



Rutland County Council

Inclusion Service

GUIDELINES ON ADMINISTRATION OF MEDICINES AND INFORMATION ON OTHER CARE PROCEDURES IN EDUCATIONAL SETTINGS

April 2013

Version 5

To be reviewed April 2014

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Foundation schools

It is the responsibility of the Governors to ensure that Public liability insurance will cover employees who administer first aid against any legal action over an allegation of negligence provided the employees act within the area in which they have been trained.

Non Foundation schools

RCC's public liability insurance will cover employees who have been trained to give first aid in order to fulfill reasonable health & safety requirements. The first aid should only be undertaken when resulting from the business of the Council, this does not mean the business of the Council includes first aid. The Public Liability insurance will cover the first aid trained employee against any legal action over an allegation of negligence provided they act responsibly and to the best of their ability.

INTRODUCTION

This provides the background to the Code of Practice

Legal Position

- A) Any staff who agree to administer medicines to pupils in School do so on an entirely voluntary basis. There is no obligation on staff to volunteer to administer medicines.
- B) Rutland County Council acknowledges that staff who do agree to administer medicines are acting within the scope of their employment.
- C.1) Some contracts of employment do acknowledge that specific requirements are needed under job specifications for administration of medicines within certain settings. Staff who do not have such contracts are acting as volunteers.
- C.2) Some staff may be required within their job description to administer and undergo training for the administration of prescribed medicines (endorsed by the LA)

D) Negligence

- (i) "A headteacher and teachers have a duty to take such care of pupils in their charge as a careful parent would have in like circumstances, including a duty to take positive steps to protect their wellbeing" (Gower v London Borough of Bromley 1999).
- (ii) Parents who allege that a member of staff has acted negligently in the administration of medicines may bring a civil action against the Local Authority which is vicariously liable for a breach of duty by headteachers, teachers, other educational professionals and support staff they employ. In the event of a civil claim for negligence being issued against a member of staff as well as against the Local Authority, then the County Council will indemnify such a member of staff against any claim or action for negligence, provided that the member of staff has acted responsibly and to the best of his or her ability and in accordance with the training received from and endorsed by the LA

E) Criminal Liability

In very rare circumstances criminal liability may arise if a member of staff were to be grossly negligent, and as a result of such gross negligence the pupil died. This situation would only arise if the member of staff were reckless or indifferent to an obvious risk of serious injury or harm.

F) Disability Discrimination

The Disability Discrimination Act provides that the Governing Body of a school is subject to an anticipatory duty to make reasonable adjustments (outside of the need to make physical adaptations to buildings and the provision of aids and equipment which fall to be met by the Local Authority) to meet the needs of disabled children in general and to ensure that appropriate policies and practices are in place in order to avoid discrimination against disabled children. Having in place a policy dealing with the voluntary administration of prescribed medicines is likely to be a 'reasonable adjustment' under the Act. Claims alleging disability discrimination from a parent are generally made against the Governing Body of the school in question or, in some circumstances, against the Local Authority and are heard by the First-Tier Tribunal (Health Education and Social Care Chamber). Such claims do not give rise to liability in respect of individual teachers, headteachers or other educational support staff.

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- G) This Code of Practice has been updated and agreed by the Children and Young People's Service (CYPS) and the LJC at Rutland County Council.

Adapted from Leicestershire County Council (Administration of Medicines)

Acknowledgement of contribution for this document

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1. GENERAL

1.1 Non Prescribed Medication.

Any medication that has not been prescribed should be questioned as to whether or not it is needed during School hours. If this is needed it can be self administered or administered under parental supervision. School staff will not administer non-prescribed medication.

1.2 Prescribed Medication

NO PRESCRIBED MEDICINE should be administered by staff unless clear written instructions to do so have been obtained from the parents or legal guardians and the school has indicated that it is able to do so (see sample pro forma – Appendix A). Schools may need to offer support in the completion of this form where parents have literacy problems or where English is not their first language. **IT MUST BE UNDERSTOOD THAT STAFF ARE ACTING VOLUNTARILY IN ADMINISTERING PRESCRIBED MEDICINES** (unless it is written into an employment contract).

1.3 The parents or legal guardians must take responsibility for updating the school with any changes in administration for routine or emergency medication and maintain an in-date supply. If this is not the case then the previous instructions must be followed.

1.4 All medicines must be clearly labelled with the child's name, route (i.e. mode of administering oral/aural etc.) dose, frequency and name of the medication being given.

1.5 **Where it is agreed by the parents and teachers prescribed medication including emergency medication or related products e.g., inhalers or creon will be carried by the child for self administration.** These may be carried in 'bum bags' or swimming pouches. (see appendix A)

1.6 **EMERGENCY MEDICATION AND RELIEVER INHALERS MUST FOLLOW THE CHILD AT ALL TIMES.** Inhalers and emergency treatment medication **MUST** follow the child to the sports field, swimming pool, etc. Children may carry their own emergency treatment, but if this is not appropriate, the medication should be kept by the teacher in charge (e.g. in a box on the touchline or at the side of the pool). The school may hold spare emergency medication if it is provided by the parents or guardians, in the event that the child loses their medication. Until this becomes the emergency treatment the spare medication should be kept securely in accordance with the instructions below.

1.7 All other medicines **except emergency medication and inhalers** should be kept securely. Controlled drugs with the exception of emergency medication must be 'doubly' secured at all times to ensure that no unauthorised access is likely. Oral medication should be in a child-proof container. Some medication needs to be stored in a refrigerator in order to preserve its effectiveness – this will be indicated on the label. In order to meet the requirement for security, it is suggested that medication is stored in a locked cash box within a refrigerator. If a refrigerator is not available, medication may be kept for a short period in a cool box or bag with ice packs, provided by the parent/guardian. If kept in a cool box with ice packs **do not** store medicine in direct contact with the ice packs as its efficacy may be affected. All medication should be kept out of direct sunlight and away from all other heat sources.

1.8 Any unused or time expired medication must be handed back to the parents or legal guardians of the child for disposal.

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- 1.9 Medicines should be administered by a named individual member of school staff with specific responsibility for the task in order to prevent any error occurring. All children who require medication to be given during school hours should have clear instructions where and to whom they report. Controlled drugs with the exception of emergency medication should have a strict recording system in place for administration.
- 1.10 Children who are acutely ill and who require a short course of prescribed medication, e.g. antibiotics, will normally remain at home until the course is finished. If it is felt by a medical practitioner that the child is fit enough to return to school, the dosage can usually be adjusted so that it is not required in school. If, however, this is not possible, by agreement with the head teacher a parent/guardian or member of staff may administer it.
- 1.11 Advice for school staff on the management of conditions in individual children (including emergency care) will be provided through the School Nurse or community paediatrician (School Doctor) on request, it may also be appropriate for advice to be sought from the child's family doctor or consultant paediatrician, at the outset of the school's consideration of the need for medication. In all instances, permission to discuss an individual child should be gained from the parent/carer.
- 1.12 If a child refuses treatment to be administered by school staff, the School should:
- **Not force the child to take treatment**
 - If the school has any concerns call an ambulance to get the child to hospital.
 - Parents/guardians should be informed immediately

2. LONG TERM MEDICATION

- 2.1 The medicines in this category are largely preventative in nature and it is essential that they are given in accordance with instructions, see section 1 above, otherwise the management of the medical condition is hindered. (NB **specific requirements** e.g., it is important that reliever inhalers are immediately accessible for use when a child experiences breathing difficulties or when specifically required prior to exercise and outings.)
- 2.2 With parental/guardian permission, it is sometimes helpful and necessary to explain the use of medication to a number of pupils in the class in addition to the affected child so that peer support can be given.

3. INJECTIONS

- 3.1 There are certain conditions e.g. Diabetes Mellitus (cross reference to Appendix E), bleeding disorders, or hormonal disorders, which are controlled by regular injections. Children with these conditions are usually taught to give their own injections or these injections are required outside school day. Where this is not the case arrangements should be made in advance and an individual care plan developed (cross reference section 5)

4. EMERGENCY TREATMENT

- 4.1
- a) No emergency medication should be kept in the school except that specified for use in an emergency for an individual child. (see section 1)
 - b) These medications must be clearly labelled with the child's name, action to be taken with the route, dosage and frequency (as in section 1)
 - c) Advice for school staff about individual children will be provided through the School Nurse or child's consultant paediatrician (hospital or community as appropriate) or family doctor on request at the outset of planning to meet the child's needs. If not provided the school should develop a '**care plan**' specific to an individual child (refer to Appendix A).
 - d) In the event of the absence of trained staff, it is essential that emergency back-up procedures are agreed **in advance** between the parents/guardian and school.
 - e) In all circumstances if the school feels concerned they will call an ambulance.
 - f) If it is necessary to give emergency treatment, a clear written account of the incident must be given to the parents or guardians of the child and a copy must be retained in the school.
 - g) Where transporting a pupil and the administration of some prescribed emergency medication is required, it may be deemed appropriate to 'stop' and park the vehicle in the first instance for safety reasons. A '999' call will then be made to summon emergency assistance. The prescribed emergency medication should then be administered.

4.2 In accordance with 4.1 above

- a) When specifically prescribed, a supply of antihistamines or pre-prepared adrenaline injection should be used if it is known that an individual child is hypersensitive to a specific allergen e.g. wasp stings, peanuts etc. **Immediate treatment needs to be given before** calling an ambulance. For the process of establishing the administration of a pre-prepared adrenaline injection and example of individual care plan and report form – Refer to Appendix B2.
- b) A supply of 'factor replacement' for injection should be kept in school where it is required for a child suffering from a bleeding disorder. If injection is necessary, it is usual for the child to be able to give their own injections. If this is not the case, the parents should be contacted immediately. If contact cannot be made emergency advice can be obtained between 08.30hrs and 16.30 by telephoning the Bleeding Disorders Clinic, Leicester Royal Infirmary on 0116 2586500. If it is outside these times then an ambulance should be called.(refer to General Care plan appendix A)
- c) For children who have repeated or prolonged fits and require the administration of rescue medication, either a small supply of Buccal Midazolam or rectal diazepam may be kept in School for administration to a specifically identified child. Appendices C & D give guidance about the process for the administration of these rescue medications including examples of individual care plans and report forms.

Where either of these rescue medicines have been administered, arrangements must be made for the child to go to the nearest hospital receiving emergencies via ambulance unless the parent or healthcare professional indicates otherwise and this is acceptable to the School.

Under extremely RARE circumstances a child may not be using the aforementioned rescue medication and may have been prescribed rectal paraldehyde by a Consultant Paediatrician Neurologist. In these cases this should be discussed with your Community Paediatrician (school doctor).

