Medicine Safety

and other health related topics

A Guidance Document for Services Working with Children and Young People

CONTENTS

FOREWORD

Most children and young people will have, at some time, a medical condition which could affect their attendance or participation in activities. This may be short-term, for instance, completing a course of medication, or a more long-term condition, which, if not properly managed, could limit their access to a particular setting and the activities that are on offer.

The aim of this guidance document is to help settings where children and young people attend; develop policies and procedures for those who have either a short-term or long-term medical need and put into place effective management systems to support them in the setting.

Individual settings are encouraged to develop their own medicines policy and maintain clear written (audited) records for supporting children and young people with medical needs, including, where necessary, individual health care plans and the safe management of medicines.

This document replaces 'Managing Medicines in Schools', which was produced in 2002; the document will be made available electronically via the schools' portal and the internet.

This guidance document has been produced by Lancashire County Council in consultation with partners from the Primary Care Trusts, schools and support services. Many thanks must be expressed to all those who have participated in producing this guidance document.

It is intended that the guidance will be reviewed on an annual basis. Comments regarding the document and its contents are welcome and should be forwarded to PolicyDevelopment@ed.lancscc.gov.uk

INTRODUCTION

This document provides guidance for Lancashire County Council, Primary Care Trusts, Schools, Early Years Settings, Private and Voluntary Organisations which provide direct services to children and young people.

This guidance is commended to all organisations listed above. It was written specifically for services provided directly by Lancashire County Council but it is not a requirement upon these services.

The guidance has been produced with reference to Managing Medicines in Schools and Early Years Settings (DoH, 2005) and the National Service Framework for Children, Young People and Maternity Services, Standard 10 (DoH, 2004), Including Me, Managing Complex Health Needs in School and Early Years Settings (DfES 2005).

It is designed to assist in the:

- Review of current policies and procedures which involve children and young people with medical needs in order to make sure that everyone, including parents and carers, are clear about their respective roles;
- Putting in place effective management systems to help support individual children and young people with medical needs;
- Making sure that medicines are handled responsibly;
- Ensuring that all staff are clear about what to do in the event of a medical emergency.

Examples of a Health Care Plan and other forms for recording medication which can be adapted to suit the child, young person and the setting are available for download at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

It is recognised that Health Care Plans and other documentation developed within particular settings, for example Primary Care Trusts, could be used in place of these.

The guidance is concerned with children and young people from birth to 19 years of age who have identified health needs and, as a consequence, require additional support and/or care in order to:

- Maintain optimal health during the day or night;
- Access the range of opportunities available to them to the maximum extent.

This guidance has been written for the following settings:

- All schools;
- Children's Centres;
- Sure Start local programmes;
- Childminders;
- Playgroups;
- Nursery schools;
- Any setting eligible to receive Nursery Education Grant funding;
- Before and after school clubs;
- Holiday play schemes;
- Residential care homes;
- Youth and community services.

NB: Throughout the document the generic term "setting(s)" will be used to describe any of the provisions shown above for Children and Young People.

The lead adult with overall responsibility in such a setting will be referred to as the ‘Lead Adult’.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

CHAPTER 1

1. Developing a Medicines Policy

For ease of reading throughout the document the generic term "setting(s)" will be used to describe any of the above provision for Children and Young People.

The lead adult with overall responsibility in such a setting will be referred to as the 'Lead Adult'.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

1.1 Introducing a Policy

A clear policy understood and accepted by staff, parents, children and young people provides a sound basis for ensuring that children and young people with medical needs receive proper care and support in a setting.

The Lead Adult has the responsibility for devising the policy. However, settings acting on behalf of the employer should develop policies and procedures that draw on the employer's overall policy but are amended for their particular provision. Policies should, as far as possible, be developed in consultation with the Lead Adult where they are not the employer. All policies should be reviewed and updated on a regular basis.

Policies should aim to enable regular attendance. Formal systems and procedures in respect of administering medicines, developed in partnership with parents and staff, should back up the policy.

A policy needs to be clear to all staff, parents and children. It could be included in the prospectus, or in other information for parents. A policy should cover:

- Procedures for managing prescription medicines which need to be taken during the day;
- Procedures for managing prescription medicines on trips and outings;
- A clear statement on the roles and responsibilities of staff managing administration of medicines, and for administering or supervising the administration of medicines;
- A statement of parental responsibilities in respect of their child's medical needs
- The need for prior written agreement from parents for any medicines to be given to a child or young person;
- The circumstances in which a child or young person may take any non-prescription medicines;
- The settings policy on assisting children and young people with long-term or complex medical needs;
- Children and young people carrying and taking their medicines themselves;
- Staff training in dealing with medical need;
- Record keeping;
- Safe storage of medicines;
- Access to the school's emergency procedures;
- Risk assessment and management procedures.

Whilst teachers and other school staff in charge of pupils have a common law duty to act as any reasonably prudent parent would to make sure that pupils are healthy and safe on school premises (and this might in exceptional circumstances extend to administering medicine and/or taking action in an emergency), school staff should not, as a general rule, administer medication without first receiving appropriate information and/or training (eg Support Staff may have specific duties to provide medical assistance as part of their contract and will have received appropriate training); whilst Section 3(5) of the Children Act provides protection to teachers acting reasonably in emergency situations. First Aiders are not trained generally as part of their first aid training to administer medication.

It is each parent's responsibility to ensure that their child is fit to attend school and any medication required whilst the child is at school should ideally be administered by the parent.

1.2 Prescribed Medicines

Parents are responsible for supplying the setting with adequate information regarding their child's condition and medication. This information must be in writing, signed and current so that procedures for each individual child or young person's medication are known. The information should be updated annually at an agreed time, or earlier, if medication is altered by the child's GP or Consultant.

All items of medication should be delivered directly to the setting by parents or escorts employed by the Authority. It is the parent's responsibility to inform the Lead Adult in writing when the medication or the dosage is changed or no longer required. It would be considered good practice if a transfer of medication book was available to be signed on arrival at the setting.

After the first receipt of medication at a setting additional medication of the same may continue to be accepted without further notice, but any changes to the prescribed medication or a change in medication, must be notified in writing to the Lead Adult or accepted Authorised Person. 'As required' medication, for example, inhalers, will only be accepted if the above procedures have been followed. A record must be maintained of all medication administered to a child or young person.

Each item of medication must be delivered to the Lead Adult or Authorised Person **in a secure and labelled container** as originally dispensed. It may be appropriate for the GP to prescribe a separate amount of medication for the settings use. This should be negotiated with the parent. Items of medication in unlabelled containers should be returned to the parent. **The setting should never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.**

Medicines should only be taken to a setting when essential; that is where it would be detrimental to a child or young person's health if the medicine were not administered during the settings 'day'. The setting should only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration, the child's name and date of dispensing.

It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable it to be taken outside the setting's hours. Parents could be encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after attending the setting and at bedtime.

The Medicines Standard of the National Service Framework (NSF) for Children[1] recommends that a range of options are explored including:

Prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside the setting's hours. Prescribers consider providing two prescriptions, where appropriate and practicable, for a child or young person's medicine: one for home and one for use in the setting, avoiding the need for repackaging or re-labelling of medicines by parents. Medication should never be accepted if it has been repackaged or relabelled by parents.

1.3 Controlled Drugs

The supply, possession and administration of some medicines are controlled by the Misuse

[1] National Service Framework for Children and Young People and Maternity Services: Medicines for Children and Young People (Department of Health/DfES, 2004). http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089102

of Drugs Act and its associated regulations (see Legal Framework). Some may be prescribed as medication for use by children and young people.

Once appropriate information and training has been received, any member of staff may administer a controlled drug to the child or young person for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.

A child or young person who has been prescribed a controlled drug may legally have it in their possession. However it would be considered good practice to have the prescribed controlled drugs stored in safe custody. However, children and young people could access them for self-medication if it is agreed that it is appropriate.
The setting should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes. A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

Misuse of a controlled drug, such as passing it to another child or young person for use, is an offence. There should be an agreed process for tracking the activities of controlled drugs and recognition that the misuse of controlled drugs is an offence.

1.4 Non-Prescription Medicines

Lancashire County Council (LCC) policy is that of not accepting non-prescription medication.

LCC as an organisation has a policy not to accept non-prescribed medication. This policy is commended to all Maintained Schools in Lancashire. However it is the schools' responsibility to agree its policy regarding non-prescription medication. All Governing Bodies and school's senior management teams should ensure that a properly instigated and understood procedure, with clear written (audited) records, which include insurance and indemnification, is maintained and is available to be audited. Arrangements to this effect should be drawn up and included in the school/early years' setting Health and Safety Policy and communicated to all concerned including parents.

