The Acorns Administration of Medicines, First Aid, Medical & Intimate Care for supporting pupils at school with medical conditions Policy (LA Adopted)

November 2021

We are a Rights Respecting School with No Outsiders

INTRODUCTION

This policy takes guidance and recommendations from the **'DfE September 2014 – Supporting Pupils At School With Medical Conditions,'** which highlights:

- Pupils at school with medical conditions should be properly supported so that they can have full access to education, including school trips and physical education.
- Governing Bodies must ensure that arrangements are in place in schools to support pupils at school with medical conditions.
- Governing Bodies should ensure that school leaders consult health and social care professionals; pupils and parents to ensure that the needs of children with medical conditions are effectively supported.

It should be noted that the guidance and procedures contained within the policy may be superseded by a child's EHC plan or Individual Care Plan, or may be used in conjunction with them.

Article 24: Every child has the right to the best possible health

INDIVIDUAL HEALTHCARE PLANS

Individual healthcare plans can help to ensure that the schools effectively support pupils with medical needs. They should be easily accessible to all who need to refer to them while preserving confidentiality. Plans should be drawn up by the Inclusion Manager or the Schools Family Liaison Officer in partnership with the school, parents, and relevant healthcare professionals. These plans should be reviewed at least annually or earlier if evidence is presented that the child's needs have changed HCP must be kept in the SEN files within the classroom and must be signed by all the members of staff involved with the child including the person who is administering medication.

MEDICAL AWARENESS

On a regular basis a Medical Awareness List will be produced by the Office and the information will be shared with all teachers via the Inclusion Manager. It is the responsibility of the class teacher to familiarise themselves with this list in the first week of term every September and to be aware of the child's condition and any intervention that is required from staff.

Any changes or additions to this list must be given to the Admin Assistants or appointed First Aiders as soon as they are known. This is especially important when children with medical conditions join the school within the academic year.

When the condition is of a more serious nature an individual health care plan is created which contains the child's photograph and is distributed to relevant staff and displayed in the register so that staff are aware of the likelihood of an emergency arising and what action to take should one occur.

It is the parent's responsibility to inform the school of any changes to the child's condition that may require the details of the care plan to be altered.

As a school, we try to ensure that we have sufficient information about the medical condition of any child with long-term medical needs and will request meetings with parents and recognised medical practitioners regularly to provide the correct level of training. Training should be specific to the individual child concerned.

The school is well supported by the School Nurse who provides staff with advice and any relevant training on request.

The kitchen staff are made aware of children with food allergies. All midday supervisors are also made aware of children with medical conditions and/or allergies to food or plasters.

All medication is kept in a locked cupboard (except where storage in a fridge is required) and only accessed by named adults, or with the permission of the Headteacher/SMT.

Lists of the current First Aiders are displayed around the school.

DEALING WITH MEDICINES SAFELY

All medicines may be harmful to anyone for whom they are not appropriate; therefore, it is essential that they are stored safely.

- We can only store, supervise and administer medicine that has been prescribed for an individual child.
- All medicines of this type should be handed in to the office in the morning and collected from the office at the end of the school day.
- All medicines are kept in the office/Nursery.
- Epipens and inhalers are kept in the classroom.
- All controlled drugs such as 'methylphenidate' will be stored in the school office.

STAFF TRAINING IN DEALING WITH MEDICAL NEEDS

All staff who agree to accept responsibility for administering prescribed medicines to a child will be given the appropriate training and guidance.

Staff must not give prescription medicines or undertake healthcare procedures without the appropriate training.

NB A first-aid certificate does not constitute appropriate training in supporting children with medical conditions.

ROLES AND RESPONSIBILITIES

Parents/Carers

Parents have a responsibility to provide all necessary information about their child's medical needs to the school.

Parents/Carers have the prime responsibility for ensuring a child's health and for deciding whether they are fit to attend school.

> Whilst it is the responsibility of the parent/carer for deciding if a child is fit to attend school, children recovering from a short-term illness/infection, who are clearly unwell should not be in school and the Headteacher can request that parents/carers keep the pupil at home if necessary.

Where a child requires medication, parents/carers are encouraged to give doses outside the school day if possible e.g. 3 times a day could be taken in the morning, after school and at bedtime.

Parents are welcome to come into school to administer medicines themselves if necessary.

Prescribed medicines can only be taken in school when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school day.

Where a child requires medication to be taken during the school day, Parents/carers have a responsibility to complete a written consent using the **'Request for Administration of Medicine in School'** form before any medicine can be given.

Parents/carers are responsible for ensuring that date-expired medicines are returned to the pharmacy for safe disposal. They should also collect medicines held at the end of every academic year.

Parents/carers are responsible for replacing date-expired medicines if still required.

Staff

Only members of staff with medication training will give medication. This will be checked and documented on the child's medication form and must include:

- The child's name
- The prescribed dose
- The expiry date
- Written instruction by the prescriber on the label or container

If there is any doubt about procedures, staff will not administer the medicines but will check with the parent/carer first.

After discussion with parents, children who are competent will be encouraged to take responsibility for managing their own medicines and procedures and this is reflected within their individual healthcare plan. Staff will, however, always supervise the child.

Staff have a responsibility to record and inform their parent/carer if a child refuses medicine. Staff will not force a child to take medicine.

Each time a medicine is given, a written record will be kept in the child's own Medication Record file which will be kept in the first aid file. This is done by signing the medicine form. Good records demonstrate that staff have exercised a duty of care. These files will transfer with the child to their next school

PROCEDURE FOR MANAGING PRESCRIPTION MEDICINES WHICH NEED TO BE TAKEN DURING THE SCHOOL DAY

- Medicines are only accepted by office staff and they must be brought in by the parent/carer, rather than via the pupil.
- With parental agreement, some over the counter medications can be given as per 'Guidance for Early Years Providers and Schools on the Use of Over-the Counter Medicines'(2018). Examples of medicines that do not require a prescription and which parents can give permission to administer include:
  • Paracetamol, ibuprofen or antihistamines - provided they are supplied in packaging with clear dosage instructions that are age appropriate for the child
  • Moisturising / soothing preparations for minor skin conditions
  • Sunscreen for routine protection while playing / learning outside
  Where Parental agreement is given, it should be recorded on CPOMs.