- d) A supply of glucose (gel, tablets, drink, food, etc) for treatment of hypoglycaemic attacks should be provided by parents/guardians and kept in schools where any pupil suffers from diabetes mellitus. If after an initial recovery a **second attack occurs within three hours repeat the treatment and child must go to the nearest hospital receiving emergencies.**
- e) It is important for children with asthma that reliever inhalers are immediately accessible for use when a child experiences breathing difficulties.
- f) For children who have reduced hormonal responses to stresses. It may be that they require an emergency dose of oral hormone replacement. The arrangements for the prescribed medication will be developed within a general care plan. (appendix A)

5. SCHOOL VISITS

- 5.1 Detailed advice and guidance regarding school visits is given in Code of Practice No. 11, Guidance for the Conduct of Educational Visits and Adventurous Activities.
 - 5.1.1 As required by Code of Practice 11, a form must be completed and returned to the Local Authority **PRIOR** to the commencement of any school visit involving an overnight stay, foreign travel or adventurous activities (see Code of Practice 11).
- 5.2 A school consent form from the child's parent or guardian must be received **PRIOR** to participation in any school trip. Any medical problems must be highlighted by the parents or guardians (see Guidance for details)
- 5.3 Where insurance cover is obtained, medical conditions must be disclosed; otherwise insurance cover may be refused.
- 5.4 A named person must be identified to supervise the storage and administration of medication (see section 1 above)
- 5.5 Wherever possible children should carry their own reliever inhalers or emergency treatment (see 1.5) but it is important that the named person (see above) is aware of this.

6 IMPLEMENTATION & REVIEW

- 6.1 This document constitutes the Approved Guidance of Rutland Local Authority. It was agreed by the Children and Young People's Service (CYPS). This guidance supersedes guidance previously published documents in 2005.

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7 ADVICE ON MEDICAL CONDITIONS

The Community Paediatrician or Nurse on request will give advice regarding medical conditions to the school. Parents or guardians of children suffering from these conditions seeking general information should be advised to seek advice from their G.P., the school health professionals (give parents the name and contact number) or from the bodies detailed below. The following bodies can also supply leaflets regarding the conditions listed.

<p>Asthma at school – a guide for teachers</p> <p>Asthma Campaign Summit House 70, Wilson Street London EC2A 2DB</p> <p>Asthma Helpline</p>	<p>National Asthma Campaign</p> <p>www.asthma.org.uk</p> <p>Tel: 0845 701 0203</p>
<p>Guidance for teachers concerning Children who suffer from fits</p> <p>www.epilepsy.org.uk</p> <p>Helpline No: Freephone 0808 800 5050</p> <p>www.helpline@epilepsy.org.uk 9am – 4.30pm 4pm on Fridays. Children, schools and families</p>	<p>Epilepsy Action The New Anstey House Gateway Drive Yeadon Leeds LS19 7XY</p>
<p>Haemophilia</p> <p>info@haemophilia.org.uk</p> <p>Mon – Fri 10-4pm Helpline 0800 018 6068</p>	<p>The Haemophilia Society First Floor Petersham House 57a Hatton Garden London EC1 8JG</p> <p>Tel: 020 7831 1020 Fax: 020 7405 4824</p>
<p>Allergies Anaphylaxis Campaign</p> <p>www.anaphylaxis.org.uk www.allergiesinschools.org.uk</p>	<p>The Anaphylaxis Campaign PO Box 275 Farnborough Hampshire GU14 6SX Help line 01252 542029</p>
<p>Thalassaemia</p> <p>www.ukts.org</p> <p>email: information or office@ukts.org</p>	<p>UK Thalassaemia Society 19 The Broadway Southgate Circus London N14 6PH</p> <p>Tel: 020 8882 0011 Fax: 020 8882 8618</p>

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Sickle Cell Disease info@sicklecellsociety.org Helpline 0800 001 5660 (24hrs)	The Sickle Cell Society 54 Station Road Harlesden London NW10 4UA Tel: 020 8961 7795 Fax: 020 8961 8346
Cystic Fibrosis and School (A guide for teachers and parents) www.cftrust.co.uk	Cystic Fibrosis Trust 11 London Road Bromley Kent BR1 1BY Tel: 020 84647211
Children with diabetes (Guidance for teachers and school staff) www.diabetics.org.uk	Diabetes UK Central Office 10 Parkway London NW1 7AA Tel: 0207 42241000
Diabetes Careline	Tel: 0845 1202960

Glossary

Care Plan (ICP) = Specific information on individual pupil requirements and their needs that need to be met while in school and any treatment needed to be administered by members of staff. Agreed by Headteacher and parents.

Transporting = To and from school and school trips

Double locked = Locked cupboard in a locked room or locked container in a room with a coded lock on the door.

Definition of Medication = as being medicines, therapeutic products, products used as a treatment for the child.

Appendix A

General Care Plan

To: Headteacher of _____ School

From: Parent/Guardian of _____ Full Name of Child

My child has been diagnosed as having: _____
_____ (name of condition)

He/She has been considered fit for school but requires the following prescribed medicine to be administered during school hours: _____
_____ (name of medication)

I allow/do not allow for my child to carry out self administration (delete as appropriate)

Could you please therefore administer the medication as indicated above
_____ (dosage) at _____ (timed)

With effect from _____ Until advised otherwise

The medicine should be administered by mouth/in the ear/nasally/other _____
(delete as applicable)

I allow/do not allow for my child to carry the medication upon themselves (delete as appropriate)

I undertake to update the school with any changes in routine, use or dosage or emergency medication and to maintain an in date supply of the prescribed medication.

I understand that the school cannot undertake to monitor the use of self administered medication of that carried by the child and that the school is not responsible for any loss of/or damage to any medication.

I understand that if I do not allow my child to carry the medication it will be stored by the School and administered by staff with the exception of emergency medication which will be near the child at all times.

I understand that staff may be acting voluntarily in administering medicines to children.

Signed _____ Date _____

Name of parent (please print) _____

Contact Details:

Home

Work

Mobile

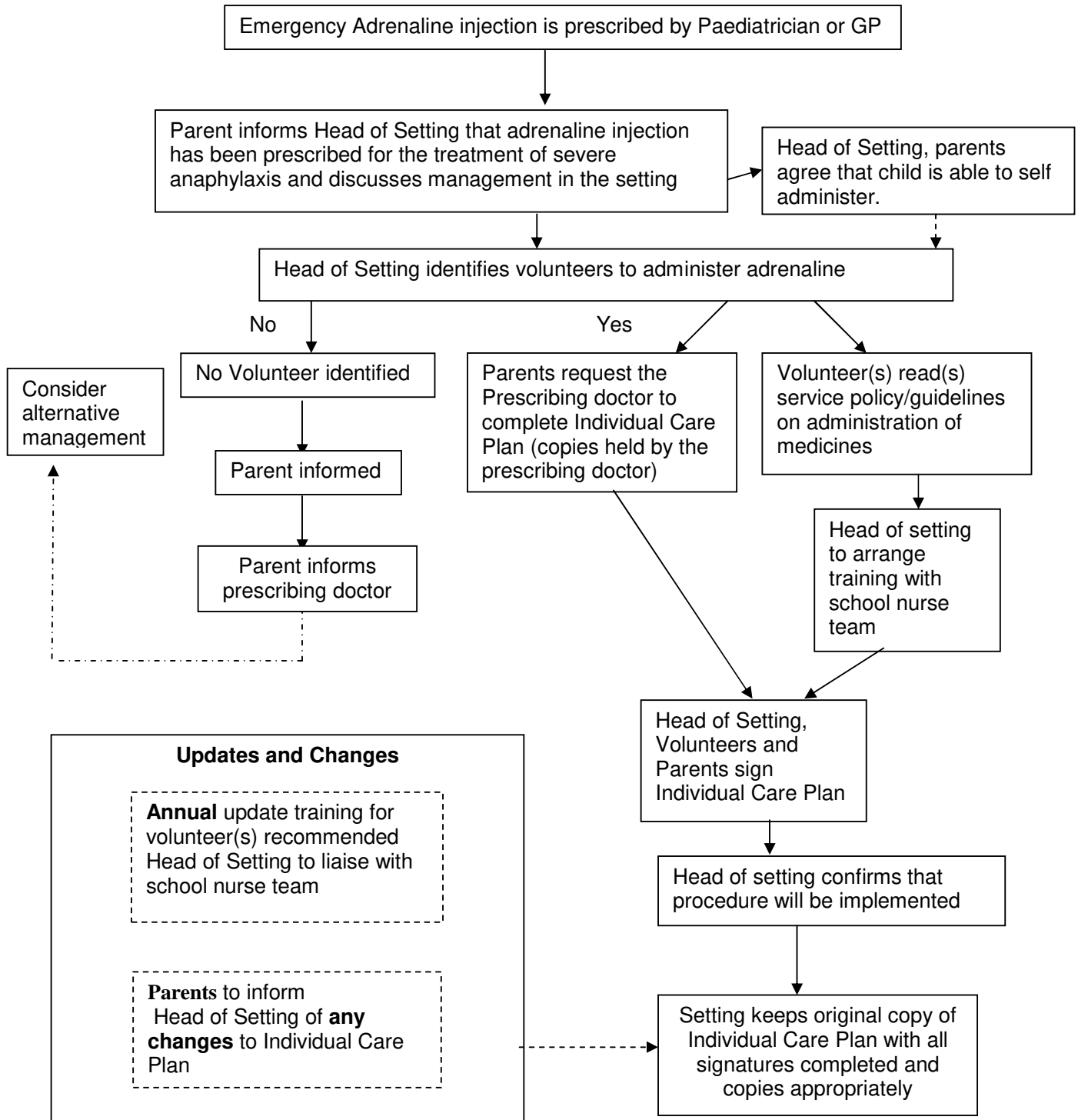
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Guidelines for non-medical staff to administer pre-prepared Adrenalin injections in response to anaphylaxis

Process

1. When a child needs a pre-prepared adrenaline injection as emergency treatment for anaphylaxis in a non-health setting (e.g. school, nursery, respite facility), then the prescribing doctor will discuss this with the parents or carers and with their agreement pre-prepared adrenaline will be prescribed.
2. It is the parent's responsibility to raise the issue with the head of the setting e.g. headteacher, nursery manager.
3. When a child is able to self administer the head of the setting with the parents will decide whether training of volunteers is required. *It is recommended that in all settings where there is a child who may require a pre-prepared adrenaline injection, that (a) volunteer(s) are trained to administer a pre-prepared injection should a situation arise where a child is too ill/unable to self administer.* If training is not required a general administration of medicines form must be completed. A child who has self administered must report to a member of staff as they will need to be reviewed in hospital.
4. When the child is unable to self administer the head then identifies (a) volunteer(s) to undertake training and subsequent administration of the prepared adrenaline injection.
5. If no volunteers are identified the parent should be informed and it is the parent who should inform the prescribing doctor. The prescribing doctor and parent may wish to reconsider and identify an alternative management plan.
6. If (a) volunteer(s) is/are identified they should read their setting's policy/guidelines on the administration of medicines. The head of the setting should then liaise with the health professional e.g. School Health Nurse/Health Visitor, to arrange a mutually convenient date for training. The standard anaphylaxis training pack available across Leicester, Leicestershire and Rutland should be used.
7. The parents need to request that an Individual Care Plan is completed by the doctor who prescribed the pre-prepared adrenalin device.
8. The health professional training the volunteer(s) will discuss with the volunteer(s) the Individual Care Plan for the administration of pre-prepared adrenaline by non-medical and non-nursing staff for a specific child. Following the training the volunteer(s) sign(s) the Training Record and the Individual Care Plan. The head of the setting then signs the Individual Care Plan. The original remains within the setting.
9. If any details in the Individual Care Plan change (eg. EpiPen rather than EpiPen Junior) required it is the parent's responsibility to inform the head of the setting. If a new Individual Care Plan is required then the process above must be discussed by those parties and the ICP completed as appropriate.
10. It is recommended that update training of volunteers should take place on an annual basis. The head of the setting will request and negotiate this with the appropriate health professional.