A young person under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.

1.5 Long-Term Medical Needs

The parent is responsible for supplying the setting with adequate information regarding their child's condition and medication. This information must be in writing, signed and current so that procedures for each individual child and young person's condition and medication are known. It is recommended that each setting has a standard set of forms for this purpose, examples of which can be downloaded at:
http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

The information should be updated annually at an agreed time or earlier if medication is altered by the GP or Consultant.

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

treatments or through the psychological effects that serious or chronic illness or disability may have on a child and their family.

The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child or young person's educational needs, rather than a medical diagnosis, which must be considered[2].

The setting would need to know about any particular needs before a child or young person is admitted, or when they first develop a medical need. For children and young people who attend hospital appointments on a regular basis, special arrangements may also be necessary. It is often helpful to develop a written health care plan for such children and young people, involving the parents and relevant health professionals.

This can include: details of a child or young person's condition, special requirement eg dietary needs, pre-activity precautions and any side effects of the medicines, what constitutes an emergency, what action to take in an emergency, what not to do in the event of an emergency, who to contact in an emergency, the role the staff can play.

Form 2 provides an example of a health care plan which settings may wish to use or adapt. This can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

1.6 Administering Medicines

No child or young person under 16 should be given medicines without their parent's written consent. Any member of staff giving medicines to a child or young person should check:

- The child or young person's name on the medicine container;
- Prescribed dose;
- Expiry date;
- Written instructions provided by the prescriber on the label or container[3] and within the medication packaging.

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

All settings should complete and sign a record each time they give medicine to a child or young person. Forms 5 and 6 provide examples which settings may wish to use or adapt for this purpose. These can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc
Good records help demonstrate that staff have exercised a duty of care.

1.7 Self-Management

It is good practice to support and encourage children and young people, who are able, to take responsibility to manage their own medicines from a relatively early age. The age at which they are ready to take care of, and be responsible for their own medicines would vary. As children grow and develop they should be encouraged to participate in decisions about their medicines.

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent. Children develop at different rates and so the ability to take responsibility for their own medicines varies. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child or young person of any age to self-manage. Health professionals need to assess, with parents and children and

[2] SEN Code of Practice (DfES/0581/2001) paragraphs 7:64-7:67.
http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DfES+0581+2001

[3] It is to be noted that adrenaline pens include manufacturer's instructions.

young people, the appropriate time to make this transition.

If a child or young person can take their medicines themselves, staff may only need to supervise. The policy should say whether a child or young person may carry and administer (where appropriate) their own medicines, bearing in mind the safety of other children and young people and medical advice from the prescriber, in respect of the individual child or young person. Form 7 provides examples which settings may wish to use or adapt for this purpose and can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

Where children and young people have been prescribed controlled drugs, staff need to be aware that these should be kept in safe custody. However, children and young people could access them for self-medication if it is agreed that it is appropriate.

1.8 Refusing Medicines

If a child or young person refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in an individual health care plan. Parents should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the setting's emergency procedures should be followed as written down in the child or young person's care plan.

1.9 Record Keeping

Parents should tell the setting about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However, staff should make sure that this information is the same as that provided by the prescriber.

Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions. In all cases it is necessary to check that written details include:

- Name of child or young person;
- Name of medicine;
- Dose;
- Method of administration;
- Time/frequency of administration;
- Expiry date;
- Date of dispensing.

Staff should check that any details provided by parents, or in particular cases by a paediatrician or specialist nurse, are consistent with the instructions on the container. Form 3 provides examples which settings may wish to use or adapt for this purpose and can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

Form 4 provides examples which settings may wish to choose or adapt to confirm, with the parents, that a member of staff will administer medicine to their child. This form can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

All early years settings must keep written records of all medicines administered to children, and make sure that parents sign the record book to acknowledge the entry.

Although there is no similar legal requirement for the setting to keep records of medicines given to children and young people, it is good practice to do so. Records offer protection to staff and proof that they have followed agreed procedures. Some settings keep a logbook for this. Forms 5 and 6 provide examples which settings may use for this purpose or adapt for medicine record sheets. These forms can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

1.10 Educational Visits

It is essential that when planning an educational visit, the school can demonstrate that it has taken all reasonable steps and has undertaken reasonable adjustments to try and ensure that the visit is accessible to children and young people with disabilities and/or medical needs.

Schools must also ensure that when included in an outdoor visit a child or young person is not put at a substantial disadvantage. These factors may include: the time and effort that might need to be expended by a disabled/medical needs child; the inconvenience, indignity or discomfort a disabled/medical needs child might suffer; the loss of opportunity or the diminished progress that a disabled/medical needs child may make in comparison with his or her peers who are not disabled or have medical needs.

Lancashire County Council has in place an Educational Visits Policy and Guidelines which was written to comply with Health and Safety at Work law. The document, the accompanying Forms and Appendices, sets out the safety policy for off-site Educational Visits, participation in adventurous outdoor activities, and the arrangements for the implementation of the Policy.

All schools/services have received hard copies of the Policy and Guidelines but the most up to date version is available on the website: https://lccsecure.lancashire.gov.uk/education/data/edintact

Lancashire County Council is the employer in the following schools/services and they have been directed to implement the arrangements in their Educational Visits Policy and Guidelines:

- Community schools, community special schools, voluntary controlled schools, maintained nursery schools and short stay schools;
- Lancashire Young People's Service;
- Lancashire Outdoor Education Service.

The legal responsibilities of Governing Bodies for Voluntary Aided and Foundation Schools are set out in the DfES document 'Health and Safety: Responsibilities and Powers'. For those Voluntary Aided and Foundation Schools that are covered by the LCC's insurance arrangements, the Policy and Guidelines are a mandatory requirement.

In respect of individual cases where there are concerns, schools should seek advice from the technical advisers (details below). However:

- It is essential that the school discusses the proposed visit and planning process with the parents and (wherever possible) the child or young person as early as possible;
- The risk assessment should cover the specific issues of the child or young person. Reasonable adjustments should be made and alternative activities may need to be considered. If it is a Type B visit, the Form 1B (Application to the Authority for Approval) and Form 5 (Risk Assessment) should clearly show that the child(ren) have been fully considered in the planning process and that any necessary reasonable adjustments have been made; These forms can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc
- The staff and volunteers on the visit must be fully briefed and particularly if there are any adjustments to the programme for the child(ren) that have any SEN or medical needs. Schools should use the relevant planning forms (Form 2A for Type A visits and Form 2B for Type B visits); These forms can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc
- Advice about activities or venues can be obtained from the appropriate technical adviser (Nursery, Primary and Special Schools - 01772 532805, Secondary Schools - 01772 532783 or 01772 531224);

- Any disputes with parents should be referred to the Legal Adviser for Schools in the County Secretary and Solicitor's Group (01772 533321).

Lancashire County Council is the employer in the following:

- Community schools, community special schools, voluntary controlled schools, maintained nursery schools and short stay schools;
- Integrated Youth Support Service;
- Lancashire Outdoor Education.

Further information on Educational Visits and the Disability Discrimination Act, 1995 can be found in Appendix 18 of this Policy: https://lccsecure.lancashire.gov.uk/education/data/edintact

If staff are concerned whether they can provide for a child or young person's safety, or the safety of other children and young people on a visit, they should seek parent views and medical advice from the School Health Service or the child or young person's GP. See DfES guidance on planning educational visits[4].

The National standards for under 8s day care and childminding mean that the registered person must take positive steps to promote safety on outings.

1.11 Sporting Activities

Most children and young people with medical conditions can participate in physical activities and extra-curricular sport. There should be sufficient flexibility for all children and young people to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and wellbeing. Any restrictions on a child or young person's ability to participate in PE should be recorded in their individual Health Care plan. All adults should be aware of issues of privacy and dignity for children and young people with particular needs.

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

1.12 Home to School Transport

Lancashire County Council arranges home to school transport where legally required to do so. It must make sure that children and young people are safe during the journey. Most children and young people with medical needs do not require supervision on school transport, but should provide appropriate trained escorts should they consider it necessary[5]. Guidance should be sought from the child or young person's GP or paediatrician.

Drivers and escorts should know what to do in the case of a medical emergency. They should never administer medication; however, some passenger assistants may have been specially trained to clear tracheotomy tubes. Drivers and passenger assistants should fully understand what procedures and protocols to follow and they should be clear about their roles, responsibilities and liabilities.

