kept where everyone can see it.

5. Medicines are available when required and the school/ service provider makes sure that unwanted medicines are disposed of safely

- Prescribed medicines must be available when needed and so continuity of supply of medicines for ongoing treatment is essential.
- Where children are in full time care, arrangements with a local pharmacy or dispensing doctor should be made in advance.
- Out-of-date, damaged or part-used medicines that are no longer required should be disposed of safely so that they cannot be taken accidentally by other people or stolen.

6. Medicines are stored safely

Medicines need to be stored so that the products:

- are not damaged by heat or dampness;
- cannot be mixed up with other people's medicines;
- cannot be stolen;
- do not pose a risk to anyone else;

7. The school/service has access to advice from a pharmacist

- Every school/service should ensure that it has the contact numbers for their local pharmacy readily available together with a named person to contact.

8. Medicines are used to cure or prevent disease, or to relieve symptoms, and not to punish or control behaviour

- Prescribing medicines is the responsibility of healthcare professionals.
- Medicines should not be used unnecessarily for sedation or restraint.

11 Receipt, Storage and Disposal of Medicines

Prescription and non-prescription medicines

Prescription medicines

Medicines should only be taken to school or services when essential - that is where it would be detrimental to a child's health if the medicine were not administered during the school or setting 'day'.

- Schools and services should only accept medicines that have been prescribed by a doctor, dentist, or qualified non-medical prescriber (nurse, pharmacist, podiatrist, optometrist and physiotherapist).

The Medicines Standard of the National Service Framework (NSF) for Children recommends that a range of options are explored including:

- prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours;
- prescribers consider providing two prescriptions, where appropriate and practicable, for a child's medicine: one for home and one for use in the school or setting, avoiding the need for repackaging or re-labelling of medicines by parents.

Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions and patient information leaflet (PIL) for administration.

- They should also be accompanied by a fully completed parental consent form
See templates 2 or 8

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

- Any changes to dosages must be authorised by a medical practitioner or responsible prescriber.

Non-prescription medicines

Non-prescription medicines are those which can readily be bought "over the counter" and children may take them to school or services for conditions such as hay-fever or period pains. Unless instructed otherwise, many will possibly keep and administer their own such medication of this type without reference to the school or service. This could lead to problems should a child be seen taking a tablet the school/service is unaware of; or, if a child carrying significant numbers of "paracetamol" which could be open to abuse by themselves or others. Schools and

services are advised that they should have very clear rules in place regarding non-prescription medicines.

- Non-prescription medicines should be accompanied by a letter of parental consent even if the child intends to keep them him/herself (templates 2 or 8 which can also be filled in by over 16's for themselves).
- Only sufficient non-prescription medication for the duration of the school day or service should be allowed - this may need parents to remove some of the medication from the original container and keep it at home so that only one day's dose comes into school in its original container.
- Medication should only be allowed into school in original containers which clearly state what they are and maximum dose and dose frequency.

Receipt of medicines

Staff must have a record of the medicines they have received and what they will be required to administer. They must know and record:

- the child for whom the medicine – including ointments and creams - is intended;
- where the child is attending school or a short break activity, parents should be advised to send only the amount of medicine required
- Where a child will be cared for overnight or longer a proper record of medicines received is required:
 - tablets should be counted (for hygiene reasons staff should wear rubber gloves where possible);
 - ointments/creams should be estimated (for example, half a tube);
 - liquids should be measured with a ruler (for example, 5 cms).
- Controlled drugs are subject to additional requirements – see section 9

Labelling of medicines

On the few occasions when medicines have to be brought into a school or service, the original or duplicate container, complete with the original dispensing label should be used.

The label should clearly state:

- name of pupil;
- date of dispensing;
- dose and dose frequency (*This may read "as directed" or "as before" if this is what is on the prescription;*
- the maximum permissible daily dose;
- cautionary advice/special storage instructions;
- name of medicine;
- expiry date – where applicable. For ointments/lotions this is usually 28 days from the date when it was opened, 3 months if a pump dispenser.

The information on the label should be checked to ensure it is the same as on the parental consent form.

- Where the information on the label is unclear, such as “*as directed*” or “*as before*” then it is vital that **clear instructions are given on the parental consent form**. If the matter is still not clear, then the medicine should not be administered and the parents should be asked for clarification.

Written instructions

All medicines that are to be **administered by staff** must be accompanied by written instructions from the parent and/or the GP/prescriber.

- Schools/services may wish to allow non-prescription medicines in accordance with the guidance earlier in this document e.g. 1 x day’s paracetamol – if accompanied by a parental consent form.
- Each time there is a variation (other than a new prescription) in the pattern of dosage, a new form should be completed and it should be accompanied by written confirmation from a medical practitioner to confirm the variation. (see also template 13).

*The parental consent form should be made readily available to parents.
Good records help demonstrate that staff have exercised a duty of care.*

Safe storage of medicines

In schools and services medicines must be stored in a cupboard that is well-constructed with a good quality lock that is big enough to safely store all the medicines that are required.

- In choosing a location for medicines storage, staff should be mindful of the fact that most medicines should be stored below 25° centigrade.
- The medicine cupboard is not to be used for the storage of non-prescription medicines (except where supplied for a specific child) nor first aid kits.
- It must not be used for any other purpose;

Some medicines need to be readily available, for example, emergency medicine.

- Such medicines must be kept in a locked cabinet when not in use but, for example, be in a teacher’s unlocked desk drawer when the child is in class

Local pharmacists can give advice about storing medicines.

Non-emergency Medicines

Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions and in the original container in which dispensed. Large volumes of medicines should not be stored.

- Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration.
- This should be easy if medicines are only accepted in the container as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child needs two or more prescribed medicines, each should be in a separate container.
- The Head teacher/manager is responsible for making sure that medicines are stored safely.
- Children should know where their own medicines are stored and who holds the key.
- Non-emergency medicines should be kept in a secure place not accessible to children.
- National standards for under 8's day care require medicines to be stored in their original containers, clearly labelled and inaccessible to children.

Controlled Drugs

Staff need to be able to identify controlled drugs. Controlled drugs must be kept in a locked cabinet which can be a separate, marked container within a locked medicines cabinet. There are also higher standards in relation to administration and record-keeping. See *Code of Practice 9*.

Refrigerated Storage

Some medicines must be stored in a refrigerator because at room temperature they break down or 'go off'.

- Staff need to know which medicines need to be kept cool.
- The Patient Information Leaflet that is supplied with a medicine will state whether the medicines needs to be kept in a fridge.
- The options for refrigerated storage are:
 - A separate fridge - this may not be necessary unless there is a constant need to refrigerate medicines that a resident takes regularly, for example, insulin;
 - Restricted access by staff only to a refrigerator holding medicines;
 - A lockable fridge; or
 - A lockable container for the medicine placed in the fridge.

The refrigerator must be cleaned and defrosted regularly and the temperature should be monitored daily and the temperature recorded.

- A maximum/minimum thermometer is recommended for this. There should be a written procedure of action to take if the temperature is outside the normal range — usually between 2 and 8 degrees Celsius.
- If the fridge breaks down, it is important to identify the fault quickly, otherwise medicines may be wasted.

Emergency Medicines

These are medicines which need to be readily available in an “emergency situation” and include medicines such as asthma inhalers and adrenaline pens - these should always be readily available to children as and when they need them.

Many children will have the capacity to keep and administer their own medication of this type and should be enabled to do so. Where pupils are deemed not to have this capacity then the medicines should be stored in such a way that they are readily accessible i.e. not locked away in a central store cupboard. Schools and services - especially those that are large, operate on more than one site and/or include off-site activities - will need to decide how best to manage this. Examples may include a box on the teacher’s desk or in an unlocked office drawer in a children’s home.

- It is, however, important that while these medicines must be readily available to the child if needed they should still only be available *to the child for whom they were prescribed* and not to any others.
- Schools should also have a system to ensure these emergency medications are readily available at times when the pupils may not be in the classroom (e.g. PE in the hall, lunch and break times and out of the classroom activities e.g. visits).

Disposal of Medicines

Medicines which have passed the expiry date must not be used

Creams and lotions will have both a manufacturer’s expiry date which must be observed and should also be considered to have expired 28 days after having been opened. Pump dispensers have a longer life, usually about 3 months. Expired medicines need to be disposed of properly by arrangement with the child’s parents, either by return to, or collection by, the parents or return to the pharmacy for safe disposal.

- Parents should be made aware of their responsibilities via the school prospectus/service brochure.

Provision for safe disposal of used needles will require appropriate special measures, e.g. a “sharps box”, to avoid the possibility of injury to others.

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- This “sharps box” must be kept secure with no access for pupils or unauthorised persons. This should be disposed of in a safe way using a specialist licensed contractor.

Hygiene and Infection Control

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.

- Guidance on infection control in schools and other childcare settings (April 2010) is available from the Health protection Agency at;
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947358374
- CAYA guidance can be found at:
http://dnet/Images/Cleaning%20of%20Bodily%20Fluid%20Spillages%202011.12%20V01_tcm10-201466.doc

NB Employee Medicines

An employee may need to bring their medicine into school. All staff have a responsibility to ensure that their medicines are kept securely and that children will not have access to them. Adequate safeguards must be taken by employees, who are responsible for their own personal supplies, to ensure that such medicines are not issued to any other employee, individual or pupil.

- *Staff medicines must not be stored in a cabinet intended for the use of children’s medicines.*

12 The Administration of Medicines

1. ADMINISTRATION OF MEDICINES - GENERAL CONSIDERATIONS

There are three general situations which apply to the administration of medicines in schools and services. These are as follows.

A The child self-administers their own medicine of which the school/service is aware

Many children will have the capability to keep and administer their own medicine themselves. It is good practice to support and encourage children who are able, to take responsibility to manage their own medicines from a relatively early age and schools/services should encourage this. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility. This should be borne in mind when making a decision about transferring responsibility to a child or young person.

There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self-manage.

- Health professionals, in consultation with parents and children, need to assess the appropriate time to make this transition.
- Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent (or staff/carer).
- In all instances where prescribed and non-prescribed medicines are brought into school/services, notification must be given on the parental consent form. *See template 2 or 8*

See also Section 7

B The child self-administers the medication under supervision

Where the Head teacher/manager or staff are willing to be involved voluntarily, the person in charge is responsible for ensuring that, as a minimum safeguard, self-administration of medicines that are safely stored is supervised by an adult.

Where schools/services supervise self-administration, measures should be taken to ensure the medicine is appropriately stored to prevent any unsupervised self-administration of the medicine.

See previous section 11

This means:

- ensuring access to the medication at appropriate times;
- the medicine is identified as belonging to the named child
- it is within the expiry date;
- a record of medicine administration is kept noting that the session was supervised:
 - the child should sign the form, staff/carers should countersign and indicate that the medication was self-administered by the child under supervision.

See templates 4/13-15

C A named and trained consenting staff member administers the medicine

The school/service will, in this circumstance, store the medicines and must comply with all requirements on the storage of medicines. In order to ensure that medicines are administered safely, the school or service must have a policy/procedures that clarify who is responsible for administering medications.

- The names of the consenting staff willing voluntarily to administer medication must be kept up to date, provide cover during periods of absence and be readily available at the storage point in cases of emergency.

Schools and services will vary in relation to the level of demand for the administration of medicines, whether by staff or under their supervision. Some will have staff on site who are trained in the administration of medicines.

Schools and services are advised to consider what the level of (future) demand is likely to be and whether or not voluntary arrangements will be appropriate and adequate.

- For some it may be appropriate to have some staff job descriptions that include responsibilities for the administration of medicines.

For further advice and information contact CAYA Health and Safety on 01629 536525

2. ADMINISTRATION OF MEDICINES BY STAFF

All staff who participates in administering medication must receive appropriate information and training for specified treatments in accordance with this guidance and the Codes of Practice. In most instances, this will not involve more than would be expected of a parent or adult who gives medicine to a child.

- Training can be accessed from different services, for example, specialist nurses, the School Health Service, Derbyshire Children's Community Nursing Training Team or the Children in Care Nurses, who will liaise as appropriate with those doctors responsible for the management and prescription of treatment, particularly in complex cases.

In schools and services, the Head teacher/manager is responsible for knowing which children are taking medication and who is responsible for administering it. In schools, Headteachers must ensure that:

- all relevant staff are aware of pupils who are taking medication and who is responsible for administering the medication;
- this person should be routinely summoned in the event of a child on medication feeling unwell, as they should be aware of any symptoms, if any, associated with the child's illness which may require emergency action;
- other trained staff who may be required, e.g. First Aider should be summoned as appropriate.

Safe administration of medicines means that they are given in such a way as to maximise benefit and to avoid causing harm. Whenever possible, children & young people should be responsible for looking after and taking their own medicines.

- Where a child/young person is unable or unwilling to be responsible for the safe storage/self-administration of medicines, staff will need to take responsibility for this.
- If staff are required, or have consented, to help supervise or administer non-prescription medication due to a child's age or ability to be responsible for their own storage and administration of the medicine, then these procedures for administering medicines must be followed.

In order to give a medicine safely, staff need to be able to:

- identify the medicines correctly. To do so, the medicine pack must have a label attached by the pharmacist or dispensing GP;
- identify the child/young person correctly – a physical description and or a photograph attached to the written instructions can provide additional safeguards;
- know what the medicine is intended to do, for example, to help the person breathe more easily;

- know whether there are any special precautions, for example, give the medicine with food.

There should be a simple easy-to-follow written procedure for giving medicines which staff must be familiar with and follow carefully. Headteachers/managers should also monitor periodically how well staff follow this procedure. Staff should only give medicines that they are competent to administer. They can give or assist children to:

- administer medication in tablet/liquid form;
- apply creams and lotions;
- administer eye drops, ear drops, nasal sprays;
- support individuals with inhalers;
- support individuals with 'when required' medications;
- support individuals with non-prescribed medications from approved list;
- support individuals who self-administer medicines.

Key responsibilities of staff:

Staff must always check:

- the child's name;
- the prescribed dose;
- the expiry date;
- the written instructions provided by the prescriber on the label or container;
- the individual treatment plan where one exists;
- whether or not it is a controlled drug;
- any requirements for refrigerated storage;
- Prior to administration, the medicine administration record (MAR) to ensure that a dosage is due and has not already been given by another person.

If in doubt about any procedure staff should not administer the medicines but check with the parents or a health professional before taking further action. If staff have any other concerns related to administering medicine to a particular child, the issue should be discussed with the parent, if appropriate, or with a health professional attached to the school/service.

- Schools and services **must** keep written records each time medicines are given. *See templates 5, 11-15*
- The administration of **controlled drugs requires 2 people**. One should administer the drug, the other witness the administration.

Managers must routinely:

- check the medicine administration records and countersign to evidence compliance with written guidance or identify and address any non-compliance

See Code of Practice 9.