FLOW CHART OF PROCESS TO ENABLE NON-MEDICAL STAFF TO ADMINISTER PRE-PREPARED ADRENALIN INJECTIONS IN RESPONSE TO ANAPHYLAXIS



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Allergy: Emergency Action Plan with Adrenaline

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

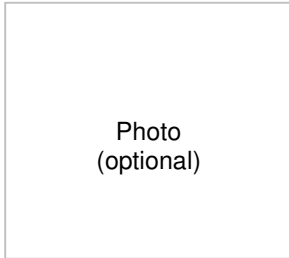


Photo
(optional)

Parent / Carer details:

1)



2)



Mild to Moderate Reaction:

- Swelling of lips, face, eyes
- Hives or itchy rash
- Itchy / tingling mouth / itchy throat
- Abdominal pain, vomiting

ACTION:

- Stay with the child
- Call for help if necessary <2yr 2.5mg (2.5ml)
- Give antihistamine: CETIRIZINE 2-6yrs 5mg (5ml)
If vomited, can give a further dose (circle)
- Contact parent / carer 6+yrs 10mg (10ml or 1 tablet)
- Locate EpiPen®

Watch for signs of ANAPHYLAXIS (severe allergic reaction):

- Difficult or noisy breathing
- Wheeze / persistent cough / hoarse voice
- Difficulty swallowing / tightness in throat
- Loss of consciousness or collapse
- Pale / floppy / suddenly sleepy

If ANY ONE of these signs are present:

- **Lie child flat.** If breathing is difficult, allow to sit
- **Give EpiPen® (circle) EpiPen® Jr EpiPen®**
- **Dial 999 for an ambulance* and say ANAPHYLAXIS (“ANA-FIL-AX-IS”)**
- **Stay with the child**
- **If no improvement after 5-10 minutes, give a further EpiPen® dose (if prescribed)**
(please check overleaf)

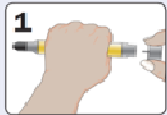
Additional instructions:

If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

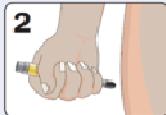
*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis.

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850.

How to give EpiPen® or EpiPen® Jr



1
Form fist around EpiPen® and PULL OFF GREY SAFETY CAP.



2
PLACE BLACK END against outer mid-thigh (with or without clothing).



3
PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.



4
REMOVE EpiPen® and DO NOT touch needle. Massage injection site for 10 seconds.

Keep your EpiPen® device at room temperature. For more information on EpiPen® and to register for the free expiry alert service, go to www.epipen.co.uk.

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCI) – www.allergy.org.au

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Allergy: Emergency Action Plan with Adrenaline

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo
(optional)

Parent / Carer details:

1)



2)



Mild to Moderate Reaction:

- Swelling of lips, face, eyes
- Hives or itchy rash
- Itchy / tingling mouth / itchy throat
- Abdominal pain, vomiting

ACTION:

- Stay with the child
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- **Stay with the child**
- **If no improvement after 5-10 minutes, give a further EpiPen® dose (if prescribed)**
(please check overleaf)

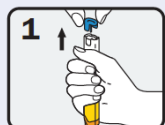
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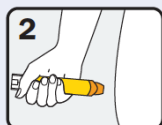
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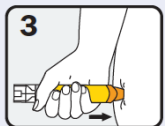
How to give EpiPen® or EpiPen® Jr



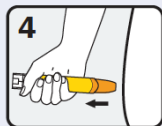
1
Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



2
PLACE ORANGE END against outer mid-thigh (with or without clothing).



3
PUSH DOWN HARD until a click is heard or felt and hold in place



4
REMOVE EpiPen®. Massage injection site for 10 seconds.

Keep your EpiPen® device at room temperature. For more information on EpiPen® and to register for the free expiry alert service, go to www.epipen.co.uk.

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA) – www.allergy.org.au

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Allergy: Emergency Action Plan with Adrenaline

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo
(optional)

Parent / Carer details:

1)



2)



Mild to Moderate Reaction:

- Swelling of lips, face, eyes
- Hives or itchy rash
- Itchy / tingling mouth / itchy throat
- Abdominal pain, vomiting

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE

<2yr 2.5mg (2.5ml)
If vomited, can give a further dose (circle) 2-6yrs 5mg (5ml)
- Contact parent / carer

6+yrs 10mg (10ml or 1 tablet)

- Locate Jext

Watch for signs of ANAPHYLAXIS (severe allergic reaction):

- Difficult or noisy breathing
- Wheeze / persistent cough / hoarse voice
- Difficulty swallowing / tightness in throat
- Loss of consciousness or collapse
- Pale / floppy / suddenly sleepy

If ANY ONE of these signs are present:

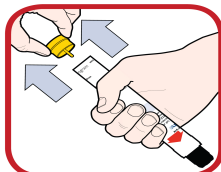
- **Lie child flat.** If breathing is difficult, allow to sit
- **Give Jext (circle) 150 micrograms 300 micrograms**
- **Dial 999 for an ambulance* and say ANAPHYLAXIS (“ANA-FIL-AX-IS”)**
- **Stay with the child**
- **If no improvement after 5-10 minutes, give a further Jext dose (if prescribed)**
(please check overleaf)

Additional instructions:

If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis.

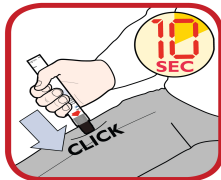
How to give Jext



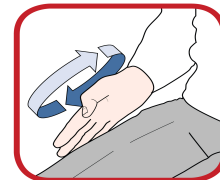
Step 1 Grasp the Jext in your dominant hand as above. Pull off the yellow cap with the other hand.



Step 2. Place the black injector tip against outer thigh, holding the injector at a right angle to thigh.



Step 3. Push the black tip firmly into thigh until you hear a “click”, then keep it pushed in. Hold firmly in place for 10 seconds then remove.



Step 4. Massage the injection area for 10 seconds. Seek immediate medical help by dialling 999 for an ambulance.

For more information on Jext and to register for the free expiry alert service, go to www.jext.co.uk.

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCI).

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850.

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Allergy: Emergency Action Plan with Adrenaline

This plan has been agreed by the following: (Block Capitals)

PARENT/GUARDIAN

Name: Tel No:

Signature: Date:

Emergency telephone contact number:

HEAD OF ADMINISTERING SETTING

Name:

Signature: Date:

VOLUNTEERS TO ADMINISTER PRE-PREPARED ADRENALINE INJECTION

Name:

Signature: Date:

Name:

Signature: Date:

Name:

Signature: Date:

Name:

Signature: Date:

PRESCRIBING DOCTOR COMPLETING EMERGENCY ACTION PLAN

Name: Tel No:

Signature: Date:

Designation:

I have prescribed a second dose of adrenaline to be given (circle) **Yes** **No**

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

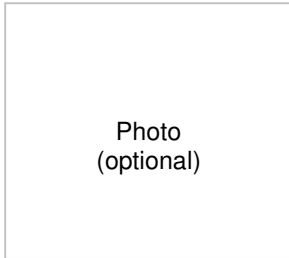
Allergy: Emergency Action Plan without Adrenaline

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:



Parent / Carer details:

1)



2)



Mild to Moderate Reaction:

- Swelling of lips, face, eyes
- Hives or itchy rash
- Itchy / tingling mouth / itchy throat
- Abdominal pain, vomiting

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: **CETIRIZINE**

<2yr	2.5mg	(2.5ml)
2-6yrs	5mg	(5ml)
- Contact parent / carer

6+yrs	10mg	(10ml or 1 tablet)
-------	------	--------------------

Watch for signs of **ANAPHYLAXIS** (severe allergic reaction):

- Difficult or noisy breathing
- Wheeze / persistent cough / hoarse voice
- Difficulty swallowing / tightness in throat
- Loss of consciousness or collapse
- Pale / floppy / suddenly sleepy

If ANY ONE of these signs are present:

- **Lie child flat.** If breathing is difficult, allow to sit
- **Dial 999 for an ambulance* and say ANAPHYLAXIS (“ANA-FIL-AX-IS”)**
- **Stay with the child**

Additional instructions:

If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis.

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850.

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Allergy: Emergency Action Plan without Adrenaline

This plan has been agreed by the following: (Block Capitals)

PARENT/GUARDIAN

Name: Tel No:

Signature: Date:

Emergency telephone contact number:

HEAD OF ADMINISTERING SETTING

Name:

Signature: Date:

VOLUNTEERS TO ADMINISTER PRE-PREPARED ADRENALINE INJECTION

Name:

Signature: Date:

Name:

Signature: Date:

Name:

Signature: Date:

Name:

Signature: Date:

PRESCRIBING DOCTOR COMPLETING EMERGENCY ACTION PLAN

Name: Tel No:

Signature: Date:

Designation:

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

REPORT FORM

Following emergency injection of pre-prepared adrenalin

Please copy this form and send to hospital with child if possible.	Date of allergic reaction: ____/____/____ Time reaction started: ____:____ hrs Time 1 st dose adrenalin given: ____:____ hrs Time 2 nd dose adrenalin given: ____:____ hrs* <small>*If prescribed</small> Time ambulance called: ____:____ hrs Time ambulance arrived: ____:____ hrs
NAME OF CHILD: Date of birth:	

Trigger for reaction (ie food type / bee-sting) Description of symptoms of reaction: Any other notes about incident (e.g. child eating anything, injuries etc) Witnesses to incident: (Position in setting)