Where children and young people have life-threatening conditions, specific Health Care Plans should be carried on vehicles. Schools would be well placed to advise the County Council and its transport contractors of particular issues for individual children. Individual transport Health Care Plans will need input from parents and the responsible medical practitioner for the child concerned. The Care Plans should specify the steps to be taken to support the normal care of the child as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training. Additionally, trained escorts may be required

[4] Health and Safety of Pupils on Educational Visits: a good practice guide (DfES, 1998) http://www.hse.gov.uk/education/visits.htm

[5] Please refer to 'Good Practice Guidelines for further information around this service. http://lccintranet/education/education_standards_and_inclusion_group/reports/pdf/home_to_school_travel.pdf

to support some children and young people with complex medical needs. These can be healthcare professionals or escorts trained by them.

Some children and young people are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

CHAPTER 2

2. Roles and Responsibilities

Responsibility for Child Safety

For ease of reading throughout the document the generic term "setting(s)" will be used to describe any of the above provision for Children and Young People.

The lead adult with overall responsibility in such a setting will be referred to the 'Lead Adult'.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

It is important that responsibility for child safety is clearly defined and that each person involved with children with medical needs is aware of what is expected of them. Close co-operation between the setting, parents', health professionals and other agencies will help provide a suitably supportive environment for children and young people with medical needs.

Children and young people with medical needs have the same rights of admission to school as other children, and cannot generally be excluded from school for medical reasons. Where a child or young person's presence at a setting represents a serious risk to the health or safety of others the Lead Adult may send the child or young person home that day, after consultation with the parents. This is not exclusion and may need to be done for medical reasons.

2.1 Parents

Parents, as defined in Section 576 of the Education Act 1996, include any person who is not a parent of a child but has parental responsibility for, or care of, a child. In this context, the phrase 'care of the child' includes any person who is involved in the full-time care of a child or young person on a settled basis, such as a foster parent, but excludes baby sitters, child minders, nannies and school staff.

It only requires one parent to agree to or request that medicines are administered. As a matter of practicality, it is likely that this will be the parent with whom the setting has day-to-day contact. Where parents disagree over medical support, the disagreement must be resolved by the courts. The setting should continue to administer the medicine in line with the consent given and in accordance with the prescriber's instructions, unless and until a court decides otherwise.

It is important that professionals understand who has parental responsibility for a child. The Children Act 1989 introduced the concept of parental responsibility. The Act uses the phrase 'parental responsibility' to sum up the collection of rights, duties, powers, responsibilities and authority that a parent has by law, in respect of a child. In the event of family breakdown, such as separation or divorce, both parents will normally retain parental responsibility for the child or young person and the duty on both parents to continue to play a full part in the child or young person's upbringing will not diminish. In relation to unmarried parents, only the mother will have parental responsibility unless the father has acquired it in accordance with the Children Act 1989. Where a court makes a residence order in favour of a person who is not a parent of the child or young person, for example a grandparent, that person will have parental responsibility for the child for the duration of the Order.

If a child is 'looked after' by Lancashire County Council, the child or young person may either be on a Care Order or be Voluntarily Accommodated. A Care Order places a child in the care of Lancashire County Council and gives them parental responsibility for the child. Lancashire County Council will have the power to

determine the extent to which this responsibility will continue to be shared with the parents. Lancashire County Council may also accommodate a child or young person under voluntary arrangements with the child's parents. In these circumstances the parents will retain parental responsibility acting, so far as possible, as partners of Lancashire County Council. Where a child is looked after by Lancashire County Council day-to-day responsibility may be with foster parents, residential care workers or guardians.

Parents should be given the opportunity to provide the Lead Adult of the setting with sufficient information about their child's medical needs if treatment or special care is needed. They should, jointly, with the Lead Adult, reach agreement on the setting's role in supporting their child's medical needs, in accordance with the employer's policy. Ideally, the Lead Adult should always seek parental agreement before passing on information about their child's health to other staff. Sharing information is important if staff and parents are to ensure the best care for a child or young person.

Some parents may have difficulty understanding or supporting their child's medical condition themselves. Local health services can often provide additional assistance in these circumstances.

2.2 The Employer

Under the Health and Safety at Work Act 1974, employers, including Lancashire County Council and school Governing Bodies, must have a health and safety policy[6]. This should incorporate managing the administration of medicines and supporting children with complex health needs, which will support the setting in developing their own operational policies and procedures.

Lancashire County Council health and safety policies and procedures are commended to all Maintained Schools in Lancashire. In Community, Community Special and Voluntary Controlled Schools, the employer is the County Council. The Governing Body is the employer in Voluntary Aided Schools and Foundation Schools.
For all Maintained Schools (Community, Community Special and Voluntary Controlled Schools, Voluntary Aided and Foundation Schools) covered by the County Council Insurance arrangements[7], the school's Governing Body should follow the health and safety policies and procedures produced by Lancashire County Council.

In the event of legal action over an allegation of negligence the employer, rather than the employee, is likely to be held responsible. Governing Bodies should therefore make sure that their insurance arrangements provide full cover in respect of actions which could be taken by staff in the course of their employment. It is the employer's responsibility to make sure that proper procedures are in place; and that staff are aware of the procedures and fully trained. Keeping accurate records is essential in such cases. Employers should support staff to use their best endeavours at all times, particularly in emergencies. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

Staff in a school or in an early years setting will be directly employed by Lancashire County Council or Governing Body, as employer. However, some care or health staff may be employed by a local health trust or possibly through the voluntary sector. In such circumstances, appropriate shared management arrangements should be agreed between the relevant agencies.

The employer is responsible for making sure that staff have appropriate training to support children and young people with medical needs. Employers should also ensure that there are appropriate systems for sharing information about a child or young person's medical needs in each setting for which they are responsible. Employers should satisfy themselves that training has given staff

6 Health and Safety: Responsibilities and Powers (DfES/0803/2001) includes information on responsibilities for health and safety in schools www.teachernet.gov.uk/_doc/4017/Responsibilites%20and%20Powers.doc

7 Insurance –A guide for schools (DfES/0256/2003) http://www.dfes.gov.uk/valueformoney/index.cfm?action=GoodPractice.Default&ContentID=22

sufficient understanding, confidence and expertise, and that arrangements are in place to update training on a regular basis. A health care professional should provide written confirmation of proficiency in any medical procedure.

Primary Care Trusts have the discretion to make resources available for any necessary training. Consideration should also be given in arranging training for staff in the management of medicines and policies about administration of medicines. This should be arranged in conjunction with local health services or other health professionals.

2.3 The Governing Body

Governing Bodies are responsible for setting the strategic direction of the school. This includes the establishment, monitoring and evaluation of policies. All schools should have a policy for medicines. In developing a policy the Governing Body must have regard to the views of the parents. It is therefore recommended that they consult with parents, and healthcare professionals.
Individual schools should develop policies to cover the needs of their own school. The policies should reflect those of their employer. The Governing Body has general responsibility for all of the school's policies even when it is not the employer. The Governing Body will generally want to take account of the views of the Head Teacher, staff and parents in developing a policy on assisting children and young people with medical needs.

2.4 The Lead Adult

The Lead Adult is responsible for putting the employer's policy into practice and for developing detailed procedures. Day-to-day decisions will normally fall to the Lead Adult or to whosoever they delegate this to, as set out in their policy.

Although the employer must ensure that staff receive proper support and training where necessary, equally, there is a contractual duty on the Lead Adult to ensure that their staff receive the training. As the manager of staff it is likely to be the Lead Adult who will agree when and how such training takes place.

The Lead Adult should make sure that all parents and staff are aware of the policy and procedures for dealing with medical needs. The Lead Adult should also make sure that the appropriate systems for information sharing are followed. The policy should make it clear that parents should keep their children at home when they are acutely unwell. The policy should also cover the approach to taking medicines in a setting. The Lead Adult and the Governing Body of schools should ensure that the policy and procedures are compatible and consistent with any registered day care operated either by them or an external provider on their premises.

For a child or young person with medical needs, the Lead Adult will need to agree with the parents exactly what support can be provided. Where parents expectations appear unreasonable, the Lead Adult should seek advice from the school nurse or doctor, the child's GP or other medical advisers and, if appropriate, the employer. In early years settings advice is more likely to be provided by a health visitor.

If staff follow documented procedures, then the employer's public liability insurance will apply if a parent should make a complaint. The Lead Adult should ask the employer to provide written confirmation of the insurance cover for staff who provide specific medical support. Registered persons are required to carry public liability insurance for day care provision.