- Children should never be given medicine to keep on their person; all medicines should be handed in to the office. Unless this is a controlled drug for example an inhaler which the child is competent in using.
    - An exception to this rule is made, however, for medicines provided for emergency treatment such as reliever inhalers for asthmatic pupils or glucose tablets for diabetics, which will be kept close to the pupil(s) concerned for immediate use.
- Medicines will be kept in a secure central position in the school (e.g. school office.)
- Medicines need to be clearly marked with the name and class of the pupil, together with the dose and the time(s) of the day at which it should be taken.
- Only medicines prescribed by a doctor can be accepted in their original container with the pharmacy label intact.
- School cannot accept any medicine that has been taken out of the container as originally dispensed or make changes to dosages on parental /carer instructions.
- Over-the-counter remedies such as throat sweets and nasal inhalers should not be brought into school as these could cause a hazard to the child or to another child if found.
- Medicines are only administered following a written request from parents/carers, using the **'Request for Administration of Medicine in School',** which clearly states the name and class of the pupil, together with the dose and time(s) of day at which it should be taken and any special conditions for storage of the medicine (i.e. kept in fridge).

PROCEDURES FOR MANAGING PRESCRIPTION MEDICINES ON SCHOOL TRIPS, RESIDENTIAL VISITS AND SPORTING ACTIVITIES

Children with medical needs, particularly of a long-term nature, are encouraged to take part on trips and where necessary risk assessments are carried out for these children. The administration of medicines follows the same procedures as for administration in school. A copy of health care plans will be taken on visits and residential in the event of information being needed in an emergency.

For the purpose of residential visits, there will be a named person with responsibility for the administration of medicines and care of children as above. Parents will be asked to complete a form and may be required to meet with the named staff to ensure that staff are aware of all medical requirements.
A risk assessment will be completed before a residential which will include any children with medical needs or any medication to be administered.

In the case of higher levels of care e.g. intimate care, the named member of staff will also meet with the school nurse, or other recognised medical advisor to ensure that they are trained in dealing with the level of care required.

PARENTAL/CARER RESPONSIBILITIES IN RESPECT OF THEIR CHILD'S NEEDS

Parents/Carers are requested to make arrangements for pupils who become unwell at school. It is the duty of parents to make arrangements for pupils who become unwell at school, by collecting them to take them home or to the doctor or hospital.

The school will attempt to contact the parents via the telephone numbers which have been made available to the school, namely home telephone numbers, work numbers and other emergency numbers.

Parents/carers should provide the Headteacher/Senior Management Team or School Family Liaison Officer with sufficient information about their child's medical needs if treatment or special care is required. Information about a medical condition should be included as recorded by the child's G.P. Parents/carers and the school will then reach an agreement on the school's role in supporting the child's medical needs.

Parents/carers should be aware that sharing information with other staff will ensure the best care for the child.

EMERGENCY PROCEDURES

In the event of an Emergency, an ambulance will be called, and a child will be accompanied to hospital by a member of staff and the parents/carers will be notified. A staff member will stay with the child until a parent/carer arrives.

In all cases, administration of medication and/or treatment to a pupil will be at the discretion of the Headteacher and Governors of the school. However, ultimate responsibility remains with the parents/carers.

ACCIDENT PROCEDURE

The school ensures that there is an established procedure for teachers to follow in the event of an accident. If an accident occurs and a pupil sustains an injury, prompt action must be taken to give first aid where this is appropriate. If the injury appears serious enough to warrant further attention, or there is a degree of doubt, arrangements must be made for the injured pupil to see a doctor or for him/her to be taken to hospital. A full report of the accident must be made on the 'PRIME' site which is situated on the LA intranet site; a copy of the report is printed off and put in the accident record file.

If an accident occurs our normal "accident" procedure should be followed, i.e.

1. Contact a First aider for support and guidance.

2. Inform Head Teacher/Deputy or a member of the Senior Management Team.

3. Whenever possible, a pupil's parents are to be contacted and a decision about professional medical help can then be made. If unable to contact a parent, then the Head/Deputy or SMT member will decide on arrangements for treatment by a doctor or hospital.

4. If possible and practicable, a member of staff will be made available to accompany the patient to hospital.

Accident Book.

All accidents, other than day to day minor bumps, are to be recorded on the "PRIME' site, which is situated on the LA's Intranet site, help and guidance can be obtained from the Admin Assistants in filling in the forms. Copies are placed in a file which is situated in the Admin Assistants Office, by the person finding or reporting the injured child. These entries will be counter-signed by the Head or First Aider. (See attached CWAC policy for reporting accidents)

ASTHMA

The Acorns Primary and Nursery school has universal salbutamol Inhalers.

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

The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

The Acorns - All inhalers are kept inside stock cupboards in classrooms for ease of access in an emergency. They are kept out of the reach of children. The use of Inhalers is recorded in the class SEND file, the dosage given is recorded and a member of staff signs the record.

MINOR ILLNESSES/INJURIES IN SCHOOL

Vomiting and Diarrhoea

If a child or member of staff vomits or has diarrhoea in school, they will be sent home immediately. Children with these conditions will not be accepted back into school until they have been completely clear of symptoms for 48 hours.

Head Lice

Staff are not allowed to touch children and examine them for head lice. If we suspect a child had head lice, a member of staff will inform the parent/carer. The SMT will make a decision on how to proceed, e.g. we will send out a standard letter to inform the parents or in extreme cases make contact with the school nurse.

Rashes/Spots and Visual Symptoms

If a child develops a rash/spots/temperature or other visual symptoms a member of staff will look at their arms or legs or torso. We would only look at the child's back or chest if we were concerned about infection to other children. In this case another adult would be present, and we would ask the child's permission to do this.

If a child has any of these infections, they will need to stay off school for a prescribed period of time.