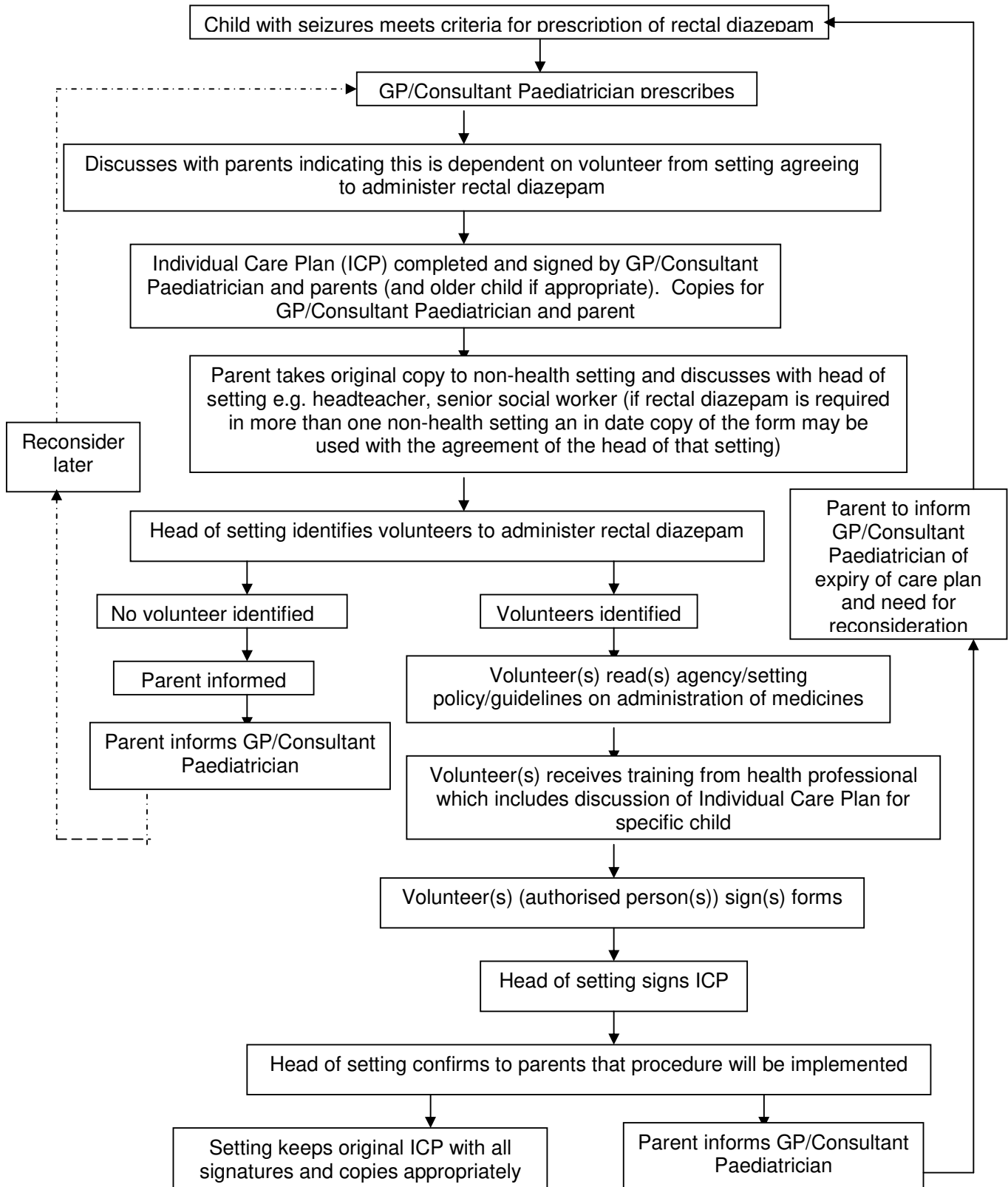
Please circle the prescribed device used: Epipen Jr 0.15mg Jext 150mcg Epipen 0.3mg Jext 300mcg Other (inc. dose) _____	Adrenalin given by: Site of injection: Problems encountered:
---	--

FORM COMPLETED BY: NAME (print): SIGNATURE: Job title:Telephone no: DATE: ____/____/20____ <p style="text-align: center;"><i>Please send copy to hospital with child if possible Please keep original copy in setting records and give copy to parents</i></p>

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

ADMINISTRATION OF RECTAL DIAZEPAM IN RESPONSE TO EPILEPTIC SEIZURES/FITS/CONVULSIONS

Protocol for Health Staff to Support Non-Medical and Non-Nursing Staff



PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

INDIVIDUAL CARE PLAN FOR THE ADMINISTRATION OF RECTAL DIAZEPAM AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-HEALTH STAFF

TO BE COMPLETED BY AN HEALTH PROFESSIONAL, PARENT, THE HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON.

THE INSTRUCTIONS ON THIS FORM **EXPIRE 1 YEAR** FROM THE DATE OF SIGNATURE OF THE HEAD OF THE SETTING.

NAME OF CHILD: _____	DOB: _____
Description of type of fit/convulsions/seizure which requires rectal diazepam:- Insert description	
* lasting _____ minutes <input type="checkbox"/>	or * repetitive over _____ minutes <input type="checkbox"/> without regaining consciousness

IF THE CHILD'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE PHONE 999 FOR AN AMBULANCE

The dose of rectal diazepam should be _____	Tube containing _____	mgs.
This should be administered by a named individual (see over) in accordance with the procedure endorsed by the indemnifying agency.		

The normal reaction to this dose is the seizure should stop in 5 to 10 minutes. If required, further actions to take are (e.g. 2 nd dose):-
--

After rectal diazepam has been given the child must be escorted to the nearest hospital receiving emergencies . Unless someone can escort the child to hospital it will be necessary to 'phone 999' for an ambulance. Remember to tell the ambulance or hospital staff the exact time and dose of rectal diazepam given (see the Report Form). <i>If the person with parental responsibility or an health professional is present, the decision about the need for transfer to the hospital can rest with them.</i>

After rectal diazepam is given, please complete a Report Form giving a clear account of the incident. A copy should go to the parent. The original should be kept by the administering setting.

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Appendix C2 continued

The parents will be responsible for:

1. informing anyone who needs to know, if rectal diazepam has been given
2. maintaining an in-date supply of medication at the setting
3. seeking renewal, on expiry of this care plan.

This care plan has been agreed by the following:

GP/CONSULTANT
(Block Capitals) _____

Signature _____ Date _____

PARENT/GUARDIAN
(Block Capitals) _____

Tel No _____

Signature _____ Date _____

OLDER CHILD/YOUNG PERSON
(Block Capitals) _____

Signature _____ Date _____

HEAD OF ADMINISTERING SETTING
(Block Capitals) _____

Signature _____ Date _____

AUTHORISED PERSON(S) TO ADMINISTER RECTAL DIAZEPAM

NAME (Block Capitals) _____

Signature _____ Date _____

NAME (Block Capitals) _____

Signature _____ Date _____

NAME (Block Capitals) _____

Signature _____ Date _____

NAME (Block Capitals) _____

Signature _____ Date _____

*COPIES OF THIS FORM SHOULD BE HELD BY THE PARENTS
and the HEALTH PROFESSIONAL
THE ADMINISTERING SETTING RETAINS the ORIGINAL*

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

RECTAL DIAZEPAM ADMINISTRATION REPORT FORM

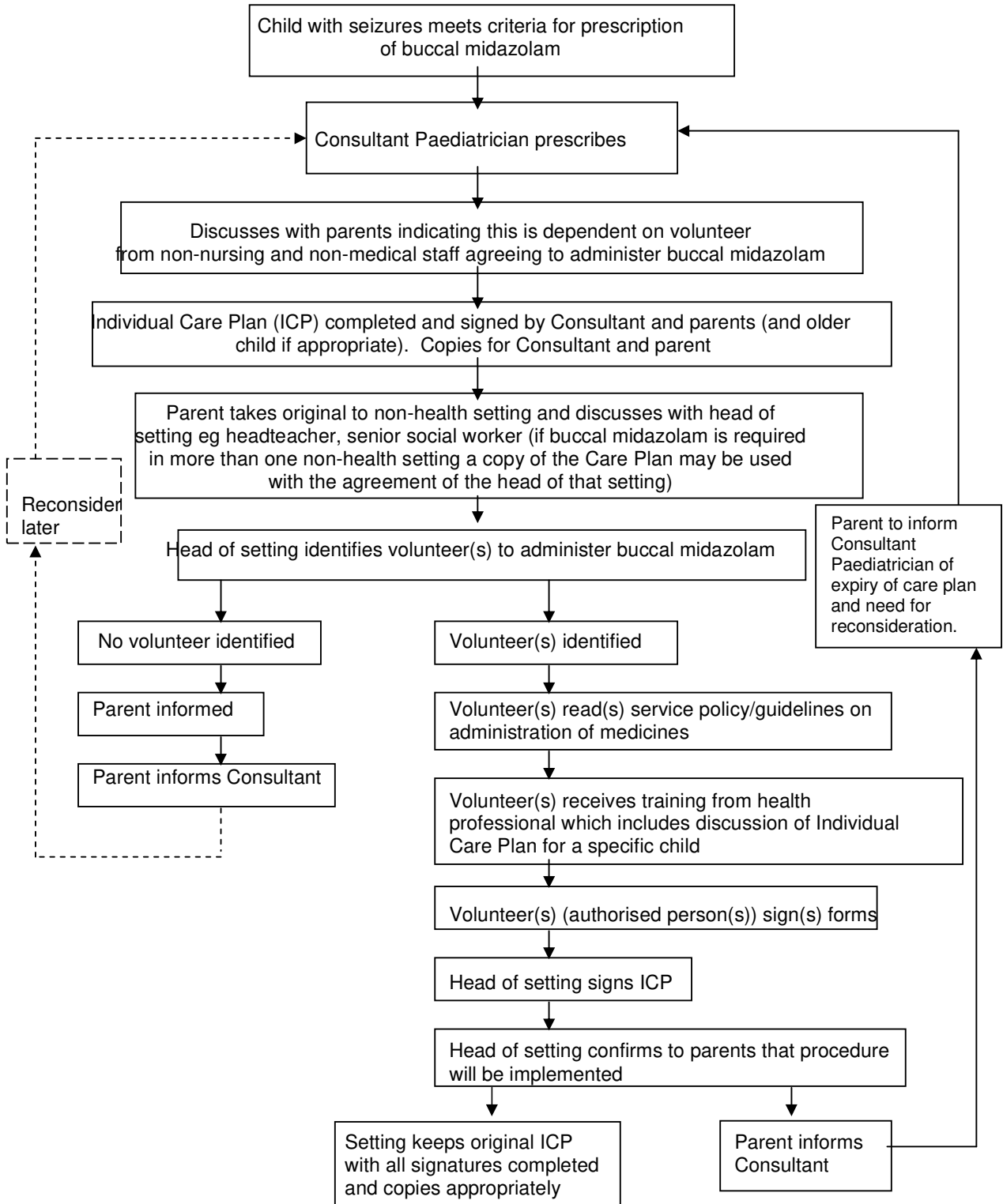
Name of Child:		DoB:	
Date of seizure/convulsion:			
Time seizure/convulsion started: Activity when seizure/convulsion began: Description of seizure/convulsion:			
Time rectal diazepam was given:	Dose given:	Mgs:	Given by:
.....
Any difficulties in administration?			
Time seizure/convulsion stopped:			
Time child was taken to hospital:			
Any other notes about incident (e.g. injuries to child or other parties, child sleepy):			
Signed (authorised person):		Name (please print):	
Date:			
Designation:			

Original to: Child's setting record
 Cc: Hospital with child (where possible)
 Parent
 Other e.g. Health and Safety Advisor for Education

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

ADMINISTRATION OF BUCCAL MIDAZOLAM IN RESPONSE TO EPILEPTIC SEIZURES/FITS/CONVULSIONS

Protocol for Health Staff to Support Non-Medical and Non-Nursing Staff



PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

INDIVIDUAL CARE PLAN FOR THE ADMINISTRATION OF BUCCAL MIDAZOLAM AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-MEDICAL AND NON-NURSING STAFF

TO BE COMPLETED BY A CONSULTANT, PARENT, THE HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON.