Criteria under the National standards for under 8s day care make it clear that day care providers should have a clearly understood policy on the administration of medicines. If the administration of prescription medicines requires technical or medical knowledge then individual training should be provided to staff from a qualified health professional. Training

is specific to the individual child concerned. Ofsted's guidance on this standard sets out the issues that providers need to think through in determining the policy. In these cases contact should be made with the appropriate health service, school nurse or health visitor.

2.5 Teachers and Other Staff

Some staff may be naturally concerned for the health and safety of a child or young person with a medical condition, particularly if it is potentially life threatening. Staff with children and young people with medical needs in their class or group should be informed about the nature of the condition, and when and where they may need extra attention. The child or young person's parents and health professionals should provide this information.

All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover should be arranged for when the member of staff responsible is absent or unavailable. At different times of the day other staff may be responsible for children, such as lunchtime supervisors. It is important that they are also provided with training and advice.

Many voluntary organisations specialising in particular medical conditions provide advice and/or information advising staff on how to support children.

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

2.6 Early Years Staff Giving Medicines

For registered day care, the conditions of employment are individual to each setting. It is therefore for the registered person to arrange who should administer medicines within a setting, either on a voluntary basis or as part of a contract of employment.

2.7 Lancashire County Council

In Community Special and Voluntary Controlled Schools and Community Nursery Schools, Lancashire County Council, as the employer, is responsible for all health and safety matters. For Lancashire County Council day nurseries, out of school clubs (including open access schemes), holiday clubs and play schemes the registered person, which may be Lancashire County Council itself, is responsible for all health and safety matters.

Lancashire County Council, as the employer, provides a general policy framework to guide settings in developing their own policies on supporting children and young people with medical needs drawn up in consultation with local Primary Care Trusts.

2.8 Primary Care and NHS Trusts

Primary Care Trusts (PCTs) have a statutory duty to purchase services to meet local needs. PCTs and National Health Service (NHS) Trusts may provide these services. PCTs, Lancashire County Council and settings should work in co-operation to determine need, plan and co-ordinate effective local provision within the resources available.

PCTs must ensure that there is a medical officer with specific responsibility for children with special educational needs (SEN)[8]. Some

[8] SEN Code of Practice (DfES/0581/2001) paragraphs 10:24 – 10:26.
http://www.child-disability.co.uk/pdf/SEN%20Code%20of%20Practice%20DfES-0581-2001_main.pdf

of these children may have medical needs. PCTs and NHS Trusts, usually through the school health service, may provide advice and training for staff in providing for a child's medical needs.

2.9 Health Services

The nature and scope of local health services to settings varies between Health Trusts. They can provide advice on health issues to children, parents, staff within the setting, and the Local Authority. The main health contact for schools is likely to be a school nurse, whilst early years settings usually link with a health visitor. The school health service may also provide guidance on medical conditions.

Most settings will have contact with the health service through a school nurse, health visitor or community paediatrician. The school nurse, health visitor or community paediatrician should help the setting draw up individual Health Care Plans for children and young people with medical needs, and may be able to supplement information already provided by parents and the child or young person's General Practitioner. The school nurse, health visitor or community paediatrician may also be able to advise on training for staff on administering medicines, or take responsibility for other aspects of support.

Every child and young person should be registered with a GP, who work as part of a primary health care team. Parents usually register their child with a local GP practice. A GP owes a duty of confidentiality to patients, and so any exchange of information between a GP and a setting should normally be with the consent of the child or young person, if appropriate, or the parent. Usually consent will be given, as it is in the best interests of the child or young person for their medical needs to be understood by staff. The GP may share this information directly or via the appropriate health professional.

Many other health professionals may take part in the care of children with medical needs. Often a community paediatrician will be involved. These doctors are specialists in children's health, with special expertise in childhood disability, chronic illness and its impact in the setting. They may be directly involved in the care of the child, or provide advice to the settings in liaison with the other health professionals looking after the child.

Most NHS Trusts with school health services have pharmacists. They can provide pharmaceutical advice to the setting. Some work closely with local authority education departments and give advice on the management of medicines within settings. This could involve helping to prepare policies related to medicines in the setting and the training of staff. In particular, they can advise on the storage, handling and disposal of medicines.

Some children and young people with medical needs receive dedicated support from specialist nurses or community children's nurses, for instance a children's oncology nurse. These nurses often work as part of a NHS Trust or PCT and work closely with the primary health care team. They can provide advice on the medical needs of an individual child, particularly when a medical condition has just been diagnosed and the child is adjusting to new routines.

2.10 Ofsted

During an inspection Ofsted will check that day care providers have adequate policies and procedures in place regarding the administration and storage of medicines. Regulations require that parents give their consent to medicines being given to their child and that the provider keeps written records.

During school inspections Ofsted inspectors must evaluate and report on how well schools ensure pupils' care, welfare, health and safety. Ofsted will look to see whether 'administration' of medicines follows clear procedures[9] and assess steps are taken to provide children and young people with a

[9] Ofsted Inspecting schools – Handbook for inspecting nursery and primary schools; http://www.archive.official-documents.co.uk/document/ofsted/inspect/primary/30107.htm
Inspecting schools – Handbook for inspecting secondary schools, http://www.archive.official-documents.co.uk/document/ofsted/inspect/secondary/29503.htm
Inspecting schools – Handbook for inspecting special schools and pupil referral units http://www.archive.official-documents.co.uk/document/ofsted/inspect/special/29502.htm (all Ofsted 2003). These include judgements about the care, welfare, health and safety of pupils.

safe environment, including the safe storage and use of medicines.
The Commission for Social Care Inspection (CSCI) has a regular programme of inspections for care homes and other types of residential establishments such as special residential and boarding schools[10] .

[10] Ofsted Inspection Guidance Document – LEA Framework 2004 – Support for health and safety, welfare and child protection (Ofsted, 2004). http://www.ofsted.gov.uk/assets/3491.doc

CHAPTER 3

3. Dealing with Medicines Safely

For ease of reading throughout the document the generic term "setting(s)" will be used to describe any of the above provision for Children and Young People. The lead adult with overall responsibility in such a setting will be referred to as the 'Lead Adult'.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

3.1 Safety Management

All medicines may be harmful to anyone for whom they are not appropriate. Where a setting agrees to administer any medicines the employer must ensure that the risks to the health of others are properly controlled. This duty is set out in the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

3.2 Storing Medicines

Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child or young person. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration; as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child or young person needs two or more prescribed medicines; each should be kept in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

Children and young people should know where their own medicines are stored and who holds the key. The Lead Adult is responsible for making sure that medicines are stored safely. All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to the child or young person and should not be locked away. Many settings allow children and young people to carry their own inhalers. Other non-emergency medicines should generally be kept in a secure place not accessible to children and young people. Criteria under the 'National standards for under 8s day care' require medicines to be stored in their original containers, clearly labelled and inaccessible to children.

Some medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines.

Local pharmacists can give advice about storing medicines.

3.3 Access to Medicines

Children and young people need to have immediate access to their medicines when required. The setting may want to make special access arrangements for emergency medicines that it keeps. However, it is also important to make sure that medicines are only accessible to those for whom they are prescribed. This should be considered as part of the policy about children and young people carrying their own medicines.

3.4 Disposal of Medicines

Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with either Lancashire County Council's Environmental Services or the PCT; alternative arrangements can also be made with private contractors if necessary.

3.5 Hygiene and Infection Control

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures[11]. Please refer to Chapter 5, 'Hand Washing and Infection Control'. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment. Ofsted guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.

3.6 Emergency Procedures

As part of general risk management processes all settings should have arrangements in place for dealing with emergency situations. This could be part of the school's first aid policy and provision[12]. Other children and young people should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. Guidance on calling an ambulance is provided in Form 1 which provides an example which settings may wish to use or adapt for this purpose. This form can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

All staff should know who is responsible for carrying out emergency procedures in the event of need. A member of staff should always accompany a child or young person taken to hospital by ambulance, and should stay until the parent arrives. At hospital it is the health professionals who are responsible for any decisions on medical treatment when parents are not available.

Staff should never take children to hospital in their own car; it is safer to call an ambulance. The National standards require early years settings to ensure that contingency arrangements are in place to cover such emergencies.

Individual Health Care Plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

[11] Guidance on infection control in schools and nurseries: http://www.hpa.org.uk/infections/topics_az/schools/schools_guidelines_2006.pdf. (Department of Health/Department for Education and Employment/Public Health Laboratory Service, 1999)

[12] Guidance on First Aid for Schools: a good practice guide (DfES, 1998). http://www.teachernet.gov.uk/_doc/4421/GFAS.pdf.