Staff must never give:

- a non-prescribed medicine to a child unless there is specific written permission from the parents on the appropriate form, and it is the medicine supplied by the parent;
- medicine to a child that does not belong to him or her - schools and services should not keep stocks of non-prescription medicines to give to children;
- medicine that belongs to another child;
- a child under 16 Aspirin or medicines containing Ibuprofen unless prescribed by a doctor.

Staff should not undertake the following unless they have satisfactorily completed additional training:

- rectal administration, e.g. suppositories, Diazepam (for epileptic seizure)
- injectable drugs such as Insulin;
- administration through a Percutaneous Endoscopic Gastrostomy (PEG);
- giving Oxygen.

The Head teacher/manager must keep a record of all relevant and approved training received by staff.

Each person who administers medication must:

- receive a copy of these guidelines and Code of Practice;
- read the written instructions/parental consent form for each child prior to supervising or administering medicines, and check the details on the parental consent form against those on the label of the medication;
- confirm the dosage/frequency on each occasion and consult the medicine record for to ensure there will be no double dosing.

See templates 4, 13-15

- be aware of symptoms which may require emergency action, e.g. those listed on an individual treatment plan where one exists;
- know the emergency action plan and ways of summoning help/assistance from the emergency services;
- check that the medication belongs to the named pupil and is within the expiry date;
- record all administration of medicines as soon as they are given to each individual;

See templates 4, 13-15

- understand and take appropriate hygiene precautions to minimise the risk of cross-contamination;
- ensure that all medicines are returned for safe storage;

- ensure that they have received appropriate training/information. Where this training has not been given, the employee must not undertake administration of medicine and must ensure that the Head teacher is aware of this lack of training/information.

3. REFUSAL TO TAKE MEDICINES

Staff can only administer medicines with the agreement of the child. Any specific instructions to assist the administration of a medicine should be recorded in the child's individual treatment plan as should any instructions in the event of refusal.

- If a child refuses to take a medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures.

See template 16

- Where there is no instruction in the child's plan, staff should follow the school's/services general policy.

The general policy should include the following:

- parents should be informed the same day;
- where refusal may result in an emergency, the school/services emergency procedures should be followed.

13 Record Keeping

Appendix One provides a range of templates which can be used to support safe and effective record keeping.

Records must include:

- an up to date list of current medicines prescribed for each child that has been confirmed in writing;
- what needs to be carried out, for whom and when;
- for children with ongoing or complex needs, a care plan that states whether the child needs support to look after and take some or all medicines or if care workers are responsible for giving them.

Staff must make a record straight after the medicine has been accepted and taken.

- The records must be complete, legible, up to date, written in ink, dated and signed to show who has made the record.
- From the records, anyone should be able to understand exactly what the staff member has done and be able to account for all of the medicines managed for an individual.

Where social care staff are responsible for requesting and/or collecting medicines for a child, they must record:

- what has been received including the name and strength of the medicine;
- how much has been received;
- when it was received;
- when the last dose was given.

In care settings, this is an important record when the person first arrives with supplies of medicine from home or another service.

14 The Individual Treatment Plan

The purpose of an individual treatment plan

The main purpose of an individual treatment plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short written agreement with parents or a parental consent form may be all that is necessary.

- Individual treatment plans are generally required for children with specific medical needs requiring specialised or emergency medication.

An individual treatment plan clarifies for staff, parents and the child, the help that can be provided. It is important for staff to be guided by the child's GP or Paediatrician. Staff should agree with the lead health professional and the child's parents how often they should jointly review the individual treatment plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.

- For children who are in care or who have a short breaks plan it is important to establish a single planning and review process to avoid duplication.

Staff should judge each child's needs individually as children vary in their ability to cope with poor health or a particular medical condition.

- The plan should include action to be taken in an emergency.

Developing an individual treatment plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child.

Templates 1/9-11 can be used or adapted.

The lead health professional will determine who needs to contribute to an individual treatment plan – they may include:

- the child's GP and Paediatrician;
- other health care professionals;
- the Head teacher or manager;
- the parent or carer;
- the child (if appropriate);
- early years practitioner/class teacher (primary schools)/form tutor/head of year (secondary schools);
- care assistant or support staff (if applicable);
- staff who are trained to administer medicines;
- staff who are trained in emergency procedures;
- social worker;
- short breaks staff;
- any worker engaged via an individual budget.

Early years settings should be aware that parents may provide them with a copy of their Family Service Plan, a feature of the Early Support Family Pack promoted through the government's Early Support Programme. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual treatment plan devised by a health professional, or indeed the record of a child's medicines.

Co-ordinating information

Co-ordinating and sharing information about the special needs and requirements of an individual child's medical needs can represent a significant challenge, both within services and settings and across them where a child uses other services.

- The Head teacher/manager should decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies.
- The child's lead professional, together with the parents, should take responsibility for the co-ordination and communication of information and instructions across the wider plan for the child.

Additional information and training

An individual treatment plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health professionals. When staff agree to assist a child with medical needs, the school or service should arrange appropriate training in collaboration with the school health services. Local health services will also be able to advise on further training needs. In every area there will be access to training, in accordance with the provisions of the National Service Framework for Children, Young People and Maternity Services, by health professionals for all conditions and to all schools and services.

Together with the parents, the Head teacher/ managers and the lead professional share responsibility for ensuring that staff who may need to deal with an emergency will need to know about a child's medical needs. The head should make sure that supply staff know about any medical needs.

Confidentiality

Medical information should always be regarded as confidential by services and staff and personal data properly safeguarded.

- Records relating to the administration of medicines are health records and should be stored confidentially.
- Instructions should be shared on a “need to know” basis in order that a child’s well-being is safeguarded and any individual treatment plan is implemented.
- Parents and older children should be engaged in “need to know” decisions which should be recorded.

Staff cannot be held to account if they fail to carry out key tasks, or do so incorrectly, because relevant information has not been shared with them. Similarly, services can only be provided where there is agreement to share relevant information.

15 Children With Complex Health Needs

1. WITH COMPLEX HEALTH NEEDS

As technology develops, growing numbers of children with complex health needs will receive their education in mainstream schools. This group of children and young people may require additional support in order to:

- maintain optimal health during the day;
- access the curriculum to the maximum extent.

Some examples of care of health needs for which children might require additional support in schools and services are:

- restricted mobility *e.g. a child with physical impairments who uses a wheelchair;*
- difficulty in breathing *e.g. a child with a tracheostomy who requires regular airway suctioning during the day;*
- problems with eating and drinking *e.g. a child who requires a gastrostomy feed at lunch time.*
- continence problems *e.g. a child who requires assistance with bladder emptying and needs catheterisation at each break time or to follow a toileting plan to aid continence of bladder and bowels*
- Susceptibility to infection *e.g. a child who is receiving steroid therapy.*

In supporting children with complex needs in schools, early years, social care and community settings there are a growing number of clinical procedures which staff may be trained to undertake. In the main such training is undertaken by Children's Community Nurses, Specialist Nurses or School Community Nurses.

- A detailed Individual Health Plan should be completed as above

Some children with complex physical needs will require a range of specialist equipment to enable them to sit, stand and walk. This equipment should be assessed for by a trained health professional; (Children's Occupational Therapist, Local Authority Moving and Handling Adviser, Physiotherapist or Community Nurse) and the appropriate Local Authority Moving and Handling Advisor or School Link Worker in accordance with the Derbyshire Inter Agency Group (DIAG) guidance document. The equipment should be adjusted to suit an individual child. On the rare occasion when one piece of equipment is used for more than one child, the health professional should supply written instructions, (or manufacturer's instructions), on altering the equipment.

Children may also require a Moving and Handling Plan, completed by school staff or a moving and handling advisor and a Therapeutic Variance Form attached to a Moving and Handling Plan, (completed by the therapist). In order

to promote physical well-being and optimise a child's learning and integration opportunities, specialised equipment should be an integral part of a child's day rather than seen as 'therapy'.

Some children with complex communication needs may require assessment for a communication aid or other relevant specialist equipment. The Speech and Language therapy Service should be involved in assessment procedures for communications aids. Advice is available from the Speech and Language Therapist when a child is a communication aid user.

2. OFF-SITE AND COMMUNITY ACTIVITIES

Off-site education or work experience

Schools are responsible for ensuring via the existing service level agreements, that work experience placements are suitable for students with a particular medical condition. They are also responsible for pupils with medical needs who, as part of key stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or further education college.

- Schools should consider whether it is necessary to carry out a risk assessment before a young person is educated off-site or has work experience.

Schools have a primary duty of care for pupils and have a responsibility to assess the general suitability of all off-site provision including college and work placements. This includes responsibility for an overall risk assessment of the activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours.

- This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

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

Educational visits/outings

Schools and services should actively promote the participation of children with medical needs in educational visits, outings, and community activities which may need to be safely managed. Schools and services should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. The national standards for under

8's day care and childminding mean that the registered person must take positive steps to promote safety on outings. This will include reviewing and revising existing information, policies and procedures so that planning arrangements will include the necessary steps to include children with medical needs.

- It might also include risk assessments for such children.

Sometimes additional safety measures may need to be put in place. An additional supervisor, a parent or another consenting staff member might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration.

- Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures.
- A copy of any individual treatment plans should be taken on visits in the event of the information being needed in an emergency.

Sporting and leisure activities

Most children with medical conditions can participate in physical activities and extra-curricular sport and leisure. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being.

- Any restrictions on a child's ability to participate in PE should be recorded in their individual treatment plan.
- All staff should be aware of issues of privacy and dignity for children with particular needs.

Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

- More details about specific health conditions can be found in the Codes of Practice.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the most appropriate person identified by the child's individual treatment plan.

- Children may not be able to participate in off-site activities where their parents do not share relevant information or decline to give their appropriate consents
- Concerned staff should contact the Health & Safety section for advice

Transporting children

Children who have additional needs and who receive services may have transport needs, including Home to School Transport, Community Transport and taxis to and from services. The Local Authority and services **must** make sure that children are safe during the journey. Most pupils with medical needs do not require supervision on school transport, but the Local Authorities will provide appropriate trained escorts for home to school transport if they consider them necessary.

Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they **must** receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles, responsibilities and liabilities.

Where children have life threatening conditions, specific individual treatment plans should be carried on vehicles. Schools and services will be well placed to advise the Local Authority and its transport contractors of particular issues for individual children. Individual transport treatment plans should be drawn up with input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations.

- All drivers and escorts should have basic first aid training. Additionally trained escorts may be required to support some pupils with complex medical needs.
- These can be healthcare professionals or escorts trained by them.

Some children are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles.

- All escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

3. EMERGENCY PROCEDURES

Where children have conditions which may require rapid intervention, parents must notify the Head teacher/manager of the condition, symptoms and appropriate action following onset – advice may need to be sought on an appropriate response. They should also share any individual treatment plan. All schools and services should have a risk management plan for such situations that covers all possible circumstances when the child is attending the school or service, including off-site activities. Planning should take into account access to a telephone in an emergency in order to summon medical

assistance or an ambulance. The Headteacher/ manager must make all staff aware of any child whose medical condition may require emergency aid and staff should know:

- which children have individual treatment plans;
- possible emergency conditions that might arise, how to recognise the onset of the condition and take appropriate action ie. summon the trained person, call for ambulance if necessary etc. and the emergency instructions contained within them;
- who is responsible for carrying out emergency procedures in the event of need;
- how to call the emergency services;
- what information from the individual treatment plan needs to be disclosed.

Other children should also know what to do in the event of an emergency, such as telling a member of staff.

When a child needs to go to hospital

Staff should not normally take children to hospital in their own car - it is safer to call an ambulance. However, in remote areas a school or service might wish to make arrangements with a local health professional for emergency cover. The national standards require early years' services to ensure that contingency arrangements are in place to cover such emergencies.

- A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives.
- Health professionals are responsible for any decisions on medical treatment when parents are not available.
- Training and practical advice on the recognition of the symptoms can usually be offered by a range of staff including Children in Care nurses, school nurses or community children's nurses who are employed by NHS Trusts.

Where an activity is planned where there is a known risk – however unlikely – that a child might need emergency health care, the risk assessment/individual treatment plan should address what should happen – exceptionally this may include a staff member using his or her own vehicle.

All such arrangements must be agreed and recorded in the child's individual treatment plan and be referred to Risk and Insurance for approval before they are carried out.

These guidelines do not cover First Aid or the role of trained First Aiders or appointed persons. Guidance is available in the County's Code of Practice for Health and Safety (First Aid) Regulations 1981 or the Children & Younger Adults' Department Health and Safety Handbook.

Unusual Occurrences, Serious Illness or Injury

All parents should be informed of the school's/service's policy concerning children who become unwell whilst in the care of the school or service. This should be contained within the school's prospectus or service brochure. This will include home/mobile/work telephone numbers and other instructions e.g. relatives who can be contacted. If parents and relatives are not available when a pupil becomes seriously unwell or injured, the Head teacher/manager should, if necessary call an ambulance to transport the child to hospital.

- *If the pupil is on medication, whether self-administered, under supervision or administered by staff, details must be provided to the emergency service, e.g. details of the written parental consent form in (Template 2 or 8 and 11), the medicine itself and a copy of the last entry on the medication record form*
- *See template 4/5 or 13-15*

These guidelines do not cover First Aid or the role of trained First Aiders or appointed persons. Guidance is available in the County's Code of Practice for Health and Safety (First Aid) Regulations 1981 or the Education Department Health and Safety Handbook.

16 Staff Training

In addition to the basic training for their roles as children's services workers across all settings, all staff must be appropriately trained in the handling and use of medication, and have their competence assessed. The school's/service policy on the administration of medicines should state how frequently this should happen and when it will be reviewed and updated. All staff training should be documented for each staff member.

The minimum training requirements are:

- the supply, storage and disposal of medicines;
- safe administration of medicines;
- quality assurance and record-keeping;
- accountability, responsibility and confidentiality.

Three levels of training need to be delivered:

- induction training;
- basic training in safe handling of medicines;
- specialised training to give medicines.

1. INDUCTION TRAINING

The school/service must identify what previous training and experience a new member of staff has had of giving medicines to people in order to ascertain whether they are competent to give medicines when they get to know the children & young people in their care and their needs.

- Staff who have never worked in a children's, health or social care service should not administer any medicines until the headteacher or manager is satisfied that they are competent to do so.
- Induction training should therefore focus upon medicines awareness - new staff members should understand the limitations of their knowledge and experience and know when and how to enlist the assistance of colleagues trained to administer medicines

2. BASIC TRAINING IN SAFE USE AND HANDLING OF MEDICINES

Basic training is intended to ensure that staff are competent to undertake the following:

Administration

Staff will be able to:

- administer medication in tablet/liquid form;
- apply creams and lotions;
- administer eye drops, ear drops, nasal sprays;
- support individuals with inhalers;
- support individuals with 'when required' medications;
- support individuals with non-prescribed medications from approved list;
- support individuals who self-administer medicines.