THE INSTRUCTIONS ON THIS FORM **EXPIRE 1 YEAR** FROM THE DATE OF SIGNATURE OF THE HEAD OF THE ADMINISTERING SETTING.

NAME OF CHILD: _____	DOB: _____
Description of type of fit/convulsions/seizure which requires buccal midazolam:- <i>Insert description</i>	
* lasting _____ minutes <input type="checkbox"/>	or * repetitive over _____ minutes <input type="checkbox"/> without regaining consciousness

IF THE CHILD'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE PHONE 999 FOR AN AMBULANCE

The dose of buccal midazolam should be	ml(s) in volume of
mg(s) in	ml(s)
	*liquid *solution
<i>This should be prepared and administered by a named individual (see over) in accordance with the procedure endorsed by the indemnifying agency.</i>	

The normal reaction to this dose is seizure should stop and this should occur in 5 to 10 minutes.
If required, further action to take is:

After buccal midazolam has been given the child must be escorted to the nearest hospital receiving emergencies. Unless someone can escort the child to hospital it will be necessary to 'phone 999' for an ambulance. Remember to tell the ambulance or hospital staff the exact time and dose of buccal midazolam given (see the Report Form). *If the parent/person with parental responsibility or an health professional is present, the decision about the need for transfer to the hospital can rest with them.*

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Appendix D2 continued

After buccal midazolam is given, please complete a Report Form giving a clear account of the incident. Copies should go to the parent. The original should be kept by the administering setting.

The parents will be responsible for:

1. informing anyone who needs to know, if buccal midazolam has been given
2. considering renewal of the care plan on expiry and
3. for maintaining an in-date supply of medication.

This plan has been agreed by the following:

CONSULTANT
(Block Capitals)

Signature Date

PARENT/GUARDIAN
(Block Capitals)

Signature Date

Tel No

OLDER CHILD/YOUNG PERSON
(Block Capitals)

Signature Date

HEAD OF ADMINISTERING SETTING
(Block Capitals)

Signature Date

AUTHORISED PERSON(S) TO ADMINISTER BUCCAL MIDAZOLAM

NAME (Block Capitals)

Signature Date

NAME (Block Capitals)

Signature Date

NAME (Block Capitals)

Signature Date

COPIES OF THIS FORM SHOULD BE HELD BY THE PARENTS, THE
CONSULTANT AND THE ADMINISTERING SETTING.

* Delete as appropriate

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

BUCCAL MIDAZOLAM ADMINISTRATION REPORT FORM

Name of Child:		DoB:	
Date of seizure/convulsion:			
Time seizure/convulsion started:			
Activity when seizure/convulsion began:			
Description of seizure/convulsion:			
Time Buccal Midazolam Given:			
Dose given	ml(s) of	mg(s) in	ml(s) *liquid *solution
Given by:			
Any difficulties in administration?			
Time seizure/convulsion stopped:			
Time child was taken to hospital:			
Any other notes about incident (e.g. injuries to child or other parties, child sleepy):			
Signed (authorised person):		Name (please print):	
Date:			
Designation:			

* delete as appropriate

Original to: Child's setting record
Cc: Hospital with child (where possible)
Parent
Other (specify)

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

GUIDANCE FOR SETTINGS ON THE MANAGEMENT OF DIABETES MELLITUS

Please ensure this appendix is read in conjunction with the rest of the Guidelines on Administration of Medicines, particularly section 4.2d.

Introduction

This guidance is specifically to address the issue of the management of Insulin Dependent Diabetic Mellitus (IDDM) in children in the non-Health settings of Early Years provision or schools. The management includes testing their blood glucose levels, recording the test results, interpreting the results and the administration of insulin injections.

Over 15,000 children of school age in the UK have diabetes with approximately 400 children of school age within Leicester, Leicestershire and Rutland.

There has been a change in the way that diabetes has been managed in the last 5 years. It is now accepted that life expectancy is improved and the risk of significant long term complications reduced when a strict routine of self care and treatment is followed. In addition the new regime allows greater flexibility and promotes the independence of the child. The regime, incorporating increased blood glucose testing, insulin dose adjustment and increased frequency of the use of insulin injections, means children will need to do these activities whilst they are attending settings.

It is important that children and young people with diabetes are properly supported in the settings they attend. This may be an awareness of their independent management of their condition, through supervision to significant assistance in these activities.

This document clarifies the law as it stands in statute and relates to published guidance from the Department of Health (DH) and the DfES (now Department for Children Schools and Families). It gives general information, and details sources of further information.

Background

The Special Educational Needs and Disability Act 2001 (SENDA) (e) requires reasonable adjustments to be made to prevent the less favourable treatment of disabled pupils. Diabetes is a disability within the definition of the Act and pupils cannot be discriminated against in terms of admission, exclusion and access to education and associated services. For example a child or young person with diabetes cannot be excluded from a school visit or sports activity for a reason directly related to their diabetes (1).

The duties of SENDA are anticipatory and include planning for a pupil with medical needs. The settings managing medicines policy should show what procedures are in place to allow a pupil requiring medication during the school day, including insulin, to have access to it and for children that don't have the independence or maturity to give their own injections of insulin to be supported in this practice. This may mean your setting recruits staff with healthcare experience and/or trains volunteering staff to meet the needs of prospective pupil's medical conditions, including diabetes (2).

For information and advice about individual pupils, settings should consult with the family, the Family Health Visitor or School Nurse or the local Diabetes Support Team (3).

Process

For those who can test their blood and/or can self inject their insulin it is still good practice for the setting to know this. (See Appendices E1 and E2)

For children with diabetes who cannot perform the management activities themselves there should be the drawing up of an Individual Care Plan (ICP see appendix E4). An ICP clarifies for health and setting staff, parents and the child or young person the responsibilities and help that will be provided.

In order for a patient to have blood glucose testing, results recording and insulin administered by a setting's volunteer, all documentation, as specified, will have to be completed in full and be up to date. An ICP will be developed during consultation **with the doctor at the diabetes clinic.** Blood glucose testing times and result reporting requirements will be stated. The type of insulin injector equipment, dose and times of insulin and injection site will be stated. **Any changes to the regime agreed between the patient and the doctor will be documented in an updated ICP and the doctor or diabetes specialist nurse (Diabetes Support Team) will inform the authorised volunteers.** The ICP will be reviewed at least yearly to see if it continues to be appropriate e.g. discontinued if self administering (use Appendices E1 and E2).

The parents are responsible for the ICP being presented to the setting along with the appropriate equipment, including the child's own 'sharps bin', supplies and medication.

Setting **staff** managing the blood testing or administration of insulin should receive appropriate **training** and support from health professionals. To support setting staff with this it is envisaged that the local Diabetes Support Team and Diabetes UK: East Midlands (5) will hold regular training and awareness sessions for setting staff working with children with diabetes (4). Once the head of the setting has identified volunteers the school should contact the Diabetes Specialist Nurse (see note 3) who will arrange the training. This would also be the process for training of new staff. Refresher sessions should be planned annually to keep staff up to date (Appendix E10).

Volunteers will be trained to the standard **to carry out the protocol** (see Appendices E8 and E9). They will keep a **copy of the appropriate protocols after their training** and their training will be **confirmed by the authorised trainer and the prescribing doctor** (Appendix E11).

Notes

1)The Disability Equality Duties (Disability Discrimination Act 2005) (d) requires schools to promote equality of opportunity between disabled persons and other persons, promote positive attitudes towards disabled persons, and take steps to take account of disabled persons' disabilities even where that involves treating disabled people more favourably than their non-disabled peers

2) To quote the Secretary for Health (a).The DfES and DH have jointly recommended to schools, in 'Managing Medicines in Schools and Early Years Settings' (2005) (b), that they should, with support from their local authority and local health professionals, develop policies on managing medicines and put in place effective management systems to support individual children with medical needs, including diabetes. The guidance advises that schools should have sufficient support staff who are trained to manage medicines as part of their duties.

3) Contact telephone numbers at Leicester Royal Infirmary 9 am – 5 pm

0116 258 6796	Diabetes Specialist Nurses Office
0116 258 7737	Consultant Paediatric Diabetologists Office

4) As well as equipping staff to fulfil the ICP drawn up for the child with diabetes needing assistance, these sessions are aimed at teachers, teaching assistants, kitchen staff, lunchtime supervisors, first-aiders and any other staff who feel they require information and advice in order to support children with diabetes in their care.

Sessions will cover:-

- Practical knowledge of diabetes
- Monitoring of blood glucose levels
- Administration of medications (including equipment)
- Treating emergency situations (including hypos)
- Access to healthy and appropriate food and carbohydrate portion estimation
- Participating in physical activity programmes
- Participating in extra curricula and social activities
- Positive case studies
- DED update/discrimination law
- Documentation (including ICP and supply of appropriate written protocol)

An example of previously held sessions in Nottingham can be found in appendix E

5) An assurance has already been given by Diabetes UK © for their participation.

References

- a) Hansard June 2007
- b) 'Managing Medicines in Schools and Early Years Settings' (2005)
- c) Diabetes UK
- d) The Disability Equality Duties (Equality Act 2010)
- e) The Special Educational Needs and Disability Act 2001

Agreement for Self Testing of Blood Glucose in the Setting

Child or Young Person's Name

DoB

Self-testing of blood glucose may be carried out in settings under the following conditions:

- 1) All test equipment is supplied from home.
- 2) The setting staff are aware of approximate times for testing.

Time(s)

3) The child or young person carries their blood glucose testing kit or independently retrieves it from the storage location at the appropriate time.

4) The test is undertaken in an area of privacy.

5) Standard hygiene procedures are applied at all times.

6) *The child or young person self tests independently

*The child or young person self tests with minimal supervision

*insert details will attend
the setting to do the tests

7) The child or young person will independently or with minimal supervision store all sharp objects and contaminated materials used for testing in a designated biohazard container (sharps bin) for which intermittent disposal and replacement arrangements are made in advance by the family\$.

8) The child or young person records the test results independently or with minimal supervision^.

9) The child or young person independently

*interprets the results and acts accordingly or

*contacts (insert details)
to interpret the results and give instructions

If none of * or ^ applicable, use Individual Care Plan.

* delete as appropriate.

\$ discuss with School Nurse or local Diabetes Support Team

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Staff are acting voluntarily in this and staff cannot undertake to monitor equipment carried by the child or young person, and the setting is not responsible for loss or damage to any equipment.