CHAPTER 4

4. Developing a Health Care Plan

Purpose of a Health Care Plan

For ease of reading throughout the document the generic term "setting(s)" will be used to describe any of the above provision for Children and Young People.

The lead adult with overall responsibility in such a setting will be referred to the 'Lead Adult'.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

The main purpose of an individual Health Care Plan for a child or young person with medical needs is to identify the level of support that is needed. Not all children and young people who have medical needs will require an individual plan; a written agreement with parents may be all that is necessary. Forms 3 and Form 4 provide examples which settings may wish to use or adapt for this purpose. These forms can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

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

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

Developing a Health Care Plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child or young person. Form 2 provides an example which settings may wish to use or adapt for this purpose. This form can be downloaded at: http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc

In addition to input from the school health service, the child's GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a health care plan include:

- The Lead Adult;
- The parent;
- The child or young person (if appropriate);
- Early Years Practitioner, class teacher (primary schools), form tutor, head of year, pastoral staff, learning mentors;
- Care assistant or support staff;
- Staff who are trained to administer medicines;
- Staff who are trained in emergency procedures.

Early years settings should be aware that parents may provide them with a copy of their Family Service Plan, a feature of the Early Support Family Pack[13]. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual Health Care Plan devised by a health professional and signed by the same professional, the parents and the setting or indeed the record of a child's medicines(s).

4.1 Co-ordinating Information

Co-ordinating and sharing information on an individual child or young person with medical

[13] Early Support Family Pack (DfES, 2004) http://www.earlysupport.org.uk/modResourcesLibrary/HtmlRenderer/Familypack.html

needs, particularly in secondary schools, can be difficult. The Lead Adult should decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies.

Staff who may need to deal with an emergency will need to know about a child or young person's medical needs. The Lead Adult should make sure that supply staff know about any medical needs.

4.2 Off-site Education or Work Experience

Schools are responsible for ensuring, under an employer's overall policy, that work experience placements are suitable for a young person with a particular medical condition. Schools are also responsible for a young person with medical needs who, as part of Key Stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or Further Education College. Schools should consider whether it is necessary to carry out a risk assessment before a young person is educated off-site or has work experience.

Schools have a primary duty of care for children and young people and have a responsibility to assess the general suitability of all off-site provision including college and work placements. This includes responsibility for an overall risk assessment of the activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

Schools should refer to guidance from DCSF[14], the Health and Safety Executive and the Learning and Skills Council for programmes that they are funding (eg Increased Flexibility Programme). Generally schools should undertake an overall risk assessment of the whole activity and schools or placement organisers should visit the workplace to assess its general suitability. Responsibility for risk assessment remain with the employer or the college. Where students have special medical needs the school will need to ensure that such risk assessments take into account those needs. Parents, children and young people must give their permission before relevant medical information is shared on a confidential basis with employers.

4.3 Staff Training

A Health Care Plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health professionals. When staff agree to assist a child or young person with medical needs, the employer should arrange appropriate training in collaboration with the appropriate health service such as the community paediatrician, school nurse, health visitor, or other appropriately trained health professional. They will also be able to advise on further training needs. In every area there will be access to training, in accordance with the provisions of the National Service Framework for Children, Young People and Maternity Services[15], by health professionals for all conditions and to all settings.

4.4 Confidentiality

The Lead Adult and members of staff should always treat medical information confidentially. The Lead Adult should agree with the child or young person where appropriate, or otherwise the parent, who else should have access to records and other information about a child or young person. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

[14] Health and Safety Executive http://www.hse.gov.uk/

[15] National Service Framework for Children, Young People and Maternity Services http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/DH_4089111

CHAPTER 5

5. Common Conditions – Practical Advice

The guidance notes provide basic information which has relevance for the support of children and young people with medical needs in situations where 'loco parentis' applies. Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

The information provided is not exhaustive and it is important that the needs of children and young people are assessed on an individual basis. Further details about any of the conditions in this section should be sought in the first instance from the appropriate health professional such as the community paediatrician, school nurse, health visitor, diabetic nurse, epilepsy nurse or other appropriately trained professional.

From April 2004 training for first-aiders in early year's settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

The medical conditions covered in this section are:

5.1 Asthma;
5.2 Epilepsy;
5.3 Diabetes;
5.4 Anaphylaxis;
5.5 Attention Deficit Hyperactivity Disorder (ADHD);
5.6 Teenage Pregnancy;
5.7 Hand Washing and Infection Control;
5.8 MRSA;
5.9 The use of Oxygen in Settings.
5.10 HIV

For further information, help line details on all of the above please refer to the appendix.

Help and advice for schools on developing a drug education policy is available from the Teacher Adviser for Drug, Alcohol and Tobacco Education.
Telephone number 01257 226900

Public Health Contact Details

Area	Telephone Number
Central Lancashire	01772 644400
East Lancashire	01282 610250
North Lancashire	01524 519333
Lancashire and Cumbria Public Health Network	01772 644483

5.1 Asthma

What is Asthma?

Children and young people with asthma have airways which narrow due to a reaction to various triggers. The triggers vary between individuals but the most common ones include grass pollen, animal fur, house dust-mites, cold air and viral infections. Exercise and stress can also cause an asthma attack.

Medicine and Control

Advice should be sought from the appropriate health professional such as the GP, community paediatrician, school nurse, health visitor or the asthma nurse. There are two main types of medicines used to treat asthma, relievers, and preventers. Usually relievers will only need to be used during the day.

Relievers (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken immediately to relieve the onset and/or during an asthma attack. They are sometimes taken before exercise.

Preventers (brown, red, orange and purple inhalers, sometimes tablets) are usually used in the morning and/or evening.
For young children and some children and young people with disabilities a spacer device (with or without a mask) may be used to dispense the medicine.

Children and young people with asthma need to have immediate access to their reliever inhalers when they need them.

Children and young people who are able to use their inhalers themselves should be allowed to carry them with them. If they are too young or immature to take personal responsibility for their inhaler the person acting in loco parentis should ensure that it is stored in a safe but readily accessible place, clearly marked with the child or young person's name. Inhalers should always be available during physical education, sports activities and educational visits.
It is important that inhalers prescribed for one child are not used to treat another; medication is only to be used by the person it has been prescribed for.

For those children and young people with severe asthma a spare inhaler may be prescribed to be kept in the setting. Spare inhalers must be clearly labelled with name and expiry date and stored in a locked cupboard. It is the parents' responsibility to ensure that any medication retained in the setting is within its expiry date.

The most common signs of an asthma attack include:

- Coughing;
- Wheezing;
- Being short of breath;
- Feeling of a tight chest;
- Being unusually quiet or having difficulty talking.

When a child or young person has an asthma attack they should be treated according to their individual Health Care Plan or asthma card as previously agreed.

An ambulance should be called if:

- The symptoms do not improve sufficiently in 5 to 10 minutes;
- The child is too breathless to speak;
- The child is becoming exhausted;
- The child looks blue.

The child or young person suffering the attack may become distressed and anxious and in severe attacks the skin and lips may turn blue. Not everyone will present with all of these symptoms.

It is important to consider that children and young people will verbalise their symptoms in language appropriate to their development.

Individual Procedures

It is the parent's responsibility to arrange regular reviews with the relevant health care professional and to ensure that a copy of the management plan is available to the setting. It is important to agree, in partnership with parents, how to recognise when their child's asthma is worse and what action should be taken.

It is the parents' responsibility to arrange regular asthma reviews with the relevant healthcare professionals and ensure that a copy of the management plan is available to the setting.

Children and young people with asthma should participate in all aspects of the setting day, which include physical activity. Reliever inhalers should be carried on all off-site activities. Some may need to take their reliever medication before any physical exertion. As with any person warm-up activities are essential before sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activity should be discussed with parents staff and the child. However children and young people should not be forced to participate if they feel unwell.

Children and young people with asthma may at some time have some sleep disturbances due to night symptoms. This may affect their concentration and may also result in non-attendance. Such issues should be discussed with the parents as appropriate.

All settings should have an asthma policy that is an integral part of the whole settings' policy on medicines and medical needs.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year to support their knowledge about asthma symptoms, medicines, and their delivery and what to do if a child has an asthma attack.

5.2 Epilepsy

What is Epilepsy?

Children and young people with epilepsy have repeated seizures sometimes called fits, turns, blackouts and convulsions and can happen to anyone at any time. A seizure is a clinical event in which there is a sudden disturbance of neurological functions, usually in association with an abnormal or excessive neuronal discharge. Epilepsy is a very individual condition and affects male and females equally.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individuals experience.