Recording

Staff will also understand:

- the need for clear instructions and accurate record keeping;
- how to receive medicines and record instructions;
- the requirements for safe storage of medicines;
- how to record medicines administered;
- the arrangements for safe disposal/return of unused medicines;
- identify medicines and associated procedures for which specific training is required;
- understand when to seek advice.

On completion, there must be a formal assessment, devised by or on behalf of the service provider or manager.

- The aim is to make sure that staff can confidently and correctly give medicines prescribed for the children and young people in their care, or oversee correct self-administration.
- This can be achieved by accompanying the staff member when they give medicines and observing that they complete key tasks in line with policies and procedures.
- This level of training will not cover giving medicines that use 'invasive' techniques such as giving suppositories, enemas, and injection nor clinical procedures for which specific training should be provided.

It should be noted that on occasions there may be additional requirements in respect of individuals. In such circumstances additional advice may need to be sought from staff such as district nurse/asthma nurse etc. regarding the administration of eye drops, ear drops, nasal sprays and inhalers with regards to person specific directions

3. SPECIALISED TRAINING TO GIVE MEDICINES

There may be occasions when workers/carers are willing or required to give medicines that registered nurses normally administer. Such training is always both person-specific and staff member specific. This only happens where:

- it is part of a child/young persons' care plan;
- a risk assessment has been carried out;
- clear roles and responsibilities are agreed by the agencies and the people involved in providing care;
- appropriate consents have been obtained from the young person or person with parental responsibility;
- appropriate training has been provided and a worker's/carer's competence to carry out the procedure established – this will need to be refreshed at intervals determined by the training provider;
- their agreement to do so has been recorded (form 11/11a).

Appendix 2 sets out the list of procedures that can be carried out by staff who have received specialist training and whose competency has been established`

4. MANAGEMENT AUDITS/QUALITY ASSURANCE

In order that managers can ensuring compliance with guidance and procedures, audits should be undertaken at agreed intervals that are commensurate with the level of medicines administered.

- Audit reports provide evidence not only to staff teams about their practice but assure external managers and inspectors that responsibilities are taken seriously and actions taken to address any areas of deficit
- A basic management audit tool can be found as form 19

FOI Status: Public

**CHILDREN AND YOUNGER
ADULTS DEPARTMENT**

Version:
Review Date:

17 Additional Guidance for Children's Social Care (and similar services)

Residential schools, children's homes, foster care and outdoor education centres

These services have additional responsibilities arising from the full time care they provide. They fall into two main groups.

- Short-break/shared care providing pre-planned short breaks with a residential unit or foster home or weekly boarding at a residential school.
- Full time care in a children's home, foster home or a boarding school.

All children living or staying in residential school, children's home or foster home attend school and may be using other services. All the guidance contained within this document has relevance for them but higher standards of information-sharing are necessary because there are more adults/carers involved in the child's life.

- Residential schools will need to put in place guidelines for care and teaching staff to ensure roles and responsibilities in relation to medicines management are clarified.
- When appropriate, and with the parental agreement, they may need to work with local NHS providers for services such as immunisation.
- Managers/heads of care will need to ensure they have in place robust arrangements for recording for each child the medication needs/ instructions and evidencing compliance with those requirements.
- The person in charge/shift leader will have responsibility for ensuring and evidencing compliance.
- Although in foster care there is not the same opportunity to countersign records as evidence of compliance, carers should nevertheless maintain proper records and retain them for inspection should this be necessary.

Services providing full-time care will need to arrange for obtaining and storing prescription medicines that children need on a regular basis or when they have episodes of illness. Most children living in full-time care placements are healthy and have no additional health care needs – others have complex needs and detailed individual treatment plans.

- For children with additional needs who are regular users of short break care, the service could consider asking the person's family or carers to arrange for the GP to write prescriptions for a new supply of medicines to cover the period of respite. The service can arrange to have these medicines dispensed in advance by their local pharmacist.
- Where a young person brings his/her own medicines into the service to cover the break or respite period, the family and carers should be asked to supply

the medicines in the original containers, supplied and labelled by the pharmacist or dispensing GP practice together with a completed consent form.

- If there is any confusion or ambiguity about what medicines or doses are to be given the care provider should make every effort to clarify the details with the prescriber. Advice could also be sought from a pharmacist or NHS Direct/NHS 24 if the prescriber cannot be contacted.
- The manager/heads of care will also need to consider what non-prescription medicines should be available for minor ailments and arrangements for seeking advice when needed.

Home-based and domiciliary care

Home-based services can be provided as a stand-alone service, as part of an outreach approach by a mainstream service, for example a short break provider or part of a package of care organised by a parent using an individual budget or direct payments approach.

- Where staff are working with children and young people in the community and are accessing medicines stored in their own homes, their parents are responsible for safe storage and they have access to this and other documents.
- This guidance should be available to parents who are encouraged to consider its relevance for their own arrangements and those services they engage directly.

Children receiving a home-based/domiciliary service will be receiving services in other settings such as school or early years and an individual treatment plan will be in place. Home-based services are similar, but not identical to, “out-of-home” services. One difference could be that medicines needed outside of the school day are different from those taken at school, or a child may be more comfortable administering his or her own medicine privately at home than in a school environment.

There may also be significant differences in relation to medicines practice. The arrangements for obtaining, storing, disposing of prescription medicines and the choice of non-prescription remedies will be a matter for the parent.

- The individual treatment plan will need to reflect this and the different levels of help that will be needed.
- Whilst the recording tools may be similar, storage arrangements will be different.
- Lone working arrangements, including recording, will differ from a team approach and may have more in common with foster care.
- How to deal with any problems that arise, for example, refusal to take medication. (see section 12, 3 p42)
- Except where parental practice is of concern to the care worker, he or she should not usually seek to influence practice.
- Where it is of concern, it should be a matter for consideration within a risk assessment and the individual treatment plan.

18 Useful Contacts

Local Organisations

Children's Community Nurse Training Team (North County)	The Den, Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire, S44 5 BL	Tel: 01246 514563 Fax: 01246 512630
Children's Community Nurse Training Team (Countywide)	The Den, Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire, S44 5 BL	Tel: 01246 514511 Fax: 01246 514424

National Organisations

Allergy UK

Allergy Help Line: (01322) 619898

Website: www.allergyfoundation.com

The Anaphylaxis Campaign

Helpline: (01252) 542029

Website: www.anaphylaxis.org.uk and www.allergyinschools.co.uk

SHINE (formerly Association for Spina Bifida and Hydrocephalus)

Tel: (01733) 555988 (9am to 5pm)

Website: www.shinecharity.org.uk

Asthma UK (formerly the National Asthma Campaign)

Asthma UK Adviceline: 0800 121 62 44 (Mon-Fri 9am to 5pm)

Website: www.asthma.org.uk

Council for Disabled Children

Tel: (0207) 843 1900; cdc@ncb.org.uk

Website: <http://www.councilfordisabledchildren.org.uk/>

Contact a Family for families with disabled children

Helpline: 0808 808 3555; helpline@cafamily.org.uk

Website: www.cafamily.org.uk

Cystic Fibrosis Trust

Helpline: 0300 373 1000

Website: www.cftrust.org.uk

Diabetes UK

Supporter Services: 0845 123 2399, Monday to Friday 9am to 5pm.

supporterservices@diabetes.org.uk

Website: www.diabetes.org.uk

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Department for Education

Telephone: 0370 000 2288
Typetalk: 18001 0370 000 2288
Fax: 01928 738248
Website: www.education.gov.uk/

Department of Health

Phone: 020 7210 4850 (Office opening hours 08:30-17:30 Mon-Fri)
Textphone: 020 7210 5025 (for people with impaired hearing)
Fax: 020 7210 5952
Online: [web contact form](#)
Website: www.dh.gov.uk

Equalities & Human Rights Commission (DRC)

Equality and Human Rights Commission Helpline: 0845 604 6610
Monday - Friday 8am - 6pm
Textphone: 0845 604 6620
Fax: 0845 604 6630
Freepost RRLG-GHUX-CTR, Arndale House, Arndale Centre, Manchester, M4 3AQ
Email: englandhelpline@equalityhumanrights.com
Website: <http://www.equalityhumanrights.com/>

Epilepsy Action

Freephone Helpline: 0808 800 5050 (Mon – Thurs 9am to 4.30pm, Fri 9am to 4pm)
Fax: (01133) 910300 (UK)
Email: epilepsy@epilepsy.org.uk
Website: www.epilepsy.org.uk

Health and Safety Executive (HSE)

HSE Infoline: 08701 545500 (Mon-Fri 8am-6pm)
Website: www.hse.gov.uk

Health Education Trust

Tel: (01789) 773915
Website: www.healthedtrust.com

Hyperactive Children's Support Group

Tel: (01243) 551313
Website: www.hacsg.org.uk

MENCAP

Learning Disability Helpline: 0808 808 1111
Mencap Direct: 0300 333 1111
Website: www.mencap.org.uk

National Eczema Society

Helpline: 0800 089 (Mon-Fri 8am to 8pm)
Website: www.eczema.org

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NHS Direct

Helpline: 0845 4647

Website: www.nhsdirect.nhs.uk/

Epilepsy Society

Helpline: (01494) 601 400 (Mon-Fri 10am to 4pm)

Website: <http://www.epilepsysociety.org.uk/>

Psoriasis Association

Tel: 0845 676 0076 (Mon-Thurs 9.15am to 4.45pm Fri 9.15am to 16.15pm)

Fax (01604) 251621

Email: mail@psoriasis-association.org.uk

Website: www.psoriasis-association.org.uk/

CODES OF PRACTICE

TO BE READ IN CONJUNCTION WITH:

Children's Homes, Boarding Schools and Foster Care: *Royal Pharmaceutical Society - The Handling of Medicines in Social Care*;
Schools, other educational settings and Early Years: *Managing Medicines in Schools and Early Years Settings*⁴

This code of practice will be subject to regular review as new guidance is drafted in response to the changing requirements of services

- 1 Allergy/Anaphylaxis
- 2 Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in school and other settings
- 3 Asthma
- 4 The asthma attack – What to do
- 5 Children with Diabetes needing insulin
- 6 Continence management & the use of Clean Intermittent Catheterisation (CIBC)
- 7 Epilepsy - Treatment of Prolonged Seizures
- 8 Action to be taken if a medicine administration error is identified
- 9 Controlled Drugs
- 10 Disposal of Medicines
- 11 Safe handling and storage of medical gas cylinders
- 12 Non-prescribed medicines/medicinal products
- 13 First Aid

⁴ The Handling of Medicines in Social Care: Royal Pharmaceutical Society
<http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf>
Managing Medicines in Schools and Early Years Settings:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108489aging-medicines-in-schools

1 ALLERGY / ANAPHYLAXIS

This code of practice only applies when the acute allergic condition is known and notified to the school or service.

What is anaphylaxis?

Anaphylaxis is an extreme and severe allergic reaction. The whole body is affected, often within minutes of exposure to the allergen but sometimes after hours.

What can cause anaphylaxis?

Common causes include foods such as peanuts, tree nuts (e.g. almonds, walnuts, cashews, Brazils), sesame, fish, shellfish, dairy products and eggs. Non-food causes include wasp or bee stings, natural latex (rubber), penicillin or any other drug or injection. In some people, exercise can trigger a severe reaction - either on its own or in combination with other factors such as food or drugs (e.g. aspirin).

What are the symptoms?

- Generalised flushing of the skin
- Nettle rash (hives) anywhere on the body
- Sense of impending doom
- Swelling of throat and mouth
- Difficulty in swallowing or speaking
- Alterations in heart rate
- Severe asthma
- Abdominal pain, nausea and vomiting
- Sudden feeling of weakness (drop in blood pressure)
- Collapse and unconsciousness

An individual would not necessarily experience all of these symptoms

Why does anaphylaxis occur?

Any allergic reaction, including the most extreme form, *anaphylactic shock*, occurs because the body's immune system reacts inappropriately in response to the presence of a substance that it wrongly perceives as a threat. An anaphylactic reaction is caused by the sudden release of chemical substances, including histamine, from cells in the blood and tissues where they are stored. The release is triggered by the reaction between the allergic antibody (IgE) and the substance (allergen) causing the anaphylactic reaction. This mechanism is so sensitive that minute quantities of the allergen can cause a reaction. The released chemicals act on blood vessels to cause the swelling in the mouth and anywhere on the skin.

There is a fall in blood pressure and, in asthmatics, the effect is mainly on the lungs.

Many reactions are mild and do not require specific treatment, but *anaphylaxis* is a very severe and life threatening allergic reaction affecting one or more of the body's systems and its organs – ie breathing difficulties or airway compromise/shock. It may happen very quickly or develop gradually.

Types of treatment

The treatment may involve both of the treatments below or just one of them, dependent on the type and severity of the reaction. At all times the individual individual treatment plan must be consulted.

- An oral **antihistamine** (Chlorphenamine)
- An **Adrenaline injection** (epinephrine) administered by Epipen or Anapen which acts quickly to constrict blood vessels, relax smooth muscles in the lungs to improve breathing, stimulate the heartbeat and help to stop swelling around the face and lips.

Immediate emergency medical aid should be called in all cases where an adrenaline injection is administered, informing the doctor/ambulance service of the acute allergic reaction.

ADDITIONAL REQUIREMENTS

In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

- **The parent** must agree to be responsible for ensuring that the school/service is kept supplied with injections which are 'in date'.
- **The Head teacher/Manager** must ensure appropriate training and yearly updates are given to staff.

In schools the School Health Service following consultation with the prescribing Paediatrician is responsible for arranging the appropriate information and training for a minimum of two responsible persons who have consented to administer adrenaline. It may be necessary for the Head teacher to arrange for the teachers and other staff to be briefed about a child's condition and about the arrangements contained in the written instructions.

- If there are no consenting staff members to administer the medication, then an ambulance must be called should a child suffer a reaction.

In full time care and short break services, a similar approach should be taken.

- Children in Care services can approach the Children In Care Health Service or the Children's Community Nurse Training Team
- Other services should approach the Derbyshire Children's Community Nursing Training Team or the Derbyshire Children's Community Health Training Team

Individual treatment plan

The instructions may include detailed arrangements for meals and that steps are taken to ensure that the child does not eat or handle any items of food other than items prepared/approved by the parents/guardians as far as is reasonably practicable. Consideration should be given to play materials, Science and Food Technology – all healthy snack initiatives/ healthy eating options.

- The School Health Service following consultation with the prescribing paediatrician is responsible for arranging the appropriate information and training for sufficient staff to be identified to administer adrenaline in schools and education settings.
- An Individual Treatment Form must be completed by the Consultant Paediatrician or the General Practitioner.
- An individual treatment plan should be completed by the lead health professional in consultation the parents, school/service and, where appropriate nurse, including contact details for parents/carers, specific symptoms and medication for the child.

It will indicate the stage at which various medications must be administered and the order of priority in contacting parents/doctor. This should be used in accordance with the training provided for that individual child. In the event of the child showing any of the signs documented in their individual treatment plan, staff and carers are instructed to follow the agreed emergency procedure for that child documented in the plan.