Staff should be aware of the emergency care for this child or young person in response to a hypoglycaemic episode (hypo).

IF THE CHILD'S OR YOUNG PERSON'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE THE SETTING WILL PHONE 999 FOR AN AMBULANCE.

As a parent I undertake to update the school with any changes and to maintain an in-date supply of equipment.

Signed: _____ Date: _____

Name of student (if appropriate): _____

Signed _____ Date: _____

Name of Parent: _____

Emergency Contact Details

Name: _____

Telephone Home: _____ Telephone Work: _____

Head of Setting - Name _____

Signed: _____ Date: _____

Setting has original
cc Parents

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

**AGREEMENT TO SELF- INJECTION OF INSULIN
FOR CHILDREN OR YOUNG PEOPLE WITH DIABETES MELLITUS**

Full name of Child/Young Person: _____ DoB: _____

This person has been diagnosed as having Diabetes Mellitus. He/she requires insulin injections during school hours at the following times: _____

- *He/she can carry their equipment and independently self administer the injections.
- *He/she needs to store their equipment but can independently self administer the injections.
- *He/she can carry their equipment but needs minimal supervision to self administer the injections
- *He/she needs to store their equipment and (*insert name*) _____
_____ will attend the setting to give the injections.

Staff are acting voluntarily in this and staff cannot undertake to monitor equipment carried by the child or young person and that the setting is not responsible for loss or damage to any medication or equipment.

Staff should be aware of the emergency care for this child or young person in response to a hypoglycaemic episode (hypo).

IF THE CHILD'S or YOUNG PERSON'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE THE SETTING WILL PHONE 999 FOR AN AMBULANCE.

As a parent I undertake to update the school with any changes in administration of medication and to maintain an in-date supply of medicine and equipment.

Signed: _____ Date: _____

Name of student (*if appropriate*): _____

Signed _____ Date: _____

Name of Parent: _____

Emergency Contact Details

Name: _____

Telephone Home: _____ Telephone Work: _____

Head of Setting - Name _____

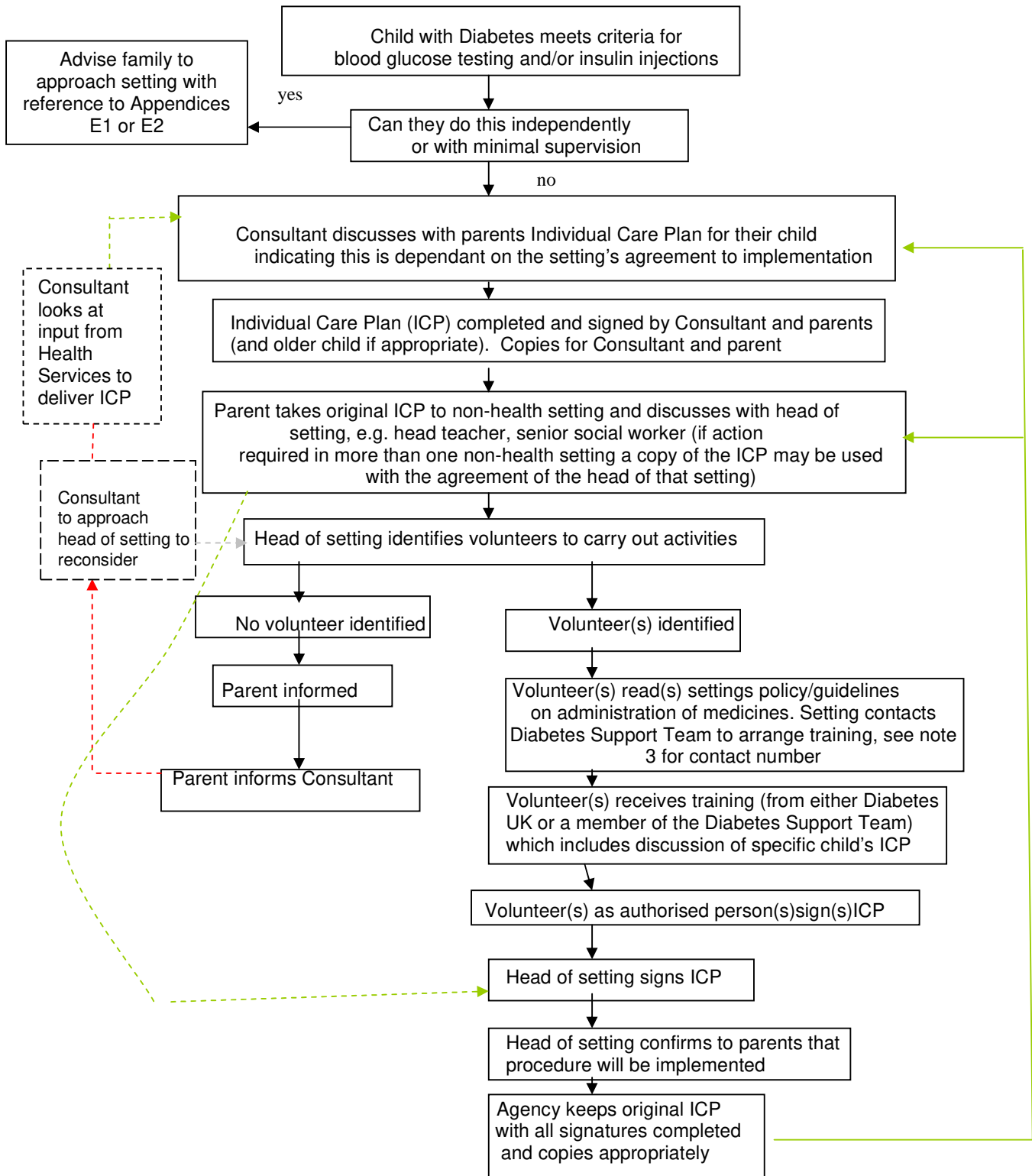
Signed: _____ Date: _____

**delete as appropriate or if none applicable use Individual Care Plan*

Setting has original
cc Parent

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

PROCESS FOR ESTABLISHING OR REVISING AN INDIVIDUAL CARE PLAN FOR THE MANAGEMENT OF DIABETES MELLITUS IN NON-HEALTH SETTINGS



PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

**INDIVIDUAL CARE PLAN FOR THE MANAGEMENT OF DIABETES MELLITUS
BY NON-MEDICAL AND NON-NURSING STAFF**

**TO BE COMPLETED BY A CONSULTANT, PARENT, THE HEAD OF THE SETTING AND THE
AUTHORISED PERSON.**

NAME OF CHILD:		DOB:	
-----------------------	--	-------------	--

This plan has been agreed by the following:

CONSULTANT (Block Capitals)	
Signature	Date
PARENT/GUARDIAN (Block Capitals)	
Signature	Date
EMERGENCY CONTACT NUMBER: _____	
OLDER CHILD/YOUNG PERSON (if appropriate)	
Signature	Date
HEAD OF SETTING (Block Capitals)	
Signature	Date
AUTHORISED PERSON(S) TO *TEST BLOOD GLUCOSE AND/OR *ADMINISTER PRE-PREPARED INSULIN INJECTION	
NAME (Block Capitals)	
Signature	Date
NAME (Block Capitals)	
Signature	Date
NAME (Block Capitals)	
Signature	Date

* delete as appropriate

**COPIES OF THIS SHOULD BE HELD BY
THE PARENTS, THE CONSULTANT AND THE SETTING AND
UPDATED AT LEAST ANNUALLY.**

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Appendix E5

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and supplies at the setting.

Staff should be aware of the emergency care for this child or young person in response to a hypoglycaemic episode (hypo).

If the child or young person refuses testing do not progress but immediately inform the parent.

BLOOD GLUCOSE TESTING

This should be carried out by an authorised person (see over) in accordance with the protocol and training endorsed by the indemnifying agency

- Check the blood glucose level at *(insert times or activities)*

Dispose of test strip and pricker into sharps bin.

Record on the Record Sheet.

*Report result to Tel No

- Check the blood glucose level prior to insulin being given

Dispose of test strip and pricker into sharps bin.

Record on the Record Sheet.

Within the range given insulin dose recorded in the Individual care plan.

Outside the range immediately report result to

Telephone:

Give insulin dose advised by the above person on this occasion only.

Record dose on Record Sheet.

- If testing required tick one only*

* *delete as appropriate*

IF THE CHILD'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE PHONE 999 FOR AN AMBULANCE.

.....
Updated Signed Name Designation

cc: retained by health professional, given to parents. Original to setting

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Appendix E6

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and medication at the setting.

Staff should be aware of the emergency care for this child or young person in response to a hypoglycaemic episode (hypo).

If the child or young person refuses injection do not progress but immediately inform the parent.

INSULIN INJECTION

This should be prepared and administered by an authorised person (see over) in accordance with the protocol and training endorsed by the indemnifying agency.

The type of insulin is prescribed as:

Penfill cartridge injection

Insulin bolus via pump

<u>TYPE OF INSULIN</u>	<u>INJECTION SITE</u>	<u>The subcutaneous DOSE OF INSULIN is</u>			
		<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Other</u> <small>enter time or activity</small>

Particular things to note are:-

Action to take:-

Dispose of needle into sharps bin.

After administration of insulin, please complete the Record Sheet.

**IF THE CHILD'S GENERAL CONDITION IS A CAUSE FOR CONCERN AT ANY STAGE
PHONE 999 FOR AN AMBULANCE.**

Updated

Signed

Name

Designation

cc: retained by health professional, given to parents. Original to setting

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Appendix E7

BLOOD GLUCOSE TEST AND/OR INSULIN ADMINISTRATION RECORD SHEET

NAME OF CHILD					DOB		
DATE	TIME 24hour clock	*BLOOD GLUCOSE RESULT	*INSULIN TYPE	*INSULIN DOSE	*INJECTION SITE	SIGNED	NOTES <i>(eg carbohydrate estimation)</i>

* delete as appropriate

Original retained at setting

cc: Parent on request
 Diabetes Support Team on request

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

Protocol for Blood Glucose Testing

Action	Rationale
Locate and obtain in a timely manner the child's blood glucose testing kit and sharps bin. Allow the child to do this if the child is able. Accompany the child to the area designated for testing.	Preparation in anticipation of blood glucose testing in an area of privacy.
Instruct the child to wash their fingers and dry them. Wash your hands.	Any surface contamination with glucose on the fingers will invalidate the blood glucose test. This is good hygiene.
Take a blood testing strip out of the sealed container and insert the strip in the glucose meter.	This is a pre-requisite first step in operating the glucose meter.
Check the testing strip code displayed on the meter matches that of the code on the side of the glucose testing strips.	If the codes don't match the glucose reading is inaccurate. Do not proceed but contact the parent or Diabetes Support Team.
Check on the meter the symbol is displayed that indicates that a blood sample can be applied to the testing strip.	Sometimes the meter shows an error reading in which case the testing strip should be discarded and a new strip inserted.
Take the finger pricker and place on the chosen finger tip on the outside of that finger, not on the pulp.	Close application of the finger pricker to the skin is required so that the pricker is able to penetrate the finger to the required depth. It is better to take a sample on the side of the finger as it hurts less.
Depress the firing button to prick the finger.	This draws the blood.
A drop of blood will appear that should then be applied onto the testing strip, look for the blood to be drawn up into the test strip and an icon on the meter will be displayed to demonstrate that the required blood has been drawn up. Now apply firm pressure to the prick site with a clean paper towel.	This is a pre-requisite step in operating the glucose meter. This stops the bleeding.
Read the blood glucose level from the meter.	This is the test result.
Wash your hands. Record the blood glucose level on the record sheet.	Good hygiene. This will allow analysis of blood glucose trends for later insulin dose titration.
Remove the testing strip from the meter and dispose of used blood glucose testing strip into the child's sharps bin.	Avoidance of blood contamination.
Dispose of used blood testing pricker into the child's sharps bin.	Avoidance of pricker injury or blood contamination
Place the glucose meter and finger pricker back in the case. Child and you each wash your hands.	So that the equipment is kept in one place and not lost. Good hygiene.