Partial Seizure
Not all seizures involve loss of consciousness. A person may remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles.

Complex Partial Seizure
Where consciousness is affected; a child or young person may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

Generalised – Tonic, Colonic Seizure
In some cases a child or young person may lose consciousness. Such seizures might start with a person crying out, then the muscles becoming stiff and rigid. The person may fall down. This may be followed by jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some may bite their tongue or cheek and may be incontinent.

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

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

Parents and health care professionals should provide information to the setting to be incorporated into the individual health care plan.

Details which should be recorded on the Health Care Plan should include:

- Any factors which might possibly have acted as a trigger to the seizure, for example, visual/auditory stimulation, emotion (anxiety, upset);
- Any unusual 'feelings' reported by the child or young person prior to the seizure;
- Parts of the body demonstrating seizure activity, for example limbs or facial muscles;

- The timing of the seizure – when it happened and how long it lasted for;
- Whether the child or young person lost consciousness;
- Whether the child or young person became incontinent.

If a child or young person experiences a seizure in a setting, details should be recorded and communicated to parents. This will help parents to give more accurate information on seizures and seizure frequency to the child or young person's specialist.

Medicine and Control

Advice should be sought from the appropriate health professional such as the GP, community paediatrician, school nurse, health visitor or the epilepsy nurse. The majority of children and young people with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Any medication which is required in a setting must be stored according to the policy for the safe storage of medicines.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children and young people with epilepsy can use computers and watch television without problems; but should not sit too close to the computer screen or television; advise should be sought from parents.

Children and young people with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child, parents as part of the Health Care Plan.

It is important that all staff in settings are aware of the child or young persons' condition and of how to react should they experience a seizure.

Individual Procedures

It is the parents' responsibility to arrange regular reviews with the relevant health care professional and to ensure that a copy of the management plan is available to the setting. During a seizure it is important to ensure that the person is safe, putting something soft under the person's head during a convulsive seizure will help to protect it. Movements should not be restricted and the seizure should be allowed to take its course. **Nothing should be placed in the person's mouth.**

After a convulsive seizure the person should be placed in the recovery position and stayed with until they are fully recovered.
Most seizures last for a few seconds or minutes, and stop of their own accord. Some may be prone to longer seizures or to one seizure after another one which may require rectal Diazepam, also a liquid solution Midazolam may be prescribed by the health professional which is administered orally or intra-nasally.

Advice and guidance regarding training and administration of medication should be sought from the appropriate health professional such as the community paediatrician, school nurse, health visitor, or GP.

Staff should protect the dignity of the person as far as possible, even in emergencies. The criteria under the National standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being given.

An ambulance should be called during a convulsive seizure if:

- It is the child or young person's first seizure;
- The child or young person has injured themselves badly;
- They have problems breathing after a seizure;

- A seizure lasts longer than the period set out in the child's Health Care Plan;
- A seizure lasts for five minutes if you do not know how long they usually last for that child or young person;
- There are repeated seizures, unless this is usual for the child as set out in the child or young person's Health Care Plan.

The above information should be an integral part of the setting's emergency procedures but should also relate specifically to the child or young person's individual Health Care Plan. The Health Care Plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

5.3 Diabetes

What is Diabetes?

Diabetes is a condition where the level of glucose (sugar) in the blood rises due to the body being unable to use it properly. Normally the amount of glucose is controlled by the hormone insulin. Children and young people with diabetes have lost either the ability to produce insulin or produce insulin effectively.

Type 1 Diabetes - the person is unable to produce enough insulin or no insulin at all and will require daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan.

Type 2 Diabetes - there is insufficient insulin for the person's needs or the insulin is not working properly. This is usually treated by diet and exercise alone, but may require some medication.

Medicine and Control

Diabetes, for the majority of children and young people, is controlled by injections of insulin each day. Most young children will be on a twice a day insulin regime of a longer acting insulin, these will usually be administered early morning and later in the evening time. If an injection is required whist the person is in a setting then it may be necessary for an adult to administer the injection. Older children may be on multiple injections, and others may be controlled on an insulin pump. Most children and young people can manage their own injections, in which case supervision may be required and also a suitable private place to carry it out.

Children and young people with diabetes may also need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and check this in their monitor. They may need to do this before meal times, before exercise or more regularly if their insulin needs adjusting. The majority of children and young people will be able to carry this out themselves and will need a suitable private place to do so. However, younger children may need adult supervision to carry out the test and/or interpret test results.

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

Children and young people with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during the day time or prior to exercise. Settings may need to make special arrangements for children and young people with diabetes if meal times are staggered/if a meal or snack is missed or after strenuous activity, the

person may experience a hypoglycaemic episode (a hypo) during which blood glucose levels fall too low. Staff in charge of PE or other physical activity sessions should be aware of the need for children and young people with diabetes to have glucose tablets or a sugary drink to hand.

The issue of close communication between parents' with the settings is fundamental to the care of children and young people with diabetes, as many aspects of growth and development will have an impact on their diabetes control.

Individual Procedures

It is the parents' responsibility to arrange regular reviews with the relevant health care professionals and ensure that a copy of the management plan is available to the school or setting.

Each child or young person may experience different symptoms and this should be discussed when drawing up a Health Care Plan.

All staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a **hypoglycaemic reaction** (hypo) in a child or young person with diabetes.

- Hunger;
- Sweating;
- Drowsiness;
- Pallor;
- Glazed eyes;
- Shaking or trembling;
- Lack of concentration;
- Irritability;
- Headache.

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

An ambulance should be called if:

- The child or young person's recovery takes longer than 10-15 minutes;
- The child or young person becomes unconscious.

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

5.4 Anaphylaxis

What is Anaphylaxis?

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

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

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

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

Medicine and Control

It is the parents' responsibility to arrange regular reviews with the relevant health care professional and to ensure that a copy of the management plan is available to the setting. Treatments for anaphylactic reactions include antihistamines, adrenaline inhalers, and for the more severe allergic reaction an injection of adrenaline (also known as epinephrine). This is delivered in a pre loaded device, known as an Epipen with the correct dose of adrenaline and is prescribed on an individual basis. The devices are available in two strengths - adult and junior.

Should a severe allergic reaction occur the adrenaline injection should be administered into the muscle of the upper outer thigh either directly or through light clothing.
In some areas school nurses have received specialist training to further support staff, children and young people who may suffer from severe allergic reactions which result in an anaphylactic episode.
Examples of Health Care Plans which can be adapted to suit the child or setting can be downloaded from:
http://www.lancashire.gov.uk/education/pdf/pid1142/form_templates.doc
It is recognised that Health Care Plans developed within particular PCT's or settings could be used.

An Ambulance Should Always be Called

Where a child or young person requires medical support in a setting on account of anaphylactic reactions, staff will have to agree to administer medicine in an emergency. Training for this will need to be provided by local health service.

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions are a well understood and safe delivery mechanism. It is not possible to overdose using an Epipen as it only contains a single dose. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the setting should hold and where to store them, has to be decided on an individual basis between the Lead Adult, the parents and the medical staff involved. The medication should be readily accessible in accordance with health and safety policies.

Where children and young people are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare Epipen kept according to health and safety policies which is accessible to all staff. In large establishments or split sites, it is often quicker to use an Epipen which is with the person rather than taking time to collect one from a central location.

It is important that staff in settings are aware of the child or young person's condition and where medication is kept in case of emergencies.

Day-to-day policy measures are needed for food management; awareness of the child or young person's needs in relation to the menu, individual meal requirements and snacks in the setting; this will help minimise the risk of an allergic reaction. It is important that the catering manager is fully aware of the child or young person's individual requirements. When new kitchen staff are employed it is important that they are also made aware of any individual needs.

A Health Care Plan should be agreed by the parents', child or young person, the setting and the appropriate health care professional.

Important issues specific to anaphylaxis to be covered within the Health Care Plan include:

- Anaphylaxis – what may trigger it;
- What to do in an emergency;
- Prescribed medicine;
- Food management;
- Precautionary measures.

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

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, the child or young person's life may continue as normal for all concerned.

5.5 Attention Deficit Hyperactivity Disorder (ADHD)

What is Attention Deficit Hyperactivity Disorder?

Attention deficit hyperactivity disorder (ADHD) is a neurobiological disorder caused by an imbalance of some of the neuro-transmitters in the brain. It is normally used to describe children and young people who have three main kinds of problems:

- Overactive behaviour (hyperactivity);
- Impulsive behaviour;
- Difficulty in paying attention and distractibility.