Infection

The highest levels of hygiene will be carried out by all First Aiders wherever possible and gloves **must** be worn to reduce the risk of infection. However, the absence of gloves must never stop emergency first aid being administered. Whenever possible, hands must be thoroughly washed prior to, and after, first aid having been given.

All first aid kits will contain disposable non-sterile gloves and some plastic bags large enough to accept used dressings. Special bins are in both Key Stages in the adult toilets.

Any surfaces contaminated with blood or other bodily fluids must be dealt with according to the correct procedure.

Injuries

If a child suffers an injury during lesson time, and the class has a First Aider attached to it, the injury will be dealt with by them. If necessary, a fully qualified First Aider will be called for. Should an emergency occur the class teacher will contact the nearest First Aider for immediate assistance.

During break times, supervisory staff will be expected to address any minor injuries which occur on the playground. Class teachers must be informed whenever one of their children suffers a significant injury, so that they can inform the child's parents.

Cuts and Grazes

All cuts and grazes must be washed thoroughly - with water preferably, or a medi-wipe - and if needed be covered with either a plaster or a sterile dressing. Minor cuts and grazes do not need to be recorded in the accident book and can be treated by any first aider. Severe cuts where there is a substantial amount of blood loss or the wound is deep must be seen by a fully qualified first aider.
Anyone treating an open wound should wear rubber gloves.

Severe wounds must be recorded in the Accident Book and the parents informed.

MAJOR INJURIES.

DO NOT MOVE. Get First Aider.

Bumped Heads and Severe Blows

Parents must be informed in writing if their child suffers any blow to the head during the school day, and if the child has suffered a significant blow to any other part of the body. Appropriate slips are kept in the accident book. They are completed by the person who dealt with the incident who will also update the log of incidents in the accident book. All bumps to the head must be recorded in the Accident Book. This is kept in the school office or in the Nursery. It is the responsibility of the class teacher to ensure that a child has received a letter when required and that it is handed personally to the parent/carer at the end of the day.

All bumps to the head or face should be treated as serious and should be assessed by a fully qualified first aider. A cold compress or ice-pack should be applied. The class teacher should be informed so that they can keep a close eye on the progress of the child and the parent should be informed by telephone or in person.
All accidents that require first aid must be documented. The Early Years file is kept In Nursery and contains bumped head slips which must be handed to the parent/carer. KS1 and KS2 have a file which is kept in the front office. These contain the bumped head slips which must be handed to the parent/carer. If a parent/carer does not collect the child staff should inform parent/carer by telephone the same day.

Look out for:
- Vomiting.
- Concussion - loss of memory re-events causing injury (brain shaking)
- Headaches.
- Loss of vision/squint/dilation of pupils.
- Dizziness/drowsiness/coma.
- Any weakness of the limbs.

A note must be taken of the history and progress of events, in order, should it be necessary, to give as much information as possible to the ambulance/hospital staff.

Nose Bleeds (use gloves)

1. Pinch nose.
2. Hold head forward about 45 degrees.
3. Hold for up to 10 minutes - if still bleeding after that time then-
4. Hold for up to a further 20 minutes.
5. If still bleeding after that time then tell parent, take to hospital.

SERIOUS ACCIDENTS

Should a serious accident occur and either a pupil, a staff member or a member of the public require hospitalisation, those staff who attend the incident will, as they see fit, call for help from other staff members, including those qualified in first aid, and act on the advice of the first aiders in deciding whether to call an ambulance.

In the event of the emergency services being called by a member of staff, they must,

1. State what has happened
2. The child's name
3. The age of the child
4. Whether the casualty is breathing and/or unconscious
5. The location of the school

A member of staff should wait by the school gate to direct the emergency services to the casualty.

If the casualty is a child their parents/carers should be contacted immediately and given all the information available. If the casualty is an adult, their next of kin should be called immediately. All contact numbers for children and staff are located in the designated place in the school office.

Any serious accidents must be recorded using the appropriate forms found in the accident file. This file is kept in the school office or in the hygiene room. A RIDDOR must be completed for accidents where the child has required medical treatment. The school secretary can provide guidance on these forms which are completed online.

INTIMATE CARE (attending to the needs of children who have wet or soiled themselves)
Only a staff member (with a full and current DBS check) is able to supervise or carry out intimate care. You must ensure that another colleague is aware that you are supporting a child's intimate care needs. In order to protect yourself from allegations, you should aim to remain potentially visible to colleagues, whilst providing privacy for the child. For example, keep the door slightly ajar. Talk to the child throughout the incident, making clear what is happening. If necessary, a second adult can be summoned.

The child should be involved as much as possible in his or her own intimate care.

All classrooms have designated toilet areas nearby. Other pupils may be directed to use alternative toilets while the intimate care needs of one child are attended to (in order to protect their privacy).

Protective gloves must be worn if contact is to be made. A supply of wet wipes and nappy sacks (for containing soiled underwear) are available in the bottom locker in the disabled toilet. Disposable plastic overalls are also available.

Care should be taken to dispose of any soiled items hygienically in the appropriate bin. Soiled clothing should be placed in a nappy sack and tied firmly for returning to parents.
Spillages of urine or faeces should be dealt with immediately.

Every child must be treated with dignity and respect. Privacy should be ensured appropriate to the child's age and situation, regardless of whether it is staff or a parent/carer attending to the child's needs.

Try to avoid doing things for the child, to allow the child to be as independent as possible. This is important for tasks such as removing underwear as well as for washing the private parts of a child's body. Support children in doing all that they can for themselves.

Be responsive to a child's reactions. Encourage the child to have a positive image of his/her own body. Confident, assertive children who feel their body belongs to them are less vulnerable to abuse. As well as the basics like privacy, the approach you take to a child's intimate care can convey messages about what his/her body is worth. Your attitude to a child's intimate care is important.

If a member of staff has concerns about managing personal or intimate care, then they should make these known to the Headteacher or in her absence a member of the SMT or a designated Child Protection coordinator.