If Adrenaline is administered then the emergency services/hospital must be given the used device for disposal and told the time of administration.

Storage and access

As the medication is required immediately, the adrenaline injection should be available to the responsible persons at all times, including off-site, trips/visits etc. It would be inappropriate to have the medication in a locked storage cabinet with limited access as any delay in administering the adrenaline is unwarranted.

- The location and access to a second syringe which may be provided as a reserve should be clearly known to the responsible persons.
- Appropriate arrangements must be agreed with parents for provision and safe handling of medication during educational visits away from the school/service.

Administration of medicines

The syringe carries a small concealed needle which needs triggering against an area of fatty tissue, e.g. side of the thigh. If a second injection is administered it must be in a different site on the thigh.

- An acute reaction not previously known must only be dealt with as a medical emergency and no medication administered.

Although the administration of injections is considered to be a matter for medical staff, the advice is that this process can be carried out with confidence after appropriate training. Training can be provided by the School Health Service, the Children in Care Health Service or the Children's Community Nurse Training Team

2. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in school and other settings

Introduction

Attention deficit disorder, with or without hyperactivity, are common problems in schools and other settings characterised by persistent and pervasive difficulties of concentration and attention control (ADD), frequently associated with hyperactivity (ADHD).

These children are easily distracted, have poor attention skills and lack the ability to concentrate for periods of time. They may also be impulsive and volatile resulting in actions they often find difficult to inhibit before it is too late. They are frequently therefore seen as “naughty”, “defiant” and “disruptive”.

Specific advice on management in schools is available via the Children & Younger Adults Department Educational Psychology Service pamphlet “Management of ADHD in schools”. ADD/ADHD may be associated with a wide range of other conditions including generalised learning difficulties, specific learning problems e.g. dyslexia and dyspraxia and in association with autism. It may also be secondary to emotional difficulties, neglect and other psychological problems.

Types of treatment

1. Behavioural strategies as outlined in ‘Management of ADHD in schools’.
2. Individual Education Plan (IEP) developed with advice of Special Educational Needs Care Officer (SENCO), Local Inclusion Officer (IO) and Educational Psychologist.
3. A written care plan or specific behaviour management strategy under the supervision of an experienced clinician such as a psychologist or child Psychiatrist
4. Short acting medication e.g. Methylphenidate, (“Ritalin”, “Equasym”), and Dexamfetamine. **These are controlled drugs.**
5. Long activating medication e.g. ‘Concerta XL’ and ‘Equasym XL’ and Atomoxetine (“Strattera”). **These are controlled drugs**

ADDITIONAL REQUIREMENTS

In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Individual treatment plan

Any changes in child's behaviour, concentration and attention should be documented carefully to allow monitoring of the treatment.

Storage and access

Controlled drugs are subject to stringent storage and recording requirements – see Code of Practice 9 “Controlled Drugs”

Administration of medicines

Methylphenidate treatment is short acting so timing of administration may be critical and may need to be adjusted to get maximum benefit with minimum side effects. Variation of dosage must be notified in writing. Older children who are competent may self administer but must be supervised to ensure medicine has been taken.

Overdose and misuse

High doses of methylphenidate may cause side effects such as irritability, drowsiness, emotional liability and tics (twitches). Any symptoms suggesting side effects should be documented carefully and reported to parents so the dose of medication may be adjusted accordingly.

There is no evidence of drug dependency developing with Methylphenidate treatment.

Accidental overdose of treatment is unlikely to cause serious side effects. Any effects are likely to resolve quickly within hours of stopping treatment. See code of Practice 8 “Action to be taken if a medicine administration error/near miss incident is identified”

Further information

Useful contacts and literature

Parent Support Group
FLARE Derbyshire ADHD support service
01246 969012
flareadhd@aol.com

3. Asthma

Introduction

Children with asthma have inflamed sensitive airways that can become acutely narrowed when in contact with certain triggers producing the characteristic symptoms of **Cough, Breathlessness & Wheeze**. Common triggers in children include viral infections, exercise, certain allergies (e.g. grasses & pollens, animal furs/feathers, house dust mite) cigarette smoke, emotion and stress.

Types of treatment

The most effective way to take asthma medications is to inhale them. This may be via :

- pressurised aerosol
- dry powder device – e.g. Diskhaler, Turbohaler, Accuhaler

The inhaled medicine has to be taken properly otherwise the medicine may spray out into the surrounding air, never getting down into the lungs and therefore have no effect.

The use of a “Spacer” (holding chamber) with the pressurised aerosol overcomes some of the problems children have using inhalers alone and is the most efficient way of getting the treatment into the lungs.

There are two types of treatment for asthma:-

- **“Relievers”**
These are bronchodilators that reduce the airway narrowing that produces the wheeze & breathlessness. They result in **immediate relief**. They are **BLUE** (Ventolin/Bricanyl) inhalers.
- **“Preventers”**
These treatments are needed to be taken regularly to reduce the inflammation & sensitivity of the airway. They are not helpful in acute attacks as they have **no immediate effects**. They are generally **BROWN/ORANGE** or **PURPLE** inhalers and contain inhaled corticosteroids.

Only “Reliever” inhalers need to be available in school and other settings.

“Preventer” treatments can all be prescribed in regimes that do not require these to be taken during school hours.

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Children may be prescribed oral steroid tablets (prednisolone, betamethasone) if their asthma is poorly controlled. Generally if they require oral steroids they are probably not fit for school. However they only need to be taken once daily & should not be required to be given in school hours.

ADDITIONAL REQUIREMENTS

In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Written instructions

Written instructions should be provided with details of the “reliever” inhaler type & dosage provided for school/services. Availability of a Spacer should be recorded & encouraged.

Instructions can also include details of how to help a child breathe. In an acute attack asthmatics tend to take quick shallow breaths and may panic. Some children are taught to adopt a particular posture which relaxes their chest and encourages them to breathe more slowly and deeply during an attack. If they have learnt such a technique encourage them to use it. The emphasis should always be on the **rapid provision of “reliever” medication.**

Labelling

There are several types of inhalers. It is the parent’s/guardians responsibility, in consultation with the child’s GP and dispensing chemist, to ensure that the inhalers rather than the boxes are clearly labelled with the **child’s name** and to identify the medicine as a “**reliever**” or “preventer” (as stated previously the availability of “preventer” inhalers in school/other settings should not be necessary). Pharmacists would not normally add this to the label and so this may appear on the label in the parents/guardians handwriting. This must then be checked against the parental consent form. **Alternatively parents/guardians can ask pharmacists to add this information to the label, this is the preferred option.**

If a Spacer is provided then this also needs to be labelled with the child’s name, again the pharmacist should be asked to add this information.

Storage and access

Asthmatic children must have immediate access to their “reliever” inhaler at all times.

Where possible children of junior school age and above should carry their own inhalers. It is not necessary to lock the inhalers away for safety reasons.

Younger children should be encouraged to be responsible and carry their own inhalers also. However when this is not practically possible then parents may request after consultation with the Head teacher/person in charge for inhalers to be kept with the supervising teacher/worker for safe-keeping and ease of access.

Where Spacers are required arrangements need to be made for appropriate storage and access to these devices as it is not practical for them to be carried around by the child.

Inhalers should be taken to swimming lessons, sports, cross country, team games etc and on educational visits and used accordingly. Some children benefit from taking a dose of their “reliever” prior to taking part in exercise and this should be supported and encouraged.

Administration of medicines

Self-administration is the usual practice. Staff need to be alert to the possible over use of “reliever” inhalers and the Head teacher/person in charge should inform parents/guardians as appropriate.

In circumstances where staff assist a child to use an inhaler, an individual treatment plan provided by the parents in consultation with the GP/asthma nurse should be followed. A record should be made in the Medicine Record Form – Appendix 2 – or equivalent.

Overdose/misuse

No significant danger to health results from occasional overdose/misuse of inhalers. They will do no harm to non-asthmatic children.

Further Information

Asthma UK provide guidelines for school and other settings to help them develop a Schools Asthma Policy. They also provide a sample “School Asthma Card” to be completed by the parent/carer giving required details of asthma medication.

Asthma UK
Summit House
70 Wilson Street
London
EC2A 2DB

or

www.asthma.org.uk

The organisation is funded by voluntary donations

Further advice and guidance can be obtained from:

- The Local School Health Team;
- Community Child Health;
- The Nurse or Designated Doctor for Children in Care;
- The author of an Individual Treatment Plan if one exists for a specific child;
- The child's family doctor or asthma nurse.

4. The Asthma Attack – What To Do

Ideally there should be a school plan of action for asthma attacks. If you do not have a plan of action follow the advice below.

If an asthmatic child becomes breathless and wheezy or coughs continually:

- 1 Let the child take their usual “reliever” treatment (**BLUE INHALER**) **immediately** – using the Spacer if available for that child

If the child has forgotten their inhaler and you do not have prior permission to use another inhaler:

- Call the parents/guardians;
- Failing that call the family doctor;
- Check the attack is not severe – see below.

- 2 **Keep calm** and reassure the child it’s treatable.

- 3 **Help the child to breathe:**

- Sit child upright – lean forward slightly (do not make them lie down);
- Encourage slow deep breaths;
- Offer a drink of water.

- 4 The reliever should work in **5 – 10 minutes**.

- 5 **If the symptoms disappear**, the child can go back to what they were doing.

- 6 **If the symptoms have improved**, but not completely disappeared, call the parents and give another dose of the inhaler while waiting for them.

- 7 If the normal medication has had **no effect**, see severe asthma attack below.

WHAT IS A SEVERE ATTACK?

Any of these signs mean severe:

- normal **relief medication does not work** at all;
- the child is **breathless** enough to have difficulty in talking normally;
- the child is **distressed** or becoming **exhausted**;
- the **pulse rate is 120 per minute** or more;
- **rapid breathing** of 30 breaths a minute or more.

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HOW TO DEAL WITH A SEVERE ATTACK

Either follow your school protocol or:

- **Call an ambulance (or the family doctor if they are likely to be able to come immediately);**
- Get someone to **inform the parents** while you stay helping the child;
- **Keep trying the usual reliever inhaler**, preferably with a supplied Spacer, **every few minutes** and don't worry about the possibility of overdosing as reliever medication is extremely safe.

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5. Children With Diabetes Needing Insulin

Introduction

These children need to monitor their blood sugars by blood testing. They are at risk of high and low blood sugars which may make them unwell.

Children with diabetes will be under the care of a hospital based diabetes team, including a Consultant Paediatrician, paediatric diabetes specialist nurses and dieticians.

The diabetic specialist nurse will be available to support the school staff. They will draw up *written care plans agreed by parents, school or care staff and medical team* for use as appropriate (see below).

New presentation of diabetes

Diabetes is becoming increasingly common in children. Typical symptoms include excessive thirst, needing to pass urine more frequently, weight loss.

If any of these symptoms are noticed by the teaching staff, the concerns should be raised with the parents so they can seek medical advice.

Routine Care

Insulin

Many children will require *2 injections a day* (one before breakfast and one before tea) and therefore are *unlikely to need to inject Insulin at school or day care settings*.

An increasing number of children will be on *4 injections a day* and will need to *inject themselves with fast acting Insulin before their lunch*.

A small number are now receiving insulin via an *'insulin pump'* and receive a continuous infusion of Insulin. They will be trained to administer insulin via the pump before meals.

Those that require insulin before their lunch time meal, will have a *pen injector device to administer Insulin*.

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Each child should have an individual Care Plan detailing:

- safe storage of the Insulin and pen injector;
- location of a private and safe room in which to do the injection;
- arrangements to ensure the child is able to eat immediately after giving the injection (e.g. pass for early school meal /packed lunch).

Blood testing

Children maybe required to test their blood sugar prior to meals, prior to exercise and in an emergency situation (see hypoglycaemia and hyperglycaemia).

Each child should have an *individual care plan* detailing:

- safe storage of glucose meter and supplies;
- the individual performing the blood test. If this is someone other than the child or young person then they must receive training which is reviewed annually;
- safe disposal of all sharps and contaminated equipment.

Food

Children with diabetes should have a healthy balanced diet like all children – low in sugar but high in fibre.

It is however important that they *eat at regular intervals* – many will be advised to have a *snack midmorning and mid afternoon*, in addition to their lunch, to avoid hypoglycaemia.

It is important that children with diabetes are:

- given priority in the queue at meal times;
- allowed to have snacks as directed by the diabetes team. These can usually be taken at break times but in some circumstances may need to be eaten during class time.

Primary school children should have their snacks and meals supervised.

Physical activity

Children with diabetes should participate in all the usual activities.

Physical activity may cause the blood sugar to fall and may cause a hypo. This can be avoided by having a snack before and possibly during or after an activity, depending on the level of activity.

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Each child should have an *Individual Care Plan* detailing:

- Recommended snack prior to, during and after exercise as appropriate.

Common problems encountered

1. Hypoglycaemia (low blood sugar)

Hypoglycaemia ('hypo') is the commonest problem encountered and occurs when the *blood sugar level falls too low* (less than 4 mmol/l).

Typical symptoms and signs include: feeling faint, sweating, pallor, trembling or shakiness, lack of concentration, irrational or aggressive behaviour.

Hypo's can result from: a missed meal or delayed meal or snack, physical activity, too much insulin.

Treatment

It is very important that a *hypo is treated quickly*. If left untreated the blood sugar will fall further and the child could become unconscious.

Each child should have an *individualised treatment plan* and an *emergency pack* available in school containing:

- fast acting sugar (e.g. glucose, dextrose or lucozade tablets / sugary drinks), Glucogel (formerly know as hypostop gel) and snack foods.

The *child should never be left unattended* and the emergency box should be taken to taken to the child.

Management is as follows:

- testing of blood sugar if kit available;
- immediate treatment with fast acting sugar to quickly raise the blood sugar e.g. lucozade drink or glucose tablets;
- if the child is conscious but unable to cooperate with this treatment the Glucogel can be given. This is sugary gel which can be rubbed into the cheek;
- if the child is unconscious then contact emergency services immediately. Do not give Glucogel;
- once the hypo has been treated then the child will require a snack (or a meal if it is meal time).

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2. Hyperglycaemia (high blood sugar)

High blood sugars cause thirst and the need to pass urine more frequently. If untreated, the child can become seriously unwell with vomiting and increasing drowsiness.

Management is as follows:

- check blood sugar;
- inform parent or carer immediately;
- if not available and child unwell: call emergency services.

Outings and Trips/Overnight Stays

Day trips

Children with diabetes should not be excluded from trips/activities which should be discussed with the parent /carer and, if necessary, the Diabetic Specialist Nurse. It is important to take: blood testing kit, extra snacks and insulin and injection kit.

Overnight trips/stays

The child would need to be confident in giving their own injections if staying overnight. A member of staff would need to take responsibility for helping with blood tests and injections. The Diabetic Specialist Nurse will be able to offer advice. Alternatively, the parent/care will need to attend and take responsibility for their child's care.