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NOTE - this is an example of one of three protocols (for different delivery equipment) please **ensure after training you receive the correct protocol for the child concerned.**

Protocol for Administration of Insulin

Action	Rationale
Locate and obtain, in a timely manner, child's insulin's administration kit. Ensure the Child is in a place of privacy. Wash your hands.	Preparation in anticipation of administration. Good hygiene.
Invert the insulin pen, plunger at the bottom. Screw on a needle and remove the needle sheath.	To puncture the seal on the insulin cartridge to allow administration of a required dose of insulin.
Tap the inverted insulin pen.	To bring any air bubbles to the top of the cartridge.
Dial up 3 units of insulin and depress the plunger to dispense an air shot, repeat this until a squirt of liquid is seen exiting the tip of needle.	To ensure that all air is expelled from the pen.
Invert the insulin pen once again through 180 degrees so that the needle points vertically downwards and dial up the agreed dose of insulin, please see ICP.	To ensure the correct dose of insulin is dispensed.
Select a pre-agreed site for the insulin injection, please see ICP. Expose the area of skin for injection.	To seek a safe, secure and correct place for the injection.
Lightly pinch up the skin and insert the needle at 90 degrees to the skin,	To ensure a subcutaneous injection of insulin. Insulin is absorbed best in this part of the skin.
Slowly and firmly depress the plunger of the pen and count to 10.	This ensures the administration of the full dose of Insulin.
Remove the insulin pen from the skin	To avoid any inadvertent extra insulin administration.
Do not re sheath needle. Unscrew needle. Dispose of the needle in child's sharps bin. Do not dispose of the insulin pen. Wash your hands.	Avoidance of needle-stick. Safe disposal of sharp objects in accordance with health and safety policy. Good hygiene.
Place the insulin pen back in the child's administration kit. Now let the child go back to normal activity	So stored safely for future use.
Complete record sheet.	To enable monitoring of administration of insulin and update child's health records.

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**RECORD OF COMPLETION OF TRAINING FOR BLOOD GLUCOSE TESTING
AND /OR INSULIN ADMINISTRATION BY NON-MEDICAL AND NON-NURSING
STAFF**

To: Head of Setting

RE: Name of person

Date of Birth

Name of setting working at

The above named person has attended training on how to safely undertake blood glucose testing and/or administer insulin injections on date

They have completed the training to a standard to be able to comply with the agreed protocols for blood glucose testing and/or insulin administration.

AUTHORISED TRAINER
(Block capitals)

Designation

Signature

Date

Agency

Contact No.

CONSULTANT
(Block Capitals)

Signature

Date

I confirm I have attended the training as recorded above:

AUTHORISED
PERSON(S) NAME
(Block capitals)

Signature

Date

COPIES OF THIS FORM SHOULD BE HELD BY THE CONSULTANT THE SETTING AND
THE AUTHORISED PERSON.

TRAINING SHOULD BE UPDATED ANNUALLY

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CHILD REQUIRING NASOGASTRIC FEEDING

Nasogastric feeding is considered if the child is unable to take sufficient feeds by mouth to grow and thrive. It is one method of artificial feeding (enteral), usually short-term though may be used long term if other methods are contraindicated. Children who require enteral feeding often have gastro-intestinal disorders, neuromuscular disorders or metabolic disorders. There are currently 204 children within Leicester, Leicestershire and Rutland who require enteral feeding.

A nasogastric tube is a flexible narrow tube which is inserted via the nose into the stomach and secured to the face by tape. Tubes are usually made of PVC, polyurethane or silicone and stay in place for several weeks. Children can pull out their nasogastric tube or it can become dislodged. If the nasogastric tube needs to be replaced **staff will NOT re-pass** the tube. The setting will need to contact the main carer straight away. The main carer will make arrangements for the tube to be re-passed and depending on the child's circumstances this may take place in the setting or the child will be able to wait until they return home.

It is **vital that the correct position of the tube in the child's stomach is confirmed on every occasion before using the tube to administer feeds, medication or water** as displacement of the tube can sometimes happen. The position of the tube is checked by sucking the tube with a syringe to obtain fluid and testing it on pH paper. **If the position is not correct DO NOT USE the TUBE** but contact the main carer.

Depending on the child's needs feeds are administered via the tube. Enteral feeds can be administered by gravity feeds or via a feeding pump. Feeds can either be as a specific feed like at meal times (bolus feed) or over an extended time (e.g. overnight). Bolus feeds can take 20 – 30 minutes depending on the child's individual need. Feeds should take place in an area acceptable to all concerned.

Each child should have a specific feeding plan detailing times, types and amounts of feed to be given. Included in the plan will be whether there is an oral component or not e.g. if drinks or tastes of food can be given. The child may also require regular mouth care if they have little or no oral intake.

Equipment for nasogastric feeding

Feed, equipment and a written feeding plan will normally be supplied by the main carer. This equipment may include a spare nasogastric tube, syringes, feeding sets, pH paper, tape, feeding pump and feed. Feeds and equipment must be stored in a suitable area. Equipment is for single use or single patient use. If for repeat use for the specific child the equipment must be cleaned after each use and stored in a container labelled with the name of that individual child. Careful planning is needed to support the child on school trips.

Training

Training should be sourced through the school nurse. It is expected that those who will be feeding the child via the nasogastric tube obtain training. Training needs to include knowledge and storage of equipment, feeds to be used, the care of the nasogastric tube and oral hygiene, identifying correct placement of tube and feeding the child by nasogastric tube according to their feeding plan. Training needs to be updated on a yearly basis.

Staff will not be trained in passing the nasogastric tube but should obtain the details of who is responsible for passing each child's tube from the main carer and who they should contact if there are concerns / problems with the tube or feeding.

CHILD REQUIRING ORAL SUCTION

The primary indication for the use of oral suction is the child's inability to independently adequately clear the airway or mouth. Suction (sucking) removes secretions.

Children who require oral suction should be cared for by staff that have completed appropriate training and are familiar with that individual child's care plan.

Equipment for oral suctioning

The child will have their own suction machine and back-up authorised by their health professional. Suction catheters or Yankeur suckers will be supplied with the child's suction machine. Tap water is required for rinsing the tubing. Parents will ensure the suction equipment is available in the setting and it is the parent's responsibility to ensure that the suction machine is maintained and serviced on a yearly basis by their provider.

Training

Training should be sourced through the school nurse. It is expected that staff who will be caring for the child should be trained in the procedure of oral suctioning. Training will include care of equipment and indications and procedure for oral suctioning. Training needs to be updated on a yearly basis.

CHILD REQUIRING OXYGEN (FROM CYLINDERS)

Children may require oxygen due to the nature of their condition. Oxygen can aid the child to breathe more easily and remain comfortable. It can enable the child to carry on with their usual activities and daily routine. Currently within Leicester, Leicestershire and Rutland there are 71 children who require oxygen.

Conditions which may require children to have long term oxygen include chronic lung disease, congenital heart disease, neuromuscular conditions and palliative care for symptom relief. Oxygen may be required continuously or intermittently depending on the child's needs. This will be in the child's individual care plan.

Oxygen is a clear colourless and odourless gas, it cannot burn or explode but can support the combustion of materials, and therefore oxygen should be stored away from any heat source, kept securely and the valve turned off when not in use.

Oxygen should be regarded as a drug and will need a prescription / care plan. The prescription/care plan should specify the mode of delivery (mask or nasal prongs), flow rate, duration of treatment and any monitoring required.

Equipment required

The child will have the appropriate equipment authorised by the health professional involved in their care. Cylinders of oxygen vary in size and the child will be provided with an appropriate size cylinder to suit their oxygen requirements. These may be portable to be with the child or static and may be delivered directly to the setting via the supplier. Tubing is attached to the cylinder and oxygen is delivered to the child via a face mask or nasal prongs. Equipment is for individual patient use.

The prescription / care plan should be provided via the parents who will obtain it from their health professional. (Specialist Respiratory Nurse)

Training required

Training should be sourced through the school nurse. It is expected that staff who will be caring for the child should be trained in the procedure of oxygen administration. Training should include use of equipment to deliver oxygen, safety in delivering and storing oxygen, monitoring and responding to condition of the child. Training needs to be updated on a yearly basis.

CHILD REQUIRING TRACHEOSTOMY CARE

A tracheostomy may be carried out to bypass an obstruction, provide and maintain an airway for breathing, to enable the removal of secretions by suctioning and to aid patients with mechanical breathing support.

A tracheostomy is the creation of an opening into the main wind pipe (trachea) through the neck. A tube is then inserted to facilitate breathing and the removal of secretions. The tube is held in place by tapes fastened around the neck. Tracheostomy tubes are available in different designs, sizes and usually made from plastic. There is at present approximately 24 patients in Leicester, Leicestershire and Rutland.

Removal of secretions from a tracheostomy tube

This can be carried out in two ways. Suctioning via a tracheostomy is performed when patients are unable to clear their own secretions. A suction catheter (fine flexible tube) is used to pass into the tracheostomy tube and suction is applied via a suction machine to remove excess secretions. (see also oral suctioning)

Secretions can also be removed if the child has a tracheostomy with an inner tube. The inner tube only can be removed from the outer tube for cleaning and replaced without disturbing the stoma site (opening).

Each child will have a care plan suited to their individual requirements.

Emergency care if tracheostomy tube is blocked or dislodged

The tracheostomy tube would not be routinely changed by setting staff, but staff would be expected to train to replace the tube in an emergency. The trained staff must be available to the child at all times.

Equipment for tracheostomy care

The child will have with them all the equipment needed to care for a tracheostomy. This includes a suction machine and emergency back – up (see also oral suctioning), spare tubes (including a smaller one for emergencies), tapes and suction catheters. The equipment must follow the child at all times including trips, sports fields, playground etc. Equipment is specific to the child and suction catheters are single use only.