Staff should report any incident causing concern to the Headteacher, or in her absence a member of the SMT or a designated Child Protection coordinator immediately.

Any of the concerns shown below must be reported immediately:

1. the child is accidentally hurt during intimate care
2. the child seems sore or unusually tender in the genital area
3. the child says something indicating misunderstanding/misinterpretation of the care being provided
4. the child appears to be sexually aroused by your actions
5. the child has a very strong emotional reaction without apparent cause (sudden crying or shouting).

Staff should be aware that intimate care is to some extent individually defined and varies according to personal experience, cultural expectation, and gender. Do not hesitate to seek advice from the Headteacher or more experienced colleagues.

FIRST AID CO-ORDINATOR – SCHEDULE OF RESPONSIBILITIES

The first aid co-coordinator will complete the following duties:

Duties	**Frequency**
Check the contents of all first aid boxes	**6 times a year**
Check the details of all first aid signs around the school	**3 times a year**
Check the medical awareness and emergency awareness lists	**September**
Check and update health care plans (Sarah Warner)	**3 times a year**

Note: References in this document to "First Aider" mean a person who has a recognised and up-to–date First Aid qualification.

Appendix 1: Members of staff available for First Aid

The Acorns

First aid at work qualification

Sarah Warner (Exp 11/24)
Claire Griffiths (Exp 06/24)
Wal Atkins (Exp 04/24)
Jane Speed (Exp 09/22)
Nathan Painter (11/23)

Paediatric first aid course

Claire Clarke (Exp 10/23)
Cali Hartley (Exp 09/22)
Siana Morris (Exp 09/23)
Anne Marie Walker (Exp 03/23)
Wendy Woodward (Exp 05/23)
Tracey Dybacz (Exp 09/23)
Emma Danks (Exp 10/23)
Sam Herbert (Exp 12/21)
Dawn Witkiss (Exp 12/21)
Sandra Caley (Exp 01/22)
Tracy Lee (Exp 01/22)
Ruth Hurst (Exp 01/22)
Sarah Hubbard (Exp 01/23)
Lindsey Dalmeny (10/23)
Jonathan Campbell (10/23)
Nicky Fuller (01/23)
Kaylie Marsden (01/23)
Emma Leslie (03/23)
Dawn Gelder (03/23)
Hayley Platt (07/23)
Chloe Ward (11/24)

MDAs

Janice Shone (Exp 20/12/21)
Karen Mayers (Exp 20/12/21)
Ellen Griffiths (Exp 20/12/21)
Nicola Griffiths (Exp 20/12/21)

Appendix 2: Guidance on infection control in schools and other childcare settings

1. Rashes and skin infections

Children with rashes should be considered infectious and assessed by their doctor.

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickenpox	Until all vesicles have crusted over	*See: Vulnerable Children and Female Staff – Pregnancy*
Cold sores, (Herpes	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x2 doses). *See: Female Staff – Pregnancy*
Hand, foot and mouth	None	Contact your local HPT if large numbers of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after starting antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x2). *See: Vulnerable Children and Female Staff – Pregnancy*
Molluscum contagiosu	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after starting appropriate antibiotic treatment	Antibiotic treatment is recommended for the affected child
Slapped cheek/fifth disease. Parvovirus B19	None (once rash has developed)	*See: Vulnerable Children and Female Staff – Pregnancy*

Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune, i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact your

2. Diarrhoea and vomiting illness

Infection or complaint	**Recommended period to be kept away from school, nursery or childminders**	**Comments**
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	
E. coli O157 VTEC Typhoid* [and paratyphoid*] (enteric fever) Shigella (dysentery)	Should be excluded for 48 hours from the last episode of diarrhoea. Further exclusion may be required for some children until they are no longer excreting	Further exclusion is required for children aged five years or younger and those who have difficulty in adhering to hygiene practices. Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts who may also require microbiological clearance. Please consult your local PHE centre for further advice
Cryptosporidiosis	Exclude for 48 hours from the last episode of diarrhoea	Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

3. Respiratory infections

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Covid – 19	Refer to most current school Risk Assessment	
Flu (influenza)	Until recovered	*See: Vulnerable Children*
Tuberculosis*	Always consult your local PHE centre	Requires prolonged close contact for spread
Whooping cough* (pertussis)	Five days from starting antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. Your local PHE centre will organise any contact tracing necessary

4. Other infections

Infection or complaint	Recommended period to be kept away from school, nursery or child minders	Comments
Conjunctivitis	A child should not be in school unless they are being treated with anti biotic eye drops	If an outbreak/cluster occurs, consult your local PHE centre
Diphtheria *	Exclusion is essential. Always consult with your local HPT	Family contacts must be excluded until cleared to return by your local PHE centre. Preventable by vaccination. Your local PHE centre will organise any contact tracing necessary
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	In an outbreak of hepatitis A, your local PHE centre will advise on control measures

Hepatitis B*, C*, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills see: *Good Hygiene Practice*
Meningococcal meningitis*/ septicaemia*	Until recovered	Meningitis C is preventable by vaccination There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close school contacts. Your local PHE centre will advise on any action is needed
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. Your local PHE centre will give advice on any action needed
Meningitis viral*	None	Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required
MRSA	None	Good hygiene, in particular, handwashing, and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact your local PHE centre
Mumps*	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x2 doses)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic

* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control). In addition, organisations may be required via locally agreed arrangements to inform their local PHE centre. Regulating bodies (for example, Office for Standards in Education (OFSTED)/Commission for Social Care Inspection (CSCI)) may wish to be informed – please refer to local policy.
Outbreaks: if an outbreak of infectious disease is suspected, please contact your local PHE centre.