Further advice

Local diabetes team:

Southern Derbyshire

Derbyshire Children's Hospital - Tel: 01332 340131

Office hours: page Paediatric Diabetic Nurse Specialists

Out of hours: ask for Children's Emergency Dept

North Derbyshire

Chesterfield Royal Hospital

Office hours: 01246 512113 and ask for Diabetic Liaison Nurse

Out of hours: 01246 277271 and ask for Paediatric registrar

Diabetes UK www.diabetes.org.uk

'Children with diabetes at school: what all staff need to know.'

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6 Contenance Management and the Use of Clean Intermittent Catheterisation (CIBC)

Introduction

There are many causes of incontinence in children and therefore the management will vary. Every child requires individual assessment.

Learning, emotional and behavioural difficulties

Bladder and bowel control are a function of physical, intellectual and social development, therefore children with learning difficulties or emotional and behavioural difficulties may be incontinent. These children will require:

1. Full assessment by a continence advisor.
2. A toileting regime designed to accommodate the demands of the school day.
3. A positive rewarding approach.

Urinary continence problems with day time wetting

Daytime wetting is very common in children, particularly younger children in reception and infants. This is usually due to an irritable bladder precipitated by changes in routine when children enter school or move from an early years setting. A few will have an intrinsic problem which may require long term treatment.

Most continence problems may be managed by:

1. Increase total daily fluids spread evenly throughout the day, including school (<5 years 1 litre fluid a day, 5-11 years 1 ½ litres fluid a day, >11 years 2 litres fluid a day).
2. Avoiding irritant fluids e.g. blackcurrant juice and carbonated drinks.
3. Regular toileting usually in natural breaks in the school day, but for some children easy and immediate access to toilets is essential (“holding on” is counter productive).
4. Medication e.g. oxybutynin may be required if other measures are insufficient and may need to be administered at school.

Neuropathic bladder and bowel

Bladder and bowel function is disrupted by abnormal development of the nerve supply and can rarely be cured by treatment. However, medication, surgery and specialist techniques can usually achieve a reasonable level of continence. To

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achieve social control requires very careful assessment by the continence adviser and doctors and a specific care plan implemented by children, parents and care staff. Such a care plan should be designed to achieve continence, encouraging as much independence as possible and respect for the child's dignity and privacy.

All children will require:

1. Regular medical and nursing supervision
2. Private and accessible toilet facilities
3. Accessible cupboard to store equipment
4. Disposal facility for soiled pads and catheters
5. Assessment of welfare support needs
6. Independence training plan
7. Access to specialist counselling as and when required

Types of treatment

Regular Toileting

Planned usually to coincide with breaks in the day. Children may however require more frequent toileting to achieve specific short term gains in agreement with staff. Bowel continence can usually be managed at home.

Medication

Anticholinergics e.g. Oxybutynin may require administration as regular treatment. Children will require this during the day.

Catheterisation (CIBC)

This is a clean (usually not sterile) procedure and can often be performed by children with appropriate supervision. Most can catheterise on the toilet or in a wheelchair alongside the toilet. Whilst independence is being developed children will need supervision to ensure appropriate techniques and regular bladder emptying.

ADDITIONAL REQUIREMENTS

In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Storage and access

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All equipment should be stored in a cupboard easily accessible to child and carer during catheterisation.

Toilet facilities must be easily accessible to the children with the advice of continence adviser and Occupational Therapist and be of sufficient size to allow procedures to take place easily but with sufficient privacy to preserve dignity and independence.

Facilities should be clean, secure, private and, if not for sole use, be accessible as required. Large schools need to consider the need for more than one facility to allow the child access to all facilities on site and access to all areas of the curriculum. Clearly this is essential for split site schools.

Administration of procedure

Training

- At least 2 suitably trained members of staff should be able to assist (perform) CIBC to cover sickness leave.
- Training should be provided by the appropriate specialist nurse through the School Health Service.
- It is the role of the school or service to supervise and support rather than carry out procedures wherever possible to aid the independence of the child.
- The child will require ongoing supervision. Skills may appear to have been lost during extended holidays but increased levels of supervision early in the term to aid settling in should restore efficiency.
- Staff training should be updated by the appropriate specialist nurse at regular intervals.
- Staff will require additional training in lifting and handling for children with additional mobility problems.

USEFUL CONTACTS

North Derbyshire

School Health Service

School Health Department,
Poplar Court, Chesterfield Royal Hospital
Calow, Chesterfield
Derbyshire S44 5BL
Tel: 01246 516102

Community Childrens Team
The Den, Chesterfield Royal Hospital
Calow, Chesterfield
Derbyshire S44 5BL
Tel: 01246 514563

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South Derbyshire

Special Needs Care Programme
(School Nursing)
Wilderslow
121 – 123 Osmaston Road
Derby DE1 2GA
Tel: 01332 363371

ERIC

34 Old School House
Britannia Road
Kingswood
Bristol
BS15 8DL

PromoCon

Redbank House
4 St Chad's Street
Manchester
M8 8QA
Tel: 0870 7774 714

**ASBAH – Association
for Spina Bifida
and Hydrocephalus**

ASBAH House
42 Park Road
Peterborough PE21 2UQ
Tel: 01733 555988

7 Epilepsy - Treatment of Prolonged Seizures

Introduction

Epilepsy is a tendency to have recurrent and unprovoked seizures. Most generalized convulsive seizures last for 2-3 minutes after which the child normally sleeps for a few hours. *Status epilepticus* develops when a seizure does not stop or one seizure happens after another without recovery in between. It is a rare occurrence, but it is a medical emergency due to abnormal breathing, stress on the heart and lack of oxygen leading to brain injury. Staff and carers are asked to give emergency medication to prevent this happening and to stop the seizure as soon as possible.

Types of Treatment

- Regular anti-epileptic medication to help prevent seizures – it is usually taken twice, very occasionally three times, a day: Sodium Valproate, Carbamazepine.
- Emergency Treatment (Rescue medication): rectal Diazepam and Buccal Midazolam.

ADDITIONAL REQUIREMENTS

In addition to the general requirements set out in the main body of this document, there are additional requirements for children with this condition.

Individual Treatment Plan

For each child who is likely to have prolonged seizures there must be an individual treatment plan signed by the most appropriate clinician i.e. epilepsy specialist nurse, paediatrician. This plan must state:

- what type of seizure to treat with emergency medication;
- what medication to give;
- the dose;
- at what point a paramedic ambulance should be called for;
- any other special instructions.

The individual treatment plan must be linked to individual treatment plan or individual safety plan - SEE APPENDIX 1 - FORM 10a, ADMINISTRATION OF EMERGENCY/RECOVERY MEDICATION INDIVIDUAL TREATMENT PLAN

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Administration of Medicines

All staff/carers administering the emergency medication should have received training and have been assessed as competent to do so. This training is available through the Derbyshire Children's Community Nursing Training Team.

- Staff and carers will sign a form to confirm they have been trained in the use of Buccal Midazolam or rectal Diazepam.
- After the initial full training this training should be updated annually.
- It is the school's/agency's responsibility to contact the trainer to provide refresher teaching.

Labelling and Storage of Medicines

~~Buccal Midazolam should be stored and managed as a controlled drug
SEE CODE OF PRACTICE SECTION 9~~

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8 Action to be taken if a medicine administration error/ near miss incident is identified

The aim of all medication-related guidance is to minimise the risk of an administration error occurring. An error in medication administration is defined as **any deviation from the prescribed dose.**

Errors fall into three different categories (plus the temporary category of unresolved at the time):

- (a) Major Error** - is an incident which results in major harm or death, admission to hospital for 24 hours or more or in the service user being rendered unconscious.
- Major errors must be reported immediately to the Manager - Head Teacher, Head of Service, Service Manager or equivalent
 - The Manager will contact the Health and Safety Section.
 - The manager should report the incident to the HSE in line with CAYA Accident Reporting Guidance if it results in a fatality or the pupil/service user going straight to hospital for treatment from the scene of the incident. This can be found at;
http://dnet/working_for_us/your_wellbeing/caya/caya_health_safety/policy_guidance/default.asp
 - The Manager should obtain any witness statements immediately or as soon as possible after the event.
 - A written report detailing the facts must be completed within 24 hours and sent to Health and Safety Section together with this form. A copy must also be filed at the workplace.
 - The Manager and a Health and Safety Officer will then compile a detailed accident investigation report
 - Services subject to inspection will also need to notify the regulatory body
- (b) Unresolved Error** - is an incident the outcome of which for the service user is unknown at the time,
- (c) Minor Error** - is an incident which results in no significant harm to the service user
- (d) Near Miss Incident** - A near miss in medication administration is defined as an incident which might have resulted in an error if it had not been noted and rectified before the error occurred. There have been no consequences for the service user.

In all circumstances where there has been a failure to comply with written instructions, whether resulting in an over or under administration:

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- advice as to what action should be taken should immediately be sought from the person who has prescribed the medication;
- if this person is not available, advice from another medical practitioner or pharmacist should be sought;
- where none of these are available, the local hospital accident and emergency department should be contacted;
- a full record of the incident and action taken is to be recorded

SEE APPENDIX 1, FORM 18

- the following should be informed:
 - Child's parents/carers
 - Health & Safety section at County Hall:
Jerry Sanderson 01629 536499
 - Where the child is in care, the child's social worker and Richard Corker, Head of Quality Assurance, 01629 538906 to identify whether or not notification to OfSTED is required.

Finally:

- the incident should be discussed with the staff team to ensure that any lessons are learned and any changes to practice/procedure introduced to ensure there is no recurrence.

9 Controlled Drugs

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act 1971 and its associated regulations. Some may be prescribed as medication for use by children. Controlled drugs likely to be prescribed to children which may need to be administered in schools and other educational settings are, for example, Methylphenidate and Dexamfetamine for ADHD or possibly Morphine/Fentanyl for pain relief.

There are legal requirements for the storage, administration, records and disposal of controlled drugs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). They do not apply to every social care service and they do not apply when a person looks after and takes their own medicines.

Any trained member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions and these guidelines.

- A child who has been prescribed a controlled drug may legally have it in their possession to bring to school/setting.
- Once the controlled drug comes into a school or service/setting it should be stored securely in a locked container within a locked cabinet to which only named staff should have access.
 - A record of the number of tablets/doses received, should be kept for audit and safety purposes.
- When administering a controlled drug, two people should normally be present - unless it has been agreed that one person may administer the drugs or that the child may administer the drugs him or herself.
- The administration of **controlled drugs requires 2 people**. One should administer the drug, the other witness the administration.
- In some circumstances a non-controlled drug should also be treated in the same way where a higher standard is considered necessary. For example, the administration of rectal diazepam or buccal midazolam – these may be requirements imposed by insurers as a condition of cover
- On each occasion the drug is administered, the remaining balance of the drug should be checked and recorded by the person(s) administering the drugs.
- A controlled drug, as with all medicines, should be safely disposed of by returning it to the pharmacy from which it was obtained or returning to the parent when no longer required to arrange for safe disposal
- If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).
- Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools and settings should have a policy in place for dealing with drug misuse.

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- Settings providing full time care should not store more than 28 days supply of a controlled drug

Lone working

It is not always possible to ensure that 2 workers are available to comply with this requirement and strict adherence at all times could lead to a child being denied access to services. In such circumstances, consideration should be given to alternative ways of providing managerial oversight . For example:

- on return to base, an outreach worker's record of medicine administered should be checked and countersigned by a second worker
- a single foster carer's records should be retrospectively checked by their supervising social worker

If staff are concerned that a medicine that is not a controlled should be managed in the same way, it can be treated as a controlled drug.

Off-site and in the Community

This will cover a range of circumstances for which appropriate arrangements will need to be made. They will cover, for example, a range from a short off-site 1:1 activity to a longer, perhaps overnight, activity with a group of young people. The minimum requirements are:

- there must be a named person responsible for safe storage and administration of the medicine;
- where possible, a second person will witness the administration;
- the named person should carry the medicine with him/her at all times; or,
- a lockable/portable device such as a cash box should be used to prevent ready access by an unauthorised person
- only the amount of medicine needed whilst off-site should be taken – it should be stored in a duplicate bottle which can be requested from the pharmacist and must have a duplicate of the original dispensing label on it.
- the controlled drugs register may also be taken where that is appropriate (e.g. a long absence where the register is not required elsewhere in respect of another young person); alternatively a record kept and the register updated on return to base.

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THE CONTROLLED DRUGS REGISTER – SPECIFIC REQUIREMENTS FOR SAFE STORAGE & ADMINISTRATION OF CONTROLLED DRUGS

Storage:

- The controlled drug must be stored in a lockable cupboard/cabinet – *this may be the safe cupboard used for all medicines, in which case there should be a separate, labelled container for the drugs and this register*
- Staff responsible for the administration of the controlled drug must be aware of its location and have access
- The controlled drug must only be given by a member of staff who has received instruction in its administration
- The dosage must be witnessed by a second member of staff, wherever possible - *where this is not possible, for example in 1-1 situations, a manger/supervisor at intervals should countersign this record to evidence compliance with the procedures*
- Any discrepancies must be reported and investigated immediately.

NB – Emergency medicines

Where a drug that is either a controlled drug or one that should be subject to the standards for controlled drugs and is designed for emergency use (Buccal Midazolam, for example), the need for ready access over-rides the general requirements in relation to safe storage.

Recording:

The receipt, administration and disposal of controlled drugs must be recorded in a book intended for that purpose. It must be bound and with numbered pages.

- Schools and services should either purchase a controlled drug register or use the one produced by the Children and Younger Adults Department – for further information
- A separate sheet is to be maintained for each child, for each controlled drug that is stored and for each strength of the drug
- The prescriber’s instructions and any additional guidelines must be followed
- The controlled drug register replaces the MAR sheet for *the specific drug only* – the health and medicine information sheet (Form 12) should also be completed
- ***Entries must never be amended/deleted nor pages removed***
- If a recording error is made, a record to that effect should be entered on that page, countersigned with a statement “go to page...”
- If it is an administration error, the Code of Practice 8 should also be followed

Derbyshire County Council has produced its own controlled drugs register format which can be printed by: DigitalPrint@derbyshire.gov.uk

Alternatively services may purchase a controlled drug recording book such as the one available from:

<http://www.medipost.co.uk/medipost-controlled-drug-recording-book-p-5867.html>

If purchasing a controlled drugs register, staff should check that it is designed – or can be adapted – to record the information set out in the templates below.