Some children and young people have significant problems in concentration and attention, but they are not necessarily overactive or impulsive. They are sometimes described as having Attention Deficit Disorder (ADD) rather than ADHD. Children with ADHD have a short attention span, find it hard to concentrate and have difficulty learning new skills. Children and young people with ADHD are often misunderstood and frequent criticism of their behaviour can lead to poor self-image and other emotional and behavioural difficulties. Many children with ADHD are more likely to have learning difficulties.

Problems with ADHD are not confined to the setting but will affect the child or young persons' behaviour at home and in the community.
It is the parents' responsibility to arrange regular reviews with the relevant health care professional and to ensure that a copy of the management plan is available to the setting.

Medicine and Control

When a child or young person has been diagnosed with ADHD or is displaying behaviours characteristically associated with ADHD, staff in the setting could adapt the environment to one which would benefit the child or young person. For example:

- Set short, achievable tasks/targets and give immediate rewards when the task/target has been achieved;
- Use large type, and provide only one or two examples per page. Avoid illustrations which are not relevant to the task;
- Using checklists and outlining the task to be completed for example, homework charts;
- Keep rules clear and simple;
- Use attention and praise to reward positive behaviour;
- Give the child or young person special responsibilities so that their peers can see them in a positive light.

Children and young people diagnosed as having ADHD will have an individual treatment programme. This is most likely to include a behaviour management/support programme which can be shared between home and the setting. Management of the child or young person's difficulties should be shared between the home, the setting and

support service including the relevant health service.

In more severe cases of ADHD medication may also be prescribed such as Methylphenidate or Dexedrine. It is important to work out exactly how this will be taken whilst the child or young person is away from home or attending a setting. Staff are not obliged to administer medication, but if they do so they must have clear instructions from the appropriate health professional.

In the first few weeks after prescription, if the dosage of Methylphenidate is adjusted at anytime it is essential that regular communication between home and the setting takes place on the effects of the drug on the person's behaviour. The setting should be informed immediately of any change to the dosage pattern.

Likely side effects include:

- Loss of appetite with or without a stomach upset. This tends to resolve itself within a month of starting treatment;
- Headaches;
- Sleepiness. The child or young person's sleep pattern may be disturbed for a short period of time;
- Aggravation of existing tics, particularly of the head and neck muscles.

It is important that the setting takes note of any side effects and inform the parents at the end of the day.

5.6 Teenage Pregnancy

Information for schools regarding health and safety arrangements for pregnant pupils

Health and Safety cannot be used as a reason for asking a pregnant pupil to stop attending school.

Pregnancy should not be equated with ill health, but the health and safety implications must be addressed.

Best practice may be for pregnant pupils to attend school for as long as possible or for alternative arrangements to be made, such as attendance at a Lancashire Education Medical Service (LEMS) teaching centre.

Schools may wish to carry out a **specific risk assessment** in conjunction with the pupil and her parents, if appropriate, and any resulting risks should be managed. Schools may wish to review the risk assessment as circumstances change or during different stages of the pregnancy and after the birth of the child.

In essence, a risk assessment for a pregnant pupil should be the same as for any pregnant member of the school community, such as teachers, welfare staff, support staff, supervisors, etc.

Attached is a flowchart for schools to help them identify risks and so develop a risk assessment suitable for use in school. The risk assessment, with its list of potential risks, is by no means exhaustive in its scope, but schools may wish to use it as a baseline document to adapt and customise to suit their individual school's needs.

Flexibility, compromise and common sense can avoid most risks and schools may identify others that have not been highlighted. Most school age pregnancies can be accommodated without too much adjustment and remaining in the home school offers the pregnant pupil the best chance of avoiding social exclusion and of fulfilling their academic potential.

Please note it is the responsibility of the school to produce a risk assessment if they feel it is appropriate. If a more detailed risk assessment is required, the Pregnancy and Parenthood Service (PPS) can be contacted for advice and assistance. Please contact the PPS Manager, or the Learning Mentor attached to your school. Contact details are listed below:

Area	Telephone Number
PPS Manager	01257 517212
Hyndburn, Ribble Valley & Rossendale	07717 543845
Chorley & West Lancashire	07887 831593
Burnley & Pendle	07887 831555
Lancaster, Morecambe & Wyre	07887 831554
Preston, South Ribble & Fylde	07789 927918

Health and safety guideline for pregnant pupils in school and attending LEMS

Rational

Health and Safety issues should not be used as a reason for asking a pregnant pupil to stop attending school. However, some pupils in advanced pregnancy (24+ weeks) and after birth (up to 12 weeks) choose to attend LEMS.

For those who choose to remain in school, however, the following guidelines may be helpful in supporting the Health and Safety of pregnant pupils and their babies.

Guidelines

Movement

- Ensure pregnant pupils have sufficient time to move around school at change of lessons and at the start and end of the teaching day.
- If pregnant pupils have to use stairs, allow extra time and ensure handrails are secure. Use lift if available.

Fatigue

- If heavy books/bags have to be carried, ensure a 'buddy' is on hand to help.
- Allow short breaks during lessons if necessary, especially if the pregnant pupil has been sitting in one place for some time.
- Be aware that new mothers will have had a broken night's sleep and may be tired.

Comfort

- Ensure the pregnant pupil has a comfortable seat which gives support to the back and allows ease of egress.
- Provide writing surfaces at an appropriate height to accommodate 'bumps'.

Facilities

- Allow pregnant pupils free access to toilet facilities and appreciate that some young women experience nausea and sickness.
- Ensure pregnant/breastfeeding pupils have unrestricted access to drinking water to minimise the risk of dehydration and reduction of breast milk.

Subjects

- Afford some 'time out' to pregnant pupils who may be affected by conditions in specific lessons eg use of VDU, fumes in science lessons, materials and equipment in practical lessons such as art and PE.

Emotional

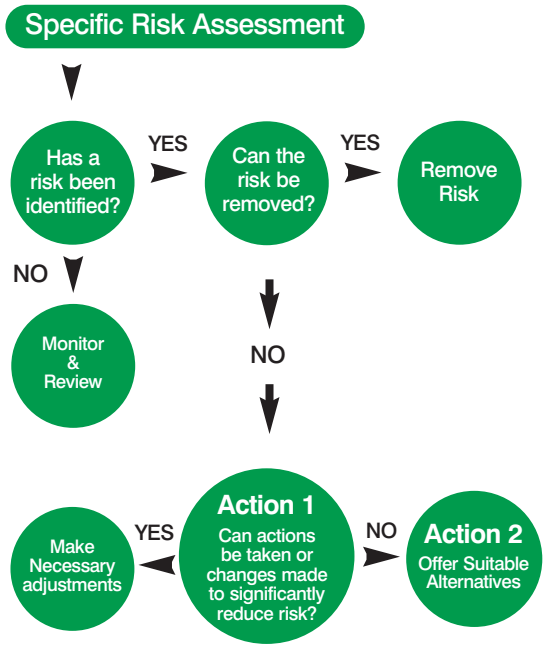
- Be aware that pregnant pupils may have more pressing immediate concerns than schoolwork as the birth approaches and so may need longer to complete tasks.
- Teenage mothers have a higher rate of post-natal depression than older mothers and so may need extra emotional support on their return to school after birth.
- Breastfeeding mothers may need support and understanding to maintain their milk flow once they return to school.

Conclusion

School staff may be experienced in supporting colleagues and/or school age parents and parents-to-be, but should a girl go into labour at school, parents should be informed immediately and 999 should be called for an ambulance.

In essence, pregnant pupils should be treated in the same way as a pregnant member of staff would be.

LEMS staff are experienced in supporting school age parents and parents-to-be, but should a girl go into labour at a centre, parents should be informed immediately and 999 should be called for an ambulance.



Hazard	Risk	Risk Level	Action
Crowded corridors and stairs	Injury, fall	High	Change lessons 5 minutes early, use lift if available
Carrying bags	Back strain	Medium	Provide locker, buddy
Toilets locked during lessons	Sickness, bladder incontinence	Medium	Provide access to toilet facilities
Sitting in one place too long	Back strain, cramp	Medium	Allow movement and provide supportive furniture
Restricted access to drinking water	Dehydration and reduction in breast milk	High	Provide drinking water
Uniform no longer fits	Discomfort	Low	Negotiate suitable clothing
Fatigue	Strain, poor concentration	Medium	Timetable negotiations
Science	Fumes	Low	Sensible seating

You may identify other potential hazards in your school and take appropriate action.