PHE centre contact details

North of England

Cheshire and Merseyside PHE Centre 5th Floor
Rail House
Lord Nelson Street Liverpool L1 1JF
Tel: 0344 225 1295

Cumbria and Lancashire PHE Centre 1st Floor, York House
Ackhurst Business Park Foxhole Road
Chorley PR7 1NY Tel: 0344 225 0602

Greater Manchester PHE Centre 5th Floor
3 Piccadilly Place London Road Manchester
M1 3BN Tel: 0344 225 0562

North East PHE Centre Floor 2 Citygate
Gallowgate
Newcastle-upon-Tyne NE1 4WH Tel: 0300 303 8596

Yorkshire and the Humber PHE Centre Blenheim House
West One Duncombe Street Leeds
LS1 4PL Tel: 0113 386 0300

Appendix 3 – Accident Reporting Policy

CHESHIRE WEST AND CHESTER COUNCIL

HEALTH & SAFETY ACCIDENT REPORTING POLICY

1. Introduction

1.1 All accidents at work should be recorded but the level of detail and reporting procedures depend on the severity of the accident.

2. Policy

2.1 All accidents must be reported via the electronic reporting system (PRIME).

2.2 Reports of serious accidents/ incidents must be notified to the Health and Safety Team. Where an immediate investigation is required, the Health and Safety Team must be notified by telephone.

2.3 Every accident submitted is assessed and those accidents/incidents classed as serious (as defined by the Reporting of Injuries Diseases and Dangerous Occurrences (RIDDOR) Regulations 1995), will be reported to the Health & Safety Executive Incident Contact Centre by the Health and Safety Team.

2.4 Any further investigation required will be carried out by a Health and Safety Advisor who will report on their findings.

2.5 Managers must also investigate accidents locally to establish the measures necessary to reduce the risk of similar accidents.

2.7 All accident report forms are recorded electronically and used for statistical purposes and hard copies are stored for a period of 25 years

3. Aims/Principles

3.1 To determine if any further measures are necessary to reduce the risk of future accidents.

3.2 To comply with the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 1995 and as evidence in the case of civil claims.

3.3 To provide statistics and establish trends.

4. Scope/Application

4.1 This policy applies to employees (including Apprentices, Trainees, Work Experience Students), members of the public, service users, pupils, volunteers, visitors and contractors.

5. Definitions

5.1 RIDDOR - the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 1995, place a legal duty on employers to report work-related deaths, major injuries, over three-day injuries, work related diseases and dangerous occurrences (near miss accidents) to the Health and Safety Executive

5.2 Accident – an unplanned uncontrolled event which results in loss or injury

5.3 Incident – an event which has the potential to cause loss or injury (including mental harm)

5.4 Serious accident – an accident which results in the injured person either leaving work early, receiving treatment from a doctor, or going to hospital (at any time after the accident) and fatalities.

Appendix 4: Individual Health Care Plan

INDIVIDUAL HEALTH CARE PLAN

Name of Pupil:	**D.O.B:** **Male Female**
Medical/physical Condition:	**School:**
SEN (Code of Practice) Stage:	**Year Group:**
IHCP Drawn up on:	**Person responsible**
People Present at the Meeting: **Apologies:**	

Name and contact of GP: **Professional Contacts:**

Summary of Additional Support:

Important Information about the Condition:

Daily Management Issues:

Medication: In school:

Out of school:

Known side effects:

Please state if medication is self-administered / administered by a member of staff or under supervision.

Member of staff/s trained to administer medication:

Equipment Used in School:

Specific Moving/Handling Adviser:

Emergency Situation & Procedures:

Action addressed from previous IHCP:

Action to be taken before next IHCP:

Transport Implications:

School Trips:

Educational Implications (other than those on an IEP):

P.E.

Family Contact information: **Contact 1:** **Name:** **Address:** **Telephone:** **Relationship**	**Contact 2:** **Name:** **Address:** **Telephone:** **Relationship:**
Contact 3: **Name:** **Address:** **Telephone:** **Relationship:**	

Copies to:

- **Parents / carers**
- **Class teacher**
- **Teaching Assistant/s**
- **Lunchtime assistants**
- **Inclusion Manager**
- **SFLO**

Appendix 5 – Templates

Individual healthcare plan

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

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

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

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Parental agreement to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

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

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

The above information is, to 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.

Signature(s) _____ Date _____

Record of medicine administered to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Record of medicine administered to all children

Name of school/setting	The Acorns Primary and Nursery and Whitley Village Federated School

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name

Staff training record – administration of medicines

Name of school/setting	
Name	
Type 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 detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Contacting Emergency Services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.

Speak clearly and slowly and be ready to repeat information if asked.

1. your telephone number
2. your name
3. your location as follows [insert school/setting address]
4. state what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code
5. provide the exact location of the patient within the school setting
6. provide the name of the child and a brief description of their symptoms
7. inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient
8. put a completed copy of this form by the phone

Department of Health

Guidance on the use of emergency salbutamol inhalers in schools

September 2014

October 2014

Title: Guidance on the use of emergency salbutamol inhalers in schools
Author: SCLGCP/CMHI/IDC/14100
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Appendix 6

Guidance on the use of emergency salbutamol inhalers in schools

Prepared by the Disabled and Ill Child Services Team, Department of Health

Contents

HOW TO RECOGNISE AN ASTHMA ATTACK

The signs of an asthma attack are

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences. Some children will go very quiet.
- May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

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

Executive summary

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to buy salbutamol inhalers, without a prescription, for use in emergencies.

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

The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

This change applies to all primary and secondary schools in the UK. Schools are not required to hold an inhaler – this is a discretionary power enabling schools to do this if they wish. Schools which choose to keep an emergency inhaler should establish a policy or protocol for the use of the emergency inhaler based on this guidance.

Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life. Parents are likely to have greater peace of mind about sending their child to school. Having a protocol that sets out how and when the inhaler should be used will also protect staff by ensuring they know what to do in the event of a child having an asthma attack.