Training

Training should be sourced through the school nurse. It is advised that a child has a maximum of 3 staff members trained to care for them and their tracheostomy, allowing exposure to the skill of caring for a tracheostomy and for pre-empting the absence of trained staff.

Training provided will cover how to recognise if a tracheostomy tube is blocked and the removal of secretions. There will be guidance of when and how to seek additional advice and support. For emergency replacement, when emergency services should be contacted and a clear procedure to follow to replace the tube.

Training can take up to 8 weeks to complete depending on experience of the staff member and the needs of the child. Basic life support training needs to be undertaken before training commences. Training needs to be updated on a yearly basis.

CHILD REQUIRING MECHANICAL VENTILATION (ASSISTED BREATHING)

There is a growing population of children who have chronic breathing failure due to conditions such as muscle disease, disorders of breathing control, or abnormalities of the airway and require long-term breathing support (mechanical ventilation). There are approximately 40 children in Leicester, Leicestershire and Rutland who require mechanical ventilation.

A ventilator is the piece of equipment used to mechanically assist breathing by delivering air to the lungs. Ventilators are small, lightweight and portable. Most of these operate on mains electric current; some have internal batteries and can be operated with external batteries as a back up. The ventilator is set to the needs of the child and eases the work of breathing and enables the child to participate in non – ambulatory educational activities.

Equipment for mechanical ventilation

Each child will be supplied with a ventilator, battery pack and 'circuit' required for their individual needs. The child uses a mask or via the tracheostomy is attached by tubing to the ventilator. This will be specified in the child's care plan. This equipment is authorised by the health professional and being portable will accompany the child to other settings from home.

The ventilator setting guide should be obtained via the parents from the health professional. This is used as a guide to check the settings are correct.

Training required

Training should be sourced through the school nurse. It is expected that staff who will be caring for the child should be trained in the procedure of oxygen administration. Training should include the use of the equipment, checking the settings and monitoring and responding to the condition of the child. Individuals working directly with the child should be trained in the above and obtain updating on a yearly basis. Basic life support training needs to undertaken before training commences

TOILETING ISSUES FOR SCHOOLS & NURSERIES

When do children become toilet trained?

Becoming continent is the result of the interaction of two processes – socialisation of the child and maturation of the nervous system. In our society this normally occurs between 2-3 years of age with most children achieving full control by the age of 4 years.

Sphincter Control at age 3 years

Around 10-15% of 3 year olds are not fully toilet trained. This is important to remember when working with nursery age children, it is not 'abnormal' for a three year old not to be fully trained (see below)

What do children need to be able to do before they are fully toilet trained?

The child has to be able to:-

- Recognise the need to pass urine and that the signal needs to take priority over, for example, watching their favourite programme on television
- Interpret the signal correctly. Is it saying you need to go now, or you can hold on until the end of the programme?
- Postpone passing urine until appropriate receptacle is reached

And

- Open doors
- Manage clothing, including zips and buttons
- Use toilet paper appropriately
- Flush the toilet
- Wash and dry their hands

Also

- Boys have to learn to stand to pass urine in the urinal or toilet
- Boys can pass urine in front of other boys but not in front of girls!
- Have to go behind a closed door to open their bowels
- Girls have to negotiate sitting on a toilet
- Boys also have to negotiate sitting on a toilet to open their bowels
- Girls need to be taught the correct way to wipe their bottoms ie. From front to back so they do not wipe germs from their back passage towards their urethra (bladder opening).

(Note – please be aware that differences to the above may be present due to cultural/social diversity)

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUNCTION WITH THE WHOLE DOCUMENT

A lot for a three year old nursery child to accomplish!

How can we help children during toilet training?

Promoting continence is important, not only from a social but also a health point of view. When promoting continence with children several factors need to be taken into account:-

Clothing

- Needs to be easy to pull up and down
- Zips and buttons can be difficult to undo when you are desperate!
- Pull up trousers with elasticated waists are better

Toilets

- Need to be accessible (not kept locked so child has to ask for a key)
- Accorded same privacy as adults
- Clean/flushed regularly
- Toilet paper always available
- Adequate hand washing facilities with soap and paper towels/dryer
- Encourage routine hand washing

Diet

Children will need a balanced diet to prevent constipation which is the underlying cause of many difficulties in toilet training.

Further information can be found in:-

- Balance of good health for children www.doh.gov.uk
- Five-a-day campaign (fruit and vegetables) www.doh.gov.uk/fiveaday

Any increase in fibre in the diet should be done gradually alongside a synonymous increase in fluids.

Drinks

- Inadequate fluid intake results in concentrated urine which can irritate the bladder and cause the child to wet
- Contribute to the development of constipation
- Fluids should not be increased at the expense of food intake but a balance achieved
- Children will need to drink at least 3-4 cups of fluid during the school day and will need access to clean, fresh drinking water (see chart below)

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Schools and Nurseries may wish to implement the recommendations of “Water is Cool in School” (Enuresis Resource and Information Centre (ERIC) 2001).

Daily Fluid Requirements: A Guide

Fluid needs of a child will depend upon his or her weight. All of the following volumes are suggested based as an average weight for that age of child.

Overweight children may require less fluids than their appropriate weight classmates.

Underweight children should have their requirements based on their weight age rather than their actual age.

Children who are constipated may require more fluids than usual.

	Aquaid Water Bottles (330ml)	120ml Plastic Cups	200ml Mug
4-6 years 1400ml	4.2	11.5	7
7-10 years 1700ml	5	14	8.5
11-14 years 2000ml	6	16.5	10
15-18 years Girls 2300ml	7	19	11.5
15-18 years Boys 2500ml	7.5	21	12.5

As a school day consists around 2/3rds of a child’s waking hours it would be recommended to achieve 2/3rds of these volumes during the day.

N.B

1. intakes of fluids should not exceed 2500ml daily
2. hot weather and pyrexia will increase requirements
3. even minimal dehydration may impair a child’s performance
4. these are average requirements so an individual child’s requirement may be more or less than that stated.

Children who have difficulties in becoming fully toilet trained

Children may present in school with varying types of continence problems:

1. **Delay in bladder and bowel control, which is within normal limits. The child will acquire these when they are ready.**

Some young children may have wetting/soiling problems due to general delay in bowel and bladder control. These children will normally be able to remain clean and dry provided they are 'prompted' and reminded to go to the toilet at suitable, regular intervals (such as play/break times). No other management/treatment is required. Most children will develop independent control by the time they are 4-5 years. As most children do not like to be seen to be different the wish to conform alongside the structured day within the educational setting will help speed up the learning process.

2. **Wetting and/or soiling problems requiring active intervention, due to an underlying problem, which normally resolves once the underlying problem (for example constipation) has been addressed and managed appropriately.**

Constipation

Constipation in childhood is a common problem and is said to account for 3% of all hospital outpatient visits and up to 25% of children referred to paediatric gastroenterologists.

'Constipation' is defined as the difficulty or delay in passing of stools (poo), without necessarily implying that the stools are hard. The difficulty or delay in passing of stools may result in pain, uncontrolled soiling and anorexia (loss of appetite) causing distress for the child.

Encopresis

Encopresis is often confused with soiling but describes the passing of normally formed stools in a socially unacceptable place and is thought to be behavioural in origin. Those children with encopresis do not normally have an underlying constipation causing the soiling. This small number of children may require a referral to the child mental health or psychological services.

Soiling

Soiling is the passing of a stool into clothing as a direct result of chronic constipation, which is outside the child's voluntary control.

The child may be unaware that soiling has taken place or of the associated smell, **children need to be treated sympathetically when this occurs**. Many children suffer low self-esteem and shame because of the soiling.

Treatment involves a multi-agency (including education) holistic approach and it should be noted that the long protracted course of treatment can evoke apathy and behavioural problems.

Using the toilet in school

Many children are reluctant to use school toilets to open their bowels. This may be due to the lack of privacy and because some children are worried about the smell they may leave behind. However, as children may be taking laxatives and are told not to 'hold on' and put off opening their bowels, easy access to a toilet is important. Schools also need to safeguard children from bullying.

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The child needs access to a 'user friendly' toilet that affords privacy, has good ventilation and a generous supply of soft toilet paper!

Daytime wetting

Wetting during the day is not an uncommon problem affecting approximately 5% of five year olds.

The child commonly presents with frequency and/or urgency.

Frequency

Here the child feels the need to pass urine at frequent intervals, which can be every 15 minutes or so. This can obviously be very distressing for the child and also disruptive if the child has to leave class frequently or urgently to go to the toilet.

Frequency may be due to the brain receiving 'full bladder' signals even though the bladder may only have a very small amount of urine in it. These children normally require some sort of formal intervention and also in some cases medication to achieve normal bladder control. Treatment usually involves a bladder re-training programme necessitating **free access to the toilet and drinks**.

A typical programme may involve the child going to the toilet 'by the clock' at 1-2 hourly intervals initially, with the aim being to fit with break times as much as possible. They will also require extra drinks during the school day.

Urgency

With urgency the child feels the need to pass urine straight away, without the ability to 'hold on'. Urgency is commonly seen in conjunction with frequency although it can occur on its own. The brain may not receive enough signals telling it that the bladder is becoming full. Only when the bladder is about to empty does the child recognise the need to 'go'. Unless the child has immediate access to the toilet they will wet.

These children may require prompting to go to the toilet to ensure their bladder is emptied regularly, for example at the end of a lesson. They may also need to learn to recognise and respond appropriately to signals from their bladder via a training programme.

Nocturnal Enuresis (bed wetting)

Nocturnal enuresis or bed wetting is the commonest type of continence problem affecting approximately 10% - 15% of 7 year olds. Bed wetting is beyond the child's control.

The majority of children will eventually 'grow out' of bed wetting but 1-2% will persist into adulthood. It is important that all children with bed wetting are offered appropriate advice, treatment and support.

Educational staff may be in a good position to recognise when there are problems with enuresis. Indicators include smelling of urine, being tired and sore groin/legs. Children undergoing treatment may also appear tired due to frequent waking.

Staff need to be sensitive to the needs of children and young people who wish to undertake overnight school trips. Some children may take medication and access to this is essential.

3. Wetting and/or soiling problems due to congenital abnormalities or injury affecting their bowel and/or bladder.

These children usually require surgery or other interventions to help manage and control their bladder/bowels.

An increasing number of children with physical disabilities are entering the main stream education setting. Some of these children may have a condition, for example spina bifida, which affects their bowel and/or bladder. No treatment could result in incontinence. Modern approaches to treatment enable the majority of children with such conditions to manage their bladders and/or bowels so that they are able to remain clean and dry independently. In the early stages, however, these children may require additional support in school.

Assessment and Treatment

The promotion and management of continence may require a multi-disciplinary holistic approach. Therefore assessment will usually be undertaken and initial management/treatment of an individual initiated by a health professional already involved with the child. However if there is no prior involvement by the healthcare team, the Family Health Visitor, School Health Nurse or GP can be contacted.