CONTROLLED DRUG REGISTER FORMAT PART 1								
NAME OF CHILD								
MEDICINE RECEIVED								
Name of medicine received:								
Strength:								
Form:								
Quantity/amount:								
Received from:		Pharmacy: or			Date			
		Parent/carer			Date			
Signed:							Date	
Witnessed:								
DISPOSAL METHOD								
Name of medicine received:								
Returned to:		Pharmacy: or			Date			
		Parent/carer			Date			
Amount: – <i>this should be the amount remaining from the administration record</i>								
Signed:							Date	
Witnessed:								
CONTROLLED DRUG REGISTER FORMAT PART 2								
Received		Administered				By whom		Stock
Amount	Date	Name	Date	Time	Amount given	Worker administering	Worker witnessing	Balance remaining

10 Disposal of Medicines

All care settings should have a written policy for the safe disposal of surplus, unwanted or expired medicines. When care staff are responsible for the disposal, a complete record of medicines should be made. The normal method for disposing of medicines should be by returning them to the supplier who can then ensure that these medicines are disposed of in accordance with current waste regulations.

Circumstances when medicines might need to be disposed of include:

- a child's treatment is changed or discontinued — the remaining supplies of it should be disposed of safely;
- the medicine reaches its expiry date. Some medicine expiry dates are shortened when the product has been opened and is in use, for example, eye drops. When applicable, this is stated in the product information leaflet (PIL);
- In the event of a child death, any medicines should be kept for seven days in case the Coroner's Office or a courts ask for them.

In order to provide a full audit trail of medicines, a record is required to identify the removal of a child's medicines. This record should detail the following:

- date of disposal/return to pharmacy;
- name and strength of medicine;
- quantity removed;
- service user for whom medication was prescribed or purchased;
- signature of the member of staff who arranges disposal of the medicines.

All medicines should be returned with the child at the end of the course of treatment or, where the child has been cared for overnight, at the end of the stay.

- In exceptional circumstances unused medicines will remain with staff or carers and will need to be disposed of.
- This record is also necessary when medication is transferred to another service provider, for example from school to a foster home or short term break and vice versa.
- This procedure includes any transfer to an NHS hospital.

When a child transfers to another care service, they should take all of their medicines with them, unless they agree to dispose of any that are no longer needed.

11 Safe Handling and Storage of Medical Gas Cylinders

General guidance

1. All personnel handling medical gas cylinders and responsible for pipeline gas supplies should have adequate knowledge of the properties of the gas and be competent in the safe use of the product, precautions to be taken, actions in the event of an emergency and the correct operating procedures for their installations.
2. If you own your cylinders you must be aware of, and discharge your statutory obligations with regard to maintenance and testing.
3. You should ensure that when cylinders are collected the driver has been properly instructed in the method of handling cylinders and in dealing with any emergency.

Storage of cylinders

1. Cylinders should be stored under cover, preferably inside, kept dry and clean and not subjected to extremes of heat or cold.
2. Cylinders should not be stored near stocks of combustible materials or near sources of heat.
3. Warning notices prohibiting smoking and naked lights must be posted clearly.
4. Emergency services should be advised of the location of the cylinder store
5. Medical cylinders containing different gases should be segregated within the store.
6. Full and empty cylinders should be stored separately. Full cylinders should be used in strict rotation.
7. Medical cylinders should be stored separately from industrial and other non-medical cylinders.
8. Cylinders must not be repainted, have any markings obscured or labels removed.
9. F size cylinders and larger should be stored vertically, E size cylinders and smaller should be stored horizontally.
10. Precautions should be taken to protect cylinders from theft.

Preparation for Use

1. Cylinder valves should be opened momentarily prior to use to blow any grit or foreign matter out of the outlet.
2. Ensure that the connecting face on the yoke, manifold or regulator is clean and the sealing washer or 'O' ring where fitted is in good condition.
3. Cylinder valves must be opened slowly.

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4. Only the appropriate regulator should be used for the particular gas concerned.
5. Pipelines for medical gases should be installed in accordance with the conditions set out in HTM 2022.
6. Cylinder valves and any associated equipment must never be lubricated and must be kept free from oil and grease.

Leaks

1. Should leaks occur this will usually be evident by a hissing noise.
2. Leaks can be found by brushing the suspected area with an approved leak test solution such as 1% *Teepol HB7 solution.
3. The gland packing around the valve spindle may become loose and can be cured by tightening the gland nut clockwise. Do not over tighten.
4. Sealing or jointing compounds must never be used to cure a leak.
5. Never use excessive force when connecting equipment to cylinders.

Use of cylinders

1. Cylinders should be handled with care and not knocked violently or allowed to fall.
2. Cylinders should only be moved with the appropriate size and type of trolley.
3. When in use cylinders should be firmly secured to a suitable cylinder support.
4. Cylinders containing liquefiable gas must always be used vertically with the valve uppermost.
5. Medical gases must only be used for medicinal purposes.
6. Smoking and naked lights must not be allowed within the vicinity of cylinders or pipeline outlets.
7. After use cylinder valves should be closed using moderate force only and the pressure in the regulator or tailpipe released.
8. When empty the cylinder valve must be closed.
9. Ensure the plastic valve cap is refitted to bullnose valves/outlets.
10. Immediately return empty cylinders to the empty cylinder store for return to BOC.

Further information concerning specific problems arising from the storage and handling of gases, hazards and first aid treatment can be obtained from companies such as BOC. <http://www.boconline.co.uk/health/index.asp>

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General References:

'Gas Safe - with Medical Gases,
'Safe Under Pressure' BOC Limited,
Handbook of Compressed Gases, Compressed Gas Association Inc., Reinhold
(1990).
Gas Data Book, Matheson Gas Products (1971).
The Road Traffic (Carriage of Dangerous Substances in Packages etc) Regulations
1986, SI.1986, No 1951 and supporting Code of Practice
*Teepol is a registered trade mark of Shell International Petroleum Company
Limited

12 Non-prescribed medicines/medicinal products⁵

General guidance

Schools and day services should not routinely maintain a stock of non-prescription remedies since the need for urgent administration that cannot wait until a child returns home should be rare and usually only administered with a parent's agreement. Care and other overnight services may need to administer such remedies and should obtain parental consent and advice in advance of the need arising.

"Over the counter" medicines and other products can be useful for dealing with minor, self-limiting ailments which would not normally require consultation with a doctor. They are not **prescribed** for individuals but help to treat the symptoms of a minor ailment such as cough, cold or diarrhoea. They do not offer a cure and are not essential for good health. Therefore, it is not compulsory that a child's carers should keep household remedies.

They are not, however, a substitute for qualified medical attention, especially if:

- The child has other health conditions e.g: asthma, diabetes, epilepsy or receives anti-coagulant (Warfarin) medication;
- The symptoms do not respond to the recommended treatment following a maximum period of 3 days.

Staff/carers should always check the child's medication record to confirm that they have no known allergy to any medicine - further information or advice can be obtained from local Pharmacists.

The medicines in this guide have been carefully selected on the basis that they are readily available from pharmacies. They have also been chosen on the basis that such products are commonly used in ordinary family homes. The safety record of the medicines is known to be good and there is evidence that the products help to treat the symptoms of minor ailments.

Remember that no medicine can be said to be wholly without side-effects.

- Always read the information leaflet before administering the medicine.
- Children below 6 years of age should **not** be treated with over the counter remedies
- Children aged between 6 and 11 years should take 'paediatric' doses.

⁵ This guidance is written mainly with children's homes, foster carers and boarding schools in mind where children are cared for overnight and where medical or nursing advice may not be available and the need for such products is most likely to arise.

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- Children aged 12 and over may take adult doses.
- If in doubt check with a pharmacist or doctor.
- Take care to use the medicines according to the dose range stated and for ***no longer than 3 days.***

Advice for children with diabetes

Children with diabetes have special dietary needs and particular care must be taken to ensure that minor ailments and household remedies do not upset blood sugar control.

- Where appropriate, separate guidance is offered and shown *in italic text*.
- Where there are practical points of relevance to the treatment of minor ailments or the use of household remedies, these are shown as separate bullet points.

Storage

- All remedies must be stored in a lockable medicine cabinet but separate from prescribed medicines.
- All dosages should be recorded in line with the service's established practice.
- The provision of all medication at each establishment should be checked at least once per year and more frequently if problems are identified.
- Remedies should remain in the original containers and be accompanied by any leaflets or information supplied.
- "Use by" dates should be monitored and observed.
- They should not be thought of as 'first-aid'.

Insect bites and stings

Insect bites and stings are best treated with calamine preparations such as calamine cream or lotion. A painkilling spray, such as Wasp-Eze may be useful, especially on outings when away from home and when away from medical backup.

- Children who are known to be allergic to wasp or bee stings should make sure that they keep emergency treatment with them at all times – creams and lotions must not be applied

If a child sustains an animal bite, medical attention should be sought and no creams or lotions applied

Burns and scalds

Apply first aid treatment only.

- Bathe or immerse in cold running water (e.g. running cold tap) for a minimum of 10 minutes.

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- Do not apply creams or ointments.
- Seek medical advice if severe.
- If medical assistance is required, follow first aid procedures.

Constipation

Most children do not really need regular doses of any laxative, so the taking of laxatives on a regular basis, unless prescribed by a doctor for medical reasons, should be discouraged. Constipation may be corrected by increasing the amount of fluid and fibre taken every day. One of the easiest ways of achieving this is to include fresh fruit in the daily diet.

Diarrhoea

The symptom of diarrhoea is usually self-limiting and the condition generally resolves itself within a few days. The most important treatment is to give plenty of fluids to prevent dehydration. If diarrhoea persists for more than three days, further investigation is required by a doctor. Doctors may be reluctant to prescribe antibiotics for diarrhoea for fear of antibiotic resistance.

- Inappropriate use of antibiotics can cause resistance of bugs to antibiotic treatment.
- Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.

Diabetics should:

- *also take plenty of fluids and seek advice from the doctor because diarrhoea might upset control of blood sugar levels;*
- *continue with insulin or oral anti-diabetic medicines and increase the frequency of blood or urine glucose monitoring;*
- *seek further advice if necessary.*

Seek assistance from a doctor if symptoms persist

Cough

This is usually a symptom of infection in the upper breathing tubes (respiratory tract) and the chest which is often minor and self-limiting. Bacteria and viruses are often responsible but the body usually successfully fights such infections without the need for antibiotics or cough medicines. Cough medicines are not particularly effective at preventing coughs and, in any case, coughing is the body's way of helping to clear the chest.

- Doctors may be reluctant to prescribe antibiotics for a chesty cough for fear of antibiotic resistance.

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- Inappropriate use of antibiotics can cause resistance of the bugs to antibiotic treatment
- Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.

If a cough is very persistent and is causing distress, then a simple paediatric linctus may be soothing and helpful.

*Diabetics should use a sugar-free product
Seek assistance from a doctor if symptoms persist*

Eye Care

Eye lotions are often sought after but are not recommended.

- Tiredness is best cured by sleep.
- If dirt or chemical substance gets in the eye, bathe the eye with plenty of tepid water.
- If the eye is red, itchy or feels gritty it is likely to have been caused by an infection.

Consult a doctor or pharmacist if these symptoms persist.

Foot Care

Athlete's foot is common but also frequently mis-diagnosed. Medicated anti-fungal creams could cause dermatitis.

- Wash and dry the skin.
- Use a non-medicated cream such as zinc and castor oil or E45 cream.
- Talcum powder may be applied to the socks (not to the foot itself) to keep skin dry.
- If the condition persists, seek medical advice.

Diabetics should always seek medical attention.

Pain (such as Headache or Period Pain)

There are numerous pain remedies available from general stores and pharmacies. Most contain either aspirin or paracetamol or a combination of the two. Many branded products are more costly but greater effectiveness has not been proven.

- Aspirin should not administered to children aged under 16 except where a parent or doctor has specified this.
- Paracetamol should be the medicine of choice.
- The non-brand name versions of paracetamol are available from pharmacies and are inexpensive.

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As with any other medication, paracetamol must be stored in a locked cabinet and staff need to be aware of its potential to cause serious harm.

- Special vigilance is required at the time of giving out medicines to children - for example, it will be necessary to guard against the possibility that a child might snatch medicines out of the hand.

Dosage:

- Children aged over 6 years of age may take paracetamol suspension (one to two 5ml spoonfuls every six hours).
- Do not exceed four doses in 24 hours.

Any persistent pain, painful movement or pain which is not controlled with paracetamol requires investigation by a doctor. Staff should check to ensure that the maximum safe dosages of paracetamol are not exceeded

Skin

Cleansing the skin should be done by washing in soap and water. Sometimes soreness can be prevented by keeping surface of the skin dry. The use of talc and tissue can help prevent soreness caused when skin surfaces touch.

The following creams and ointments are of value in the treatment of sore skin.

- Aqueous cream - a useful moisturiser for dry skin.
- CreamE45 - a non-greasy softening and soothing, unperfumed cream useful for dry or chapped skin.
- Drapolene - good for urinary rash.
- Sudocrem - contains lanolin (so beware of allergy). Useful for minor skin sores.
- Zinc and castor oil - an old favourite in the treatment of urinary rash and for pressure sores.
- Vaseline (White soft paraffin) - an invaluable barrier ointment for soothing and softening and also useful for chapped lips.

Once opened, creams and lotions should be considered out of date after 28 days and disposed of – pump action dispensers normally have a longer life.

Where tubs of cream are used by more than one child, wherever possible staff should, for hygiene reasons, wear rubber gloves because of the risk of contamination.

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Sore throat

Sore throat often occurs with the common cold and is typically caused by both bacterial and viral infections. It is usually self-limiting and not worth treating. In severe cases, sucking a soothing non-medicated lozenge as required such as glycerine, lemon and honey (any brand) may help.

- Sometimes the infection may not be treatable with antibiotics - the inappropriate use of antibiotics can cause resistance of the bugs to antibiotic treatment.
- Continued misuse of antibiotics could eventually mean that antibiotics become useless in the treatment of severe infections.
- Doctors may be reluctant to prescribe antibiotics for the above reasons.
- If the infection persists, take advice from the child's G.P.

13 First Aid

First aid can save lives and prevent minor injuries becoming major ones. It does not include giving tablets or medicines to treat illness. Although the regulations are intended to cover employees, the same level of treatment should be provided for all other persons – pupils/service users, parents, visitors, staff, contractors, members of the public etc.

Staff should consult their organisations Health & Safety at Work procedures

**APPENDIX ONE
USEFUL PRO-FORMAS**

Based on DFES Guidance for schools and early years settings	
Form 1	Individual treatment plan
Form 2	Parental Consent for Schools/Setting to Administer Medicine
Form 3	Head teacher/Head of Setting Agreement to Administer Medicine
Form 4	Record of medicine administered to an individual child
Form 5	Record of Medicines Administered to all Children
Form 6	Request for child to carry his/her own medicine
Form 7	Staff training record – Administration of Medicines

DCC Social Care/Short Breaks	
Form 8	Medical consent for a child attending a short break or a full-time placement
Form 8a	Medical consent given by a young person attending a short break or a full-time placement
Form 9	Checklist – individual safety plan for children with disabilities and/or health/medication needs
Form 10	Clinical procedure plan
Form 10a	Administration of emergency/recovery medication individual treatment plan
Form 11	Clinical Procedures training record – individual
Form 11a	Clinical Procedures training record – team
Form 12	Health & medicines information sheet
Form 13	Temporary variation to medical instruction
Form 14 (MAR1)	Medication administration record requirements
Form 15 (MAR2)	Medication administration record administration record
Form 16 (MAR3)	Medication administration record – observations and variation
Form 17	Body maps for use with creams and lotions
Form 18	Medication error/near miss incident report

Form 1 – Individual treatment plan

Name of School/Setting

Childs name

Date of birth

Group/Class/Form

Childs Address

Medical diagnosis or condition

Date

Review Date

Family Contact Information – First Contact

Name

Phone Number (work)

(home)

(mobile)

Family Contact Information – Second Contact

Name

Phone Number (work)

(home)

(mobile)

Clinic/Hospital Contact

Name

Phone Number

General Practitioner (G.P.)