The protocol could be incorporated into a wider medical conditions policy which will be required by *Supporting Pupils* from 1st September 2014. The protocol should include the following – on which this guidance provides advice:

- arrangements for the supply, storage, care, and disposal of the inhaler and spacers in line with the school's policy on supporting pupils with medical conditions
- having a register of children in the school that have been diagnosed with asthma or prescribed a reliever inhaler, a copy of which should kept with the emergency inhaler
- having written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan
- ensuring that the emergency inhaler is only used by children with asthma with written parental consent for its use
- appropriate support and training for staff in the use of the emergency inhaler in line with the school's wider policy on supporting pupils with medical conditions
- keeping a record of use of the emergency inhaler as required by *Supporting pupils* and informing parents or carers that their child has used the emergency inhaler
- having at least two volunteers responsible for ensuring the protocol is followed

1. About this guidance

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to obtain, without a prescription, salbutamol inhalers, if they wish, for use in emergencies.[1] This will be for any pupil with asthma, or who has been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

This change applies to all primary and secondary schools in the UK.[2] Schools are not required to hold an inhaler – this is a discretionary power enabling schools to do this if they wish. Please note that only those institutions described in regulation 22 of the Human Medicines (Amendment) (No. 2) Regulations 2014, which amends regulation 213 of the Human Medicines Regulations 2012 may legally hold emergency asthma inhalers containing salbutamol.

Regulation 27 of the Human Medicines (Amendment) (No. 2) Regulations 2014 amends Schedule 17 of the Human Medicines Regulations 2012, and sets out the principles of supply to schools.

This guidance is non-statutory, and has been developed by the Department of Health with key stakeholders, to capture the good practice which schools in England should observe in using emergency inhalers and which should form the basis of any school protocol or policy. The guidance has been updated to take account of issues raised during the public consultation, and the Department is grateful to all who submitted comments and suggestions, which we have endeavoured to incorporate.

This guidance does not apply to schools in Wales, Northern Ireland and Scotland, which as devolved administrations have responsibility for issuing their own guidance for schools which wish to make use of this power (and have their own distinct policies on how staff may support children's health needs in the school setting). The principles of safe usage of inhalers in this guidance however are universal and based on recognised good practice.

The Children and Families Act 2014 requires governing bodies of English schools to make arrangements for supporting pupils at school with medical conditions. This duty came into force on 1st September 2014 and will be supported by the statutory guidance *Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England*, [3] referred to hereafter as *Supporting pupils*. This guidance is therefore designed to be read in conjunction with *Supporting pupils*, and every school's protocol or policy on use of the inhaler should have regard to it.

Supporting Pupils expects schools to:

- develop policies for supporting pupils with medical conditions and review them regularly;
- develop individual healthcare plans for pupils with medical conditions that identify the child's medical condition, triggers, symptoms, medication needs, and the level of support needed in an emergency.

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[1] http://www.legislation.gov.uk/uksi/2014/1878/contents/made

[2] Including maintained schools, independent schools, independent educational institutions, pupil referral units and alternative provision academies. Maintained nursery schools are also eligible to hold an emergency salbutamol inhaler.

[3] https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions

- have procedures in place on managing medicines on school premises;
- ensure staff are appropriately supported and trained.

2. Introduction

Asthma is the most common chronic condition, affecting one in eleven children. On average, there are two children with asthma in every classroom in the UK.[4] There are over 25,000 emergency hospital admissions for asthma amongst children a year in the UK.[5]

Children should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them.

However, an Asthma UK survey found that 86% of children with asthma have at some time been without an inhaler at school having forgotten, lost or broken it, or the inhaler having run out. However, before 1 October 2014, it was illegal for schools to hold emergency salbutamol inhalers for the use of pupils whose own inhaler was not available.

In 2013 in response to this, and following advice from the Commission of Human Medicines 2013 the Medicines and Healthcare Products Regulatory Agency (MHRA) recommended changes to legislation to enable schools to purchase and hold emergency salbutamol inhalers, without a prescription. A public consultation was held (the results can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341902/Department_of_Health_response_to_asthma_consultation.pdf). There was overwhelming support for changing the regulations to allow schools to hold an emergency inhaler.

The regulations which enable this come into force on 1st October 2014. The MHRA also recommended that the use of emergency inhalers be supported by appropriate protocols and this guidance provides advice on what such a protocol should contain.

Any school which chooses to hold an emergency inhaler may wish to consider including a cross-reference to the asthma policy in the school's policy for supporting pupils with medical conditions. The use of an emergency asthma inhaler should also be specified in a pupil's individual healthcare plan where appropriate.

There are a number of resources which provide information on asthma, and how it can be treated listed in section 7 together with contact details for support organisations. This guidance is not intended to be a detailed guide to the diagnosis or treatment of asthma in general. If any member of staff has reason to suspect a child has asthma or a respiratory condition, they should notify the parents, so they can take the child to a doctor. Section 5 gives advice on what to do in an emergency.

A school's medical conditions policy or asthma policy may already cover elements of the emergency inhaler protocol, for example ensuring appropriate support and training for teachers. Policies will likely already cover elements such as arrangements for storage, care, and disposal of medication, ensuring written consent for administration or supervision of administration of medication, keeping a record of administration of medication, and informing parents in relation to children's own inhalers, and could simply be expanded to cover the emergency inhaler.

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[4] Asthma UK, 'Asthma Facts and FAQs', http://www.asthma.org.uk/asthma-facts-and-statistics

[5] The NHS Atlas of Variation in Healthcare for Children and Young People gives the numbers of emergency admissions of children and young people for asthma in each former PCT / local authority area http://www.sepho.org.uk/extras/maps/NHSatlasChildHealth/atlas.html

3. Arrangements for the supply, storage, care and disposal of the inhaler

Supply

Schools can buy inhalers and spacers (these are enclosed plastic vessels which make it easier to deliver asthma medicine to the lungs) from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed. Schools can buy inhalers in small quantities provided it is done on an occasional basis and is not for profit.

Fig. 1 – a child being helped to use an inhaler with spacer.

A supplier will need a request signed by the principal or head teacher (ideally on appropriately headed paper) stating:

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

Schools may wish to discuss with their community pharmacist the different plastic spacers available and what is most appropriate for the age-group in the school. Community pharmacists can also provide advice on use of the inhaler. Schools should be aware that pharmacies cannot provide inhalers and spacers free of charge and will charge for them.

The emergency kit

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler;
- at least two single-use plastic spacers compatible with the inhaler;
- instructions on using the inhaler and spacer/plastic chamber;
- instructions on cleaning and storing the inhaler;
- manufacturer's information;
- a checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded;
- a note of the arrangements for replacing the inhaler and spacers (see below);

- a list of children permitted to use the emergency inhaler (see section 4) as detailed in their individual healthcare plans;
- a record of administration (i.e. when the inhaler has been used).

Schools should consider keeping more than one emergency asthma kit, especially if covering more than one site, to ensure that all children within the school environment are close to a kit. The experience of some respondents to the consultation on this guidance suggested a stock of 5 spacers would be adequate for a typical school.

Salbutamol

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild and temporary and are not likely to cause serious harm. The child may feel a bit shaky or may tremble, or they may say that they feel their heart is beating faster.

The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential therefore that schools ensure that the inhaler is only used by children who have asthma or who have been prescribed a reliever inhaler, and for whom written parental consent has been given. Section 5 provides essential information on the safe use of an inhaler.

Storage and care of the inhaler

A school's asthma policy should include staff responsibilities for maintaining the emergency inhaler kit. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available;
- that replacement inhalers are obtained when expiry dates approach;
- replacement spacers are available following use;
- the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or that replacements are available if necessary.

Schools will wish to ensure that the inhaler and spacers are kept in a safe and suitably central location in the school, such as the school office, or staffroom, which is known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with manufacturer's guidelines), usually below 30C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any child's inhaler which is stored in a nearby location and the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler. An inhaler should be primed when first used (e.g. spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by spraying two puffs.

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use.

The inhaler itself however can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place.

However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of.[6]

Disposal

Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled. Schools should be aware that to do this legally, they should register as a lower- tier waste carrier, as a spent inhaler counts as waste for disposal. Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years.

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

[6] This advice is in line with the British Thoracic Society's *The use of placebo inhaler devices, peak flow meters and inspiratory flow meters in clinical practice. Practical Recommendations* (2005) http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Asthma/Other%20useful%20links/placeboinhalersfinal.pdf

4. Children who can use an inhaler

The emergency salbutamol inhaler should only be used by children:

- who have been diagnosed with asthma, and prescribed a reliever inhaler;
- OR who have been prescribed a reliever inhaler;

AND for whom written parental consent for use of the emergency inhaler has been given.

This information should be recorded in a child's individual healthcare plan.

A child may be prescribed an inhaler for their asthma which contains an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhaler is not accessible – it will still help to relieve their asthma and could save their life.

There should already be procedures in place to ensure that schools are notified of children that have additional health needs and this information, will enable them to compile an asthma register. Some schools will already have such a register as part of an asthma policy or medical conditions policy.

The asthma register is crucial as in larger schools and secondary schools in particular, there may be many children with asthma, and it will not be feasible for individual members of staff to be aware of which children these are (in primary settings, where a teacher has responsibility for a single class each year this is more reasonable). Consequently, schools should ensure that the asthma register is easy to access, and is designed to allow a quick check of whether or not a child is recorded as having asthma, and consent for an emergency inhaler to be administered. A school may wish to include – with parental consent - a photograph of each child, to allow a visual check to be made.

As part of the school's asthma policy, when the emergency inhaler is to be used, a check should be made that parental consent has been given for its use, in the register. Schools should have in their asthma policy a proportionate and flexible approach to checking the register.

The school should seek written consent from parents of children on the register for them to use the salbutamol inhaler in an emergency. A draft consent form is at Annex B. Schools will want to consider when consent for use of the inhaler is best obtained. Options include:

- obtaining consent at the same time as for administering or supervising administration of a child's own inhaler under an asthma policy or medical conditions policy, or as part of development of an individual healthcare plan
- obtaining consent at the same time as seeking consent for the flu vaccination or other vaccinations

Keeping a record of parental consent on the asthma register will also enable staff to quickly check whether a child is able to use the inhaler in an emergency. Consent should be updated regularly – ideally annually - to take account of changes to a child's condition.

5. Responding to asthma symptoms and an asthma attack

Salbutamol inhalers are intended for use where a child has asthma. The symptoms of other serious conditions/illnesses, including allergic reaction, hyperventilation and choking from an inhaled foreign body can be mistaken for those of asthma, and the use of the emergency inhaler in such cases could lead to a delay in the child getting the treatment they need.

For this reason, the emergency inhaler should only be used by children who have been diagnosed with asthma, and prescribed a reliever inhaler, or who have been prescribed an reliever inhaler AND whose parents have given consent for an emergency inhaler to be used.

It is recommended that each school's asthma policy includes general information on how to recognise and respond to an asthma attack, and what to do in emergency situations. Staff should be particularly aware of the difficulties very young children may have in explaining how they feel. Often guidance provided to schools by local authorities will provide this information. Some schools will already have this information in an asthma policy or medical conditions policy.

Asthma UK has produced demonstration films on using a metered-dose inhaler and spacers suitable for staff and children.
http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

Education for Health is a charity providing asthma training with the most up to date guidelines and best practice
http://www.educationforhealth.org

Common 'day to day' symptoms of asthma are:

- Cough and wheeze (a 'whistle' heard on breathing out) when exercising
- Shortness of breath when exercising
- Intermittent cough

These symptoms are usually responsive to use of their own inhaler and rest (e.g. stopping exercise). They would not usually require the child to be sent home from school or to need urgent medical attention.

Signs of an asthma attack include:

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Being unusually quiet
- The child complains of shortness of breath at rest, feeling tight in the chest (younger children may express this feeling as a tummy ache)
- Difficulty in breathing (fast and deep respiration)
- Nasal flaring
- Being unable to complete sentences
- Appearing exhausted

- A blue / white tinge around the lips
- Going blue

If a child is displaying the above signs of an asthma attack, the guidance below on responding to an asthma attack should be followed.