Name

Phone Number

Describe medical needs and give details of child's symptoms

Daily care requirements (e.g. before sport/at lunchtime)

Describe what constitutes an emergency for the child, and the action to take if this occurs

Follow up care

Who is responsible in an emergency (state if different for off-site activities)

Form copies to

Form 2 - Parental Consent for Schools/Setting to Administer Medicine

The school/Setting will not give your child medicine unless you complete and sign this form, and has a policy that staff can administer medicine, and staff consent to do this.

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

Name of School/Setting

Date

Childs name

Date of birth

Group/Class/Form

Medical condition or illness

Medicine

Name/type of medicine/strength
(as described on the container)

Date dispensed

Expiry date

Agreed review date to be initiated by
(name of member of staff)

Dosage and method

Timing – when to be given

Special precautions

Any other instructions

Number of tablets/quantity to be given to
School/Setting

Are there any side effects that the
School/Setting needs to know about?

Self administration

Procedures to take in an emergency

Contact Details – First Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Contact Details – Second Contact

Name

Daytime telephone number

Relationship to child

Address

I understand that I must deliver the medicine personally to (agreed member of staff)

Name and phone number of G.P.

The above information is, to be the best of my knowledge, accurate at the time of writing and I give consent to School/Setting staff administering medicine in accordance with the School/Setting policy. I will inform the School/Setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I accept that this is a service that the School/Setting is not obliged to undertake.
I understand that I must notify the School/Setting of any changes in writing

Date _____ Signature(s) _____

Parent's signature _____

Print name _____

Date _____

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

For School/Setting Use

Reviewed by	Date	Signature	Print Name

To be reviewed annually or if dose changes

Form 3 - Head teacher/Head of Setting Agreement to Administer Medicine

Name of School/Setting

It is agreed that (name of child) _____ will receive (quantity and name of medicine) _____ every date at (time medicine to be administered e.g. lunchtime or afternoon break) _____.

(Name of child) _____ will be given/supervised whilst he/she takes their medication by (Name of member of staff) _____

This arrangement will continue until (either end date of course of medication or until instructed by parents)

_____.

Date _____

Signed _____

(The Head teacher/Head of Setting/named member of staff

Form 4 - Record of medicine administered to an individual child

Name of School/Setting	<input style="width: 100%;" type="text"/>
Childs name	<input style="width: 100%;" type="text"/>
Date of birth	<input style="width: 100%; text-align: center;" type="text" value="Day / Month / Year"/>
Group/Class/Form	<input style="width: 100%;" type="text"/>
Date medicine provided by parent	<input style="width: 100%;" type="text"/>
Quantity received	<input style="width: 100%;" type="text"/>
Name and strength of medicine	<input style="width: 100%;" type="text"/>
Expiry date	<input style="width: 100%; text-align: center;" type="text" value="Day / Month / Year"/>
Quantity returned	<input style="width: 100%;" type="text"/>
Dose and frequency of medicine	<input style="width: 100%;" type="text"/>
Staff signature	<hr style="border: none; border-top: 1px solid black;"/>
Signature of parent	<hr style="border: none; border-top: 1px solid black;"/>

Date	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>
Time given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Dose given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Name of member of staff	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Staff initials	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Date	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>
Time given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Dose given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Name of member of staff	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Staff initials	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Date	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>	<input style="width: 20%; text-align: center;" type="text" value="/ /"/>
Time given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Dose given	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>
Name of member of staff	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>	<input style="width: 20%;" type="text"/>

Staff initials

Date / / / / / /

Time given

Dose given

Name of member of staff

Staff initials

Date / / / / / /

Time given

Dose given

Name of member of staff

Staff initials

Date / / / / / /

Time given

Dose given

Name of member of staff

Staff initials

Form 5 - Record of Medicines Administered to all Children

(This form is optional if form 4 is used)

Name of School/Setting

Date	Childs name	Time	Name of medicine	Dose given	Any reaction	Signature of staff	Print Name
/ /							
/ /							
/ /							
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/ /							
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/ /							
/ /							
/ /							
/ /							

Form 6 - Request for Child to Carry His/Her Own Medicine

This form must be completed by parents/guardian/pupil over 16 (delete as appropriate)

If staff have any concerns discuss this request with healthcare professionals

Name of School/Setting

Childs name

Date of birth

Group/Class/Form

Address

Name of medicines

Procedures to be taken in an emergency

Contact Information

Name

Daytime phone number

Mobile Number

Relationship to child

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

Signed _____

Date _____

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

Form 7 - Staff Training Record – Administration of Medicines

Name of School/Setting

Name

Types of training received

Date of training completed

Training provided by

Profession and title

I confirm that (name of member of staff) _____ has received the training details above, is competent and has agreed to carry out any necessary treatment. *

** Use continuation sheet where more than one member of staff has been trained*

I recommend that the training is updated (please state how often) _____

Trainers signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

We are updating these forms

FORM 8 PARENTAL MEDICAL CONSENT FOR A CHILD ATTENDING A SHORT BREAK OR A FULL-TIME PLACEMENT				
This form must be completed in full and a signed copy given to staff/ carers when the child is placed.				
CHILD'S NAME				DOB
Consent to medical treatment				
I/we				
<i>Names of parent or other person with parental responsibility</i>				
Emergency treatment Consent given for emergency, surgical, medical and dental examinations and intervention (including anaesthetics)	Yes		No	
Routine treatment Consent given for routine medical and dental intervention/treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child/young person (including immunisations)	Yes		No	
Planned treatment Consent given for planned surgical intervention/ treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child/young person	Yes		No	
Additional agreements and consents these might be required for children and young people with complex health needs. For example, agreement to psychiatric/psychological assessments, consent to the administration of non prescription medicines such as Calpol or consent to the use and provision of specialist equipment such as tube feeding				
Description of additional agreements	Yes		No	
Health – Parent's comments and approval				
<ul style="list-style-type: none"> parent or other person with parental responsibility may wish to give their views about any of the treatments above or procedures below 				
Signature of parent(s) or person with parental responsibility and explanation of consents acknowledged identified above				
<ul style="list-style-type: none"> the issue of consent to medical treatment has been explained to me 	Yes		No	
<ul style="list-style-type: none"> I understand that these permissions will be delegated to the named staff/carers looking after my child and that these names will be updated if the staff/carers change 	Yes		No	
Signature(s)				Date
Consent, delegation and additional agreements as set out above				
Name		Position		Date
Name		Position		Date
Name		Position		Date
Name		Position		Date

FORM 8a CONSENT GIVEN BY A YOUNG PERSON ATTENDING A SHORT BREAK OR A FULL-TIME PLACEMENT				
This form must be completed in full by a young person able and willing to give his or her own consent and a signed copy given to staff/ carers when the child is placed.				
NAME				DOB
Consent to medical treatment				
I				
<i>Name of young person</i>				
Emergency treatment Consent given for emergency, surgical, medical and dental examinations and intervention (including anaesthetics)			Yes	No
Routine treatment Consent given for routine medical and dental intervention/treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child/young person (including immunisations)			Yes	No
Planned treatment Consent given for planned surgical intervention/ treatment deemed by an appropriately qualified medical practitioner to be in the best interests of the child/young person			Yes	No
Additional agreements and consents these might be required for children and young people with complex health needs. For example, agreement to psychiatric/psychological assessments, consent to the administration of non prescription medicines such as Calpol or consent to the use and provision of specialist equipment such as tube feeding				
Description of additional agreements			Yes	No
Health – Young person’s comments and approval				
<ul style="list-style-type: none"> <i>The young person may wish to give views about any of the treatments above or procedures below</i> 				
Signature and explanation of consents acknowledgement identified above				
<ul style="list-style-type: none"> the issue of consent to medical treatment has been explained to me 			Yes	No
<ul style="list-style-type: none"> I understand that these permissions will be delegated to the named staff/carers looking after my child and that these names will be updated if the they change 			Yes	No
Signature(s)				Date
Consent, delegation and additional agreements as set out above				
Name		Position		Date
Name		Position		Date
Name		Position		Date
Name		Position		Date

FORM 9 CHECKLIST – INDIVIDUAL SAFETY PLAN FOR CHILDREN WITH DISABILITIES AND/OR HEALTH/MEDICATION NEEDS

CHILD'S NAME		DOB	
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Please tick yes or no box to indicate whether or not a plan or a risk assessment is required. If you tick yes please state what document you have and where it can be found.

	Plan or Risk assessment required		LOCATION OF PLAN OR RISK ASSESSMENT Where existing/new document will be kept
	Y	N	
Allergies			
Health Issues			
Medication			
Feeding Plan			
Moving & Handling			
Behaviour			
Child Protection Plan			
Home Visiting			
Travelling			
Personal evacuation plan			
Other			

Completed by:		Date:	
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To be reviewed in line with usual processes

FOI Status: Public	CHILDREN AND YOUNGER ADULTS DEPARTMENT	Version: Review Date:
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FORM 10 CLINICAL PROCEDURE PLAN

CHILD'S NAME		DOB	
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Type of procedure	
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Is this a procedure covered by a Code of Practice?	Yes		No	
-----------------------------------------------------------	------------	--	-----------	--

If **yes**, please cross reference with the relevant code of practice.

If **no**, there should be a meeting with a manager, health & safety officer, clinicians, legal advisor, parent and others as necessary to consider alternative ways of meeting the needs and seeking to ensure that the health care needs do not become a barrier to service provision. The meeting should identify the following:

Instructions to staff/carers	
Under what conditions or circumstance do they apply?	

Possible difficulties that can be anticipated	Agreed Response

Risk to the child if plan is not followed	
--------------------------------------------------	--

The service will not be provided until the minimum training requirements have been fulfilled

Training needs identified	To be provided by

Plan agreed by:	Name	Signature
Parent/carer		
Worker		
Manager		

FORM 10a ADMINISTRATION OF EMERGENCY/RECOVERY MEDICATION INDIVIDUAL TREATMENT PLAN		
CHILD'S NAME		DOB

Name of Medication			
Its purpose			
When to be given List types of seizures including description of seizure and actions to be taken for each type NB always cross-reference with the child's current care plan			
Dose to be given			
Method of administration			
Child's usual response to the medication			
Further action			
Can a second dose be given and when?	Yes		Comments
	No		
At what point a paramedic ambulance should be called for			

Name of clinician completing this form			
Title			
Signature			
Date			
Contact details			

Name of parent			
Signature			
Date			
Contact details			

Or:

Signature of older child			
Date			

**FORM 11: CLINICAL PROCEDURE TRAINING RECORD -
INDIVIDUAL STAFF MEMBER/CARER**

Worker/Carer Name:		Post:	
Setting and Address:			

Procedure:	
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To be completed at time the procedure is demonstrated/competencies checked

1.	MEDICAL PROFESSIONAL	
I confirm that I have instructed the following in the above protocol/procedure in respect of:		
(Child's name):		
Signed, designation & date:		

2.	WORKER / CARER	
I confirm that I have received medical instruction and training for the above protocol/procedure from a medical professional and agree to carry it out.		
Signed & date:		

3.	PARENT	
I confirm that following training I am happy for the above-named worker/carers to carry out the above protocol procedure for my child.		
Signed & date:		

FORM 11a: CLINICAL PROCEDURE TRAINING RECORD - STAFF TEAM

Setting and Address:	
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Procedure:	
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To be completed at time the procedure is demonstrated/competencies checked

1.	MEDICAL PROFESSIONAL	
I confirm that I have instructed those named below in the above protocol/procedure in respect of:		
(Child's name):		
Signed, designation & date:		

3.	PARENT	
I confirm that following training I am happy for those named below to carry out the above protocol procedure for my child.		
Signed & date:		

Name	Post:	Signed	Date

I confirm that I have received medical instruction and training for the above protocol/procedure from a medical professional and agree to carry it out.

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FORM 12 HEALTH & MEDICINES INFORMATION SHEET		Date completed	
CHILD'S NAME		DOB	

Disability/ condition									
Summary of health care needs									
Allergies									
Medication including recovery medication	Name	Form	Route	Purpose	Maximum dose in 24 hours	Time between doses	Effective for how long?	Equipment	Special instructions/ when medical advice should be sought

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ADULTS DEPARTMENT**

	Provider	Training	By whom	Fitted by
Equipment used/required				
Diet				
GP			Tel	
Address				
Consultant/ Community Nurse/ Other			Tel	
Address				
Optician			Tel	
Address				
Dentist			Tel	
Address				
Form completed by:			Date:	

FORM 13 TEMPORARY MINOR VARIATION TO MEDICAL INSTRUCTION**CHILD'S NAME****DOB**

This form is to be used for *minor variations only* to medication given to a child whilst in short break care that does not require a health signature. (i.e. change of dose or non-prescription medication)

If this change is to be a permanent one, a new medication form properly authorised will be required as soon as possible. Staff agreeing to a temporary variation must ensure parents/carers understand this.

Date	New Instruction	Parent/Carer/ Person requesting change to medical instruction	Manager/worker accepting the request to change medical instruction	Medicine administered by

FORM 14 (MAR P1)

MEDICATION ADMINISTRATION RECORD INSTRUCTIONS & REQUIREMENTS

CHILD'S NAME:		DOB	
GP:		Tel:	
Address:			

All entries must be completed from a letter/report from a GP or Consultant & checked against the medicine label

Medication: Name Strength Amount received Amount returned/disposed of	Dosage, route & time between doses	Maximum doses in 24 hours	Frequency & time 1	Frequency & time 2	Frequency & time 3	Frequency & time 4	Special instructions/ when medical advice should be sought
1.							
2.							
3.							
4.							

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**FORM 15 (MAR P2) MEDICATION ADMINISTRATION RECORD:
ADMINISTRATION RECORD**

*Record physical description of child here
and/or attach photo*

**Prior to child's arrival, were all
medicines administered as
required – if not give details**

Medication: Name & strength	Dose & time	Day →						
		Date →						
1	1.							
	2.							
	3.							
	4.							
2	1.							
	2.							
	3.							
	4.							
3	1.							
	2.							
	3.							
	4.							
4	1.							
	2.							
	3.							
	4.							
5	1.							
	2.							
	3.							
	4.							