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

Responding to signs of an asthma attack

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward.
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with child while inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of the salbutamol via the spacer immediately
- If there is no immediate improvement, continue to give two puffs every two minutes up to a maximum of 10 puffs, or until their symptoms improve. The inhaler should be shaken between puffs.
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE
- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way
- The child's parents or carers should be contacted after the ambulance has been called.
- A member of staff should always accompany a child taken to hospital by ambulance and stay with them until a parent or carer arrives.

Recording use of the inhaler and informing parents/carers

Use of the emergency inhaler should be recorded. This should include where and when the attack took place (e.g. PE lesson, playground, classroom), how much medication was given, and by whom. *Supporting pupils* requires written records to be kept of medicines administered to children.

The child's parents must be informed in writing so that this information can also be passed onto the child's GP. The draft letter at Annex B may be used to notify parents.

6. Staff

Any member of staff may volunteer to take on these responsibilities, but they cannot be required to do so. These staff may already have wider responsibilities for administering medication and/or supporting pupils with medical conditions.

In the following advice, the term 'designated member of staff' refers to any member of staff who has responsibility for helping to administer an emergency inhaler, e.g. they have volunteered to help a child use the emergency inhaler, and been trained to do this, and are identified in the school's asthma policy as someone to whom all members of staff may have recourse in an emergency.

Schools will want to ensure there are a reasonable number of designated members of staff to provide sufficient coverage. In small schools, it may be that all members of staff are designated members of staff.

Schools should ensure staff have appropriate training and support, relevant to their level of responsibility. *Supporting Pupils* requires governing bodies to ensure that staff supporting children with a medical condition should have appropriate knowledge, and where necessary, support.

It would be reasonable for **ALL** staff to be:

- trained to recognise the symptoms of an asthma attack, and ideally, how to distinguish them from other conditions with similar symptoms;
- aware of the asthma policy;
- aware of how to check if a child is on the register;
- aware of how to access the inhaler;
- aware of who the designated members of staff are, and the policy on how to access their help.

As part of the asthma policy, the school should have agreed arrangements in place for all members of staff to summon the assistance of a designated member of staff, to help administer an emergency inhaler, as well as for collecting the emergency inhaler and spacer. These should be proportionate, and flexible – and can include phone calls being made or responsible secondary school-aged children asking for the assistance of another member of staff and/or collecting the inhaler (but not checking the register), and procedures for supporting a designated member's class while they are helping to administer an inhaler.

The school's policy should include a procedure for allowing a quick check of the register as part of initiating the emergency response. This does not necessarily need to be undertaken by a designated member of staff, but there may be value in a copy of the register being held by at least each designated member. If the register is relatively succinct, it could be held in every classroom.

Designated members of staff should be trained in:

- recognising asthma attacks (and distinguishing them from other conditions with similar symptoms)
- responding appropriately to a request for help from another member of staff;

- recognising when emergency action is necessary;
- administering salbutamol inhalers through a spacer;
- making appropriate records of asthma attacks.

The Asthma UK films on using metered-dose inhalers and spacers are particularly valuable as training materials.
http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

Children with inhalers will also be able to demonstrate to their teacher how they use it; the school nurse may also be able to advise on appropriate use.

In a number of areas, local asthma teams have provided training for school staff in supporting children with asthma, including use of the inhaler, and schools could contact their local NHS Hospital Trust for information on how children with asthma are supported, and improving links between the NHS and the school.

It is recommended that schools should also ensure that:

- a named individual is responsible for overseeing the protocol for use of the emergency inhaler, and monitoring its implementation and for maintaining the asthma register;
- at least two individuals are responsible for the supply, storage care and disposal of the inhaler and spacer.

Liability and indemnity

Supporting pupils requires that governing bodies ensure that when schools are supporting pupils with medical conditions, they have appropriate levels of insurance in place to cover staff, including liability cover relating to the administration of medication.

Local Authorities may provide schools which are administering inhalers with appropriate indemnity cover; however, schools will need to agree any such indemnity cover directly with the relevant authority or department.

7. Useful links

For convenience both hot links and full URLs are given below.

***Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England* (Department for Education, 2014).** https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions

***Access to Education and Support for Children and Young People with Medical Needs* (Welsh Assembly Government Circular No: 003/2010, May 2010)**
http://wales.gov.uk/topics/educationandskills/publications/guidance/medicalneeds/?lang=en

***The Administration of Medicines in Schools* (Scottish Executive, 2001),**
http://www.scotland.gov.uk/Publications/2001/09/10006/File-1

***Supporting Pupils with Medication Needs*, (Department of Education, Department of Health, Social Services and Public Safety, 2008)**
http://www.deni.gov.uk/index/support-and-development-2/special_educational_needs_pg/special_educational_needs-supporting_pupils_with_medication_needs-2.htm

Asthma UK Website
http://www.asthma.org.uk/

Education for Health
http://www.educationforhealth.org

School Asthma Cards
http://www.asthma.org.uk/Shop/school-asthma-card-pack-of-20-healthcare-professionals

NHS Choices, Asthma in Children
http://www.nhs.uk/conditions/asthma-in-children/pages/introduction.aspx

NICE Quality Standard
http://publications.nice.org.uk/quality-standard-for-asthma-qs25

Children and Maternal Health Intelligence Network
http://www.chimat.org.uk/

Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action (March 2012).
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.p df

Annex A

CONSENT FORM:
USE OF EMERGENCY SALBUTAMOL INHALER
[Insert school name]

Child showing symptoms of asthma / having asthma attack

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

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

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

Signed: Date: ……

Name (print)……

Child's name: ……

Class: ……

Parent's address and contact details:

……

……

……..……

Telephone: ……

Email:…….

Annex B

SPECIMEN LETTER TO INFORM PARENTS OF EMERGENCY SALBUTAMOL INHALER USE

Child's name:

Dear……

This letter is to formally notify you that…….has had problems with his / her breathing today. This happened when……

A member of staff helped them to use their asthma inhaler.

They did not have their own asthma inhaler with them, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given …… puffs.

Their own asthma inhaler was not working, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given …… puffs.

[*Delete as appropriate*]

Although they soon felt better, we would strongly advise that you have your seen by your own doctor as soon as possible.

Yours sincerely,