FORM 16 (MAR P3) MEDICATION ADMINISTRATION RECORD: OBSERVATIONS AND VARIATION

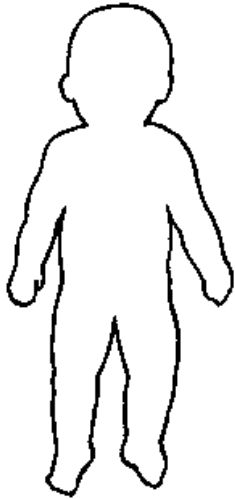
This form is to be used to record any changed, missed or refused dosages or adverse reactions

If a medicine administration error/near miss incident is identified the incident form in the Code of Practice Section 8 should also be completed

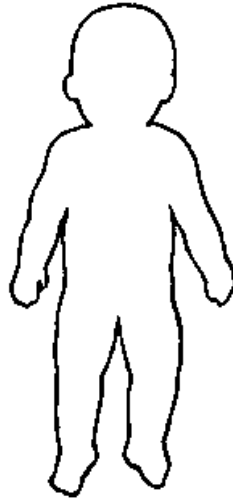
Medicine	Dose, date & time	Reason	Action taken	Worker	Manager

FORM 17

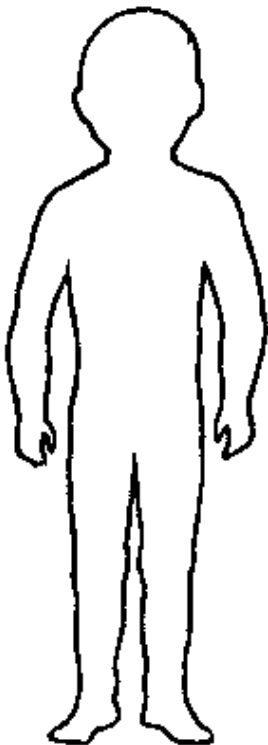
BODY MAPS FOR USE WITH CREAMS AND LOTIONS



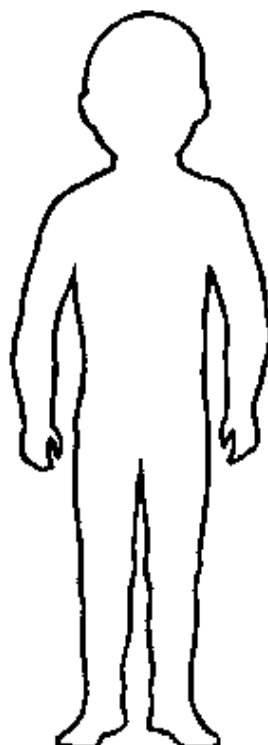
Baby Posterior
(Back) View



Baby Anterior
(Front) View



Child Posterior
(Back) View



Child Anterior
(Front) View

FORM 18 MEDICATION ERROR/NEAR MISS INCIDENT REPORT

1.	Level of Error			✓
	(a) Major Error	(Incident resulting in major harm or death)		
	(b) Unresolved Error	(The outcome at present unknown)		
	(c) Minor Error	(No serious harm suffered)		
	(d) Near Miss	(Error was avoided)		
2.	Service details			
	Service name			
	Address			
	Telephone			
	Person in Charge			
3.	Person completing this form – sign and date at end of form			
	Name			
	Job Title			
4.	Person(s) involved in the incident			
	Name 1			
	Job Title			
	Name 2			
	Job Title			
	Name 3			
5.	Details of the medication error or near miss			
	Name of Child/ Young Person			
	Date and time error occurred			
	Date and time error discovered			
	Details of the error - attach separate report if necessary			
6.	Health professionals involved with the child/young person			
	GP			
	Consultant			
	Nurse			
	Pharmacist			
7.	All others staff/persons involved in the incident			
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	
	Name		Job Title	

8. Who was contacted for advice?						
GP	Yes	No	NHS Direct	Yes	No	
Consultant	Yes	No	H&S Officer	Yes	No	
Nurse	Yes	No	Parent	Yes	No	
Pharmacist	Yes	No		Yes		
Time of Contact	Advice received:					
Time of Contact	Advice received:					
9. Advice and Action						
By whom - name and contact details			Time			
Advice given						
Action Taken						
By Whom			Time			
Advice given						
Action Taken						
10. Who has been informed about the incident						
			If no, give reasons			
Child/young person	Yes	No				
Parent/Person with PR	Yes	No				
Other Carer	Yes	No				
Manager	Yes	No				
H&S Officer	Yes	No				
Head of Quality Assurance	Yes	No	If child/young person is in care			
	Yes					
11. Type of incident						
Type of incident	Detail					✓
Wrong service user						
Wrong quantity given						
Wrong strength of medicine administered						
Wrong form of the medicine						
Dose omitted						
Wrong medicine given						
Medicine out of date						
Recording error						
Medicine given at wrong time						
Medicine refused/staff unable to administer						
Other						

12.	Cause of incident	Detail	✓
	Unclear labelling caused confusion		
	Unclear instructions caused confusion		
	Wrong service user name		
	Product out of date		
	Interruptions		
	Service user refused		
	Staff/carer unable to administer		
Other cause			
13.	Immediate action to be taken		✓
	Investigation by manager		
	Investigation by Health and Safety Officer		
	Investigation under complaints procedure		
	Investigation by external body		
14.	Action to prevent a recurrence		✓
	Workplace procedures/systems review		
	Workplace training		
	Wider procedures/systems review		
	Wider training		
15.	Additional Notifications – Major Incident Only		✓
	Health & Safety Officer		
	Health & Safety Executive		
	Senior Departmental Manager		
	OFSTED		
	CQC		
Name		Position	
Signed		Date	

FORM 19 ADMINISTRATION OF MEDICINES: MANAGER'S AUDIT TOOL

Date of last audit		Time		Undertaken by	
Outcome	Audit Satisfactory?		Yes		No
Actions required following audit					
Actions taken following audit					

Date of this audit		Day		Time	
Staff on duty					
Have staff been trained to carry out tasks that are/may be required	Yes		No		Comments

CONSENTS, INSTRUCTIONS, RECEIPT OF MEDICINES

Number of children receiving a service		Number on medication	
Number of children with correct details of medicines		Number of children with correct medicine received/instructions	
Number of children with copies of complete and signed consents			
Findings			
Actions required following audit			
Actions taken following audit			

ADMINISTRATION & RECORDING

Number of children whose medicine was administered correctly		Number of children whose record of administration is complete and correct	
Findings			
Actions required following audit			
Actions taken following audit			

STORAGE OF MEDICINES				
Are all medicines stored in a lockable cupboard ?	Yes		No	
Was the temperature below 25°C?	Yes		No	
Did any medicines require refrigeration?	Yes		No	
Were they correctly stored?	Yes		No	
Were there any controlled drugs on the premises?	Yes		No	
Were they stored correctly?	Yes		No	
Were there any emergency medicines?	Yes		No	
Were they readily accessible?	Yes		No	
Findings				
Actions required following audit				
Actions taken following audit				
NON-PRESCRIPTION MEDICINES (regulated services only)				
Are all medicines stored in a lockable cupboard ?	Yes		No	
Was the temperature below 25°C?	Yes		No	
Were they kept apart from prescribed medicines?	Yes		No	
Were all medicines within the expiry dates?	Yes		No	
Were all medicines appropriate?	Yes		No	
Findings				
Actions required following audit				
Actions taken following audit				
OUTCOME OF AUDIT	Audit Satisfactory?	Yes	No	
Actions required following audit				

Audit undertaken by:		Signed	
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FOI Status: Public

**CHILDREN AND YOUNGER
ADULTS DEPARTMENT**

Version:
Review Date:

Report distribution:

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APPENDIX TWO**PROCEDURES THAT CAN BE CARRIED OUT BY STAFF WHO HAVE RECEIVED SPECIALIST
TRAINING AND WHOSE COMPETENCY HAS BEEN ESTABLISHED**

Below is a table showing the procedures that are:

1. Approved to be undertaken with appropriate training.
2. Need approval to be undertaken and require the provision of specific documentary evidence.

The table has regard to guidance from the RCN (Royal College of Nursing) January 2008 Guidance on permitted tasks for non-health qualified staff. It will be overseen and updated on a quarterly basis by a group of health and local authority staff, including:

Jerry Sanderson, Adela Green, Alex Howlett
Helen Parkes and Helen Burgess

Derbyshire County Council
Health Providers

Procedures that can be carried out without referral to Risk and Insurance:

If the procedure is shown as not requiring the confirmation of the Risk and Insurance Manager it can be carried out subject to:

1. Any stated conditions in the "Insurer Conditions" column being complied with.
2. Appropriate documented training having been completed.
3. Any relevant care plans, parent consent forms and staff consent forms being in place before commencement.
4. Any other record forms recommended in this guidance document are in place.

Where any of these are not in place the Risk and Insurance Manager and/or Health and Safety Team should be contacted for further advice.

Procedures that must be referred to Risk and Insurance

If the procedure requires the confirmation of the Risk and Insurance Manager the following information and documentation must be provided to obtain approval for commencement of the procedure:

1. Copy of the Care Plan
2. Full details of the training undertaken and copy of the competency sign-off form the qualified trainer
3. Parental Consent Form
4. Staff Member Consent form – confirming agreement to undertake the task

The Authority's current insurance policy does not cover some of the listed procedures and this information is required to seek Insurer approval or to agree to accept the risk within the Council's Insurance Fund. To access specialist training, contact Helena Atkin or Amanda Young, Clinical Administrative Co-ordinators, Women & Children's Directorate, Chesterfield Royal Hospital NHS Foundation Trust:

Helena.Atkin@chesterfieldroyal.nhs.uk or Amanda.Young@chesterfieldroyal.nhs.uk
[Tel:01246 514511](tel:01246514511)

The following information is subject to regular review. The most current version is maintained in the electronic version on the Derbyshire County Council Intranet/Extranet:

Procedures can only be performed where staff are following written guidelines, have been trained and been judged to be competent to carry out a procedure

For advice on whether or not a procedure can be performed or for approval to be sought email the requirements to: HealthandSafetyCAYA@derbyshire.gov.uk

TASK/PROCEDURE	Confirmation of insurance required from Risk and Insurance Manager before commencement	INSURER or INDEMNITY CONDITIONS
Anal Plugs	Yes	
Apnea monitoring	No	Covered for monitoring via a machine following written guidelines. There is NO cover available in respect of visual monitoring
Bladder washout	Yes	
Blood samples	No	Covered - but only by Glucometer following written guidelines
Buccal midazolam by mouth	No	Covered - following written guidelines
Bursting blisters	Yes	
Catheters (urinary) including mitrofanoff - clean/change of bag	No	Covered - following written guidelines for the changing of bags and the cleaning of tubes. There is no cover available for the insertion of tubes.
Catheters (urinary) including mitrofanoff - insertion of tube	Yes	
Chest drainage exercise	No	
Colostomy/ileostomy/vesicostomy Stoma care - change of bag & cleaning	No	Covered - following written guidelines in respect of both cleaning and changing of bags

TASK/PROCEDURE	Confirmation of insurance required from Risk and Insurance Manager before commencement	INSURER or INDEMNITY CONDITIONS
Defibrillators/First Aid only	No	Covered - following written instructions and appropriate documented training.
Dressing Care - Application & replacement	No	Covered - following written health care plan for both application and replacement of dressings
Ear/Nose drops	No	Covered - following written guidelines
Eye care/ Eye Drops	No	Covered - following written guidelines for persons unable to close eyes
Gastrostomy & Jejunostomy care • General Care • Administration of medicine • Bolus or continuous pump feed	No	Covered - in respect of feeding and cleaning following written guidelines but no cover available for tube insertion unless maintenance of Stoma in an emergency situation.
Gastrostomy & Jejunostomy tube - insertion/reinsertion	Yes	Covered - in respect of feeding and cleaning following written guidelines but no cover available for tube insertion unless maintenance of Stoma in an emergency situation.
Hearing aids - Checking, fitting and replacement	No	Covered for assistance in fitting/replacement of hearing aids, following written guidelines
Inhalers, and nebulisers	No	Covered - following written guidelines for both mechanical and hand held
Injections - pre-packed doses. (Includes epipens & dial-up diabetic insulin pens.	No	Covered but only for the administering of pre-packaged dosage using pre-assembled pen on a regular basis pre-prescribed by a medical practitioner and written guidelines
Injections - non pre-measured doses	Yes	
Injections - intramuscular and sub-cutaneous injections involving assembling syringe	Yes	

TASK/PROCEDURE	Confirmation of insurance required from Risk and Insurance Manager before commencement	INSURER or INDEMNITY CONDITIONS
Manual Evacuation	No	
Mouth toilet	No	Covered
Naso-gastric/jejunal tube feeding	No	Covered - following written guidelines but cover is only available for feeding and cleaning of the tube. There is no cover available for tube insertion which should be carried out by a medical practitioner
Naso-gastric/jejunal tube - reinsertion	Yes	
Oral prescribed medication	No	Covered subject to being pre-prescribed by a medical practitioner and written guidelines. Where this involves children, wherever possible Parents/Guardians should provide the medication prior to the child leaving home. A written consent form will be required from Parent/Guardian and this should be in accordance with LEA procedure on medicines in schools etc.
Oxygen administration - assistance	No	Covered but only in the respect of assisting user following written guidelines, i.e applying a mask or nasal canula
Oxygen and care of liquid oxygen administration including filling of portable cylinder from main tank	No	All covered subject to adequate training except filling of portable cylinder from main tank as subject to HSE guidelines.
Pessaries	Yes	
Pressure area care (bed sores etc)	No	
Pressure bandages	No	Covered - following written guidelines.
Physiotherapy	Yes	Refers to physiotherapy provided by a professional physiotherapist or the drawing up of a treatment programme. Physiotherapy undertaken by trained volunteers carrying out prescribed exercises is allowed.

TASK/PROCEDURE	Confirmation of insurance required from Risk and Insurance Manager before commencement	INSURER or INDEMNITY CONDITIONS
Rectal administration generally eg. morphine	Yes	
Rectal midazolam in pre- packaged dose	No	Covered - following written guidelines and two members of staff must be present.
Rectal diazepam in prepackaged dose	No	Covered - following written guidelines and two members of staff must present.
Rectal Paraldehyde	Yes	
Stoma care	No	Including maintenance of patency of stoma in an emergency
Suction Machine - Oral Suction Yanker Sucker	Yes	
Suppositories	Yes	Applies to suppositories other than pre-packed midazolam or diazepam (which are shown separately)
Syringe drivers - programming	Yes	
Swabs - External	No	Covered - following written guidelines.
Swabs - Internal	Yes	No - other than oral following written guidelines.
Topical Medication	No	
Tracheostomy - clean external	No	Cover is only available for cleaning around the edges of the tube following written guidelines.
Tracheostomy - removal and re-insertion	Yes	
Vagas Nerve Stimulator	No	As long as written care plan is in place.
Ventilators	Yes	Covered - following written guidelines.