5.7 Good Practice Guidelines for Infection Control – Hand Washing

Young children in particular are prone to catching various infections. There are many potential sources of infection within the home and other settings and the main causes are likely to be as follows:

- Other children or adults;
- Domestic and farm animals;
- Contaminated or uncooked food;
- Contaminated water.

Infections can be transmitted in a variety of ways – by touch, consuming contaminated food or water, or by airborne transmission. However the main transfer of potentially unpleasant and hazardous infections within a setting can be simply and effectively controlled by the establishment of good hygiene procedures. A number of strategies are likely to be involved in this respect including advice on cleaning, heating, and the use of disinfectants. The single most effective weapon against infection is hand washing.

Hand Washing

- Hand washing is a simple procedure which, if carried out correctly, contributes significantly to the control of infection. However, it is often neglected or carried out ineffectively. Hands should be wet thoroughly with water before applying soap. All surfaces of both hands should be vigorously massaged with the lather, remembering to pay particular attention to the finger tips, thumbs and between the fingers as these areas are frequently missed;
- Make sure all the soap is rinsed off under running water and then dry the hands thoroughly;
- Always cover any cuts with waterproof plasters;
- Wherever possible apply hand cream as this product protects hands and helps to prevent dryness and cracking;

- The hands normally have a 'resident' population of micro-organisms. Other organisms (germs) are picked up during every-day activities, and these are termed 'transient' organisms;
- Many infection control problems are caused by these transient organisms;
- Hand washing should remove these transient organisms before they are transferred to another person or to a susceptible area on the same person;
- The potential chain of infection is broken by effective hand hygiene.

Good Practice

- Fingernails should be kept clean and short;
- Ideally jewellery should not be worn;
- Breaks anywhere on the skin should be covered with a waterproof dressing;
- Medical advice should be sought for skin damage by other agents eg. Eczema.

Hands Should Be Washed and Dried:

- After visiting the toilet;
- Before handling food;
- When hands are visibly soiled;
- Before a clean procedure;
- After a dirty procedure, even if gloves are worn;
- Between care episodes for an individual person.

5.8 MRSA – Methicillin Resistant Staphylococcus Aureus

Staphylococcus Aureus is a common bacteria and at any one time approximately one third of the population, adults and children, is colonised with the bacteria. This means that the organism lives harmlessly on a person's skin or in the nose and normally does not cause any infection beyond the occasional mild skin irritations. These infections are easily treated by antibiotics.

However some strains of Staphylococcus Aureus bacteria are resistant to the more common antibiotics and these strains are referred to under the general heading of MRSA.

Who is at Risk from MRSA?

MRSA can only be detected by laboratory tests and as it normally does not cause any symptoms most people will never know if they are colonised with MRSA. MRSA may cause problems if it infects persons with surgical wounds, catheters, or drips which allows bacteria to enter the body. Caution also needs to be exercised in instances where a person with MRSA may come into close contact with another person who has a severely reduced resistance to infection, for instance a person who is immuno-supressed, eg a person receiving treatment for cancer, or who have an immuno-deficient conditions eg HIV. Further advice should be sought from the local Community Infection Control Nurse or Public Health Department in such circumstances. However, it is always worth bearing in mind that although MRSA is found not only in hospitals but also in nursing and residential homes and in the community at large, it usually only causes problems to vulnerable patients in the hospital setting.

Can MRSA be Treated?

A limited number of antibiotics are still effective against MRSA infections but they can cause quite severe side effects. That is why in the UK the focus of intervention tends to be on prevention and control. The majority of individuals with MRSA will be colonised rather that infected and so antibiotic treatment would not be necessary.

Prevention and Control

As with most infections, MRSA is mainly transferred by touch and so attention to good hygiene procedures and to effective handwashing techniques remain the most effective ways in which to prevent MRSA from spreading. All staff and children and young people in settings should be encouraged to wash their hands:

- After using the toilet;
- After handling any soiled linen, nappies, or dressings;

- After touching animals;
- When their hands appear dirty.

No special cleaning methods are required and ordinary soap is just as effective as anti-bacterial brands provided that hands are washed and dried thoroughly.

If basic hygiene precautions are followed a person with MRSA is not a risk to others, including babies and pregnant women. Good hygiene procedures in a setting are important to prevent the spread of all potentially infectious bacteria, not just MRSA. Cutlery, toys teaching and play materials, toilet areas and changing beds do not need to be subject to any additional hygiene precautions or procedures beyond the settings usual cleaning regime because they have been used by children and young people know to be colonised with MRSA.

Points of Guidance for Staff

- Cuts, sores and surgical wounds in staff and children and young people should be covered by a waterproof dressing to prevent infection;
- If blood or other body fluids have to be cleaned up, a disposable apron and disposable gloves should be worn and paper towels used. All of these items should then be placed in plastic bags and disposed of safely and hygienically;
- Staff who have Eczema or Psoriasis should not perform any intimate care procedures on children and young people with MRSA;
- Children and young people with MRSA do not need to be taught separately from others or kept in any form of isolation within the setting;
- Children and young people with MRSA should be allowed to participate in out-of-school activities and visits, again with good hygiene procedures being undertaken when necessary.

MSRA Guidelines for the Portage Service in Lancashire

Basic infection control measures are required to minimise the spread of MRSA; these include:

- Disposable plastic aprons must be worn and discarded after each visit;
- All fresh cuts/abrasions that are less than 24 hours old should be covered by an impermeable dressing (if in doubt wear disposable latex gloves);
- Hands must be washed and dried thoroughly after each visit. If the portage worker is in any doubt about handwashing facilities available, then the hands may be washed and dried again before commencing work with the next client. It may be necessary to take soap and towel to the visit;
- All rings with stones, watches and bracelets must be removed or covered during client contact. This is necessary to enable effective handwashing. If you wear a wedding ring wash underneath it;
- Equipment/toys specifically kept for a child's usage must be washed and dried thoroughly before putting back into general use. Ordinary detergent and water is sufficient for this;
- Soft toys and wooden toys without coatings should not be used. Plastic toys that are easily cleaned are preferable. If a specific item/toy is required that does not meet this criteria it may be used for that child but not put back into general use afterwards;
- Staff with Eczema or Psoriasis should seek further advice before attending to children with know MRSA colonisation (See below).

Swabbing

Repeated swabs will not normally be required from the affected child, however, there may be specific incidences when these may be requested, eg if the child is to be admitted into hospital.

In the Home

When basic good hygiene practices are followed, individuals with MRSA are not at risk to others including members of their family (including babies, children and pregnant women), visitors or portage staff. Good hygiene is important to prevent the spread of all infections not just MRSA.

Help and Advice

To find out more or to get specific advice you should contact the Lancashire Early Years SEN service, Area Manager or you local Health Protection Agency who has been appointed to give infection control advice in the community.

Contact	Telephone Number
Health Protection Agency,Lancashire & Cumbria Health Protection Unit	01257 246450

5.9 Procedure for the Safe Use and Administration of Oxygen in Cylinders in Pre-School Settings

The following procedures outline the safety measures that must be followed when oxygen cylinders are present on any premises maintained by Lancashire County Council registered as eligible for Nursery Education Grant Funding or Ofsted registered as premises suitable for the provision of childcare anywhere else where Lancashire Early Years SEN Services employees are required to work, (referred to as a setting) in order that Lancashire County Council and its employees can fulfil their responsibilities under Health and Safety Legislation.

Oxygen is a colourless and odourless gas which is slightly heavier than air. In the event of a leak, oxygen is initially likely to be found close to ground level.

The presence of oxygen cylinders can increase the risk of fire, for although oxygen itself does to burn; it may support and accelerate combustion, and may cause substances to ignite more easily and to burn more fiercely.

It is important that no-one is allowed to smoke in any area where an oxygen cylinder is either stored or in use. This would include home settings when Early Years SEN Staff are present.

Storage of Cylinders

Oxygen cylinders should only be held at a setting's premises in agreed cases where oxygen is required for medical purposes by specific service users as part of an agreed multi-disciplinary plan. The plan should be reviewed regularly and details recorded on the individual service user's file/care plan. The file/care plan must be led and signed by an appropriate medical professional. Staff must receive training from an appropriate medical professional and must have documents to show that they have been deemed competent by that professional to administer and oversee the use of oxygen.

If oxygen is to be stored at the setting, supplies should be kept at the lowest possible levels ie do not store spares. Oxygen will normally be supplied in small two litre cylinders.

Once there is no further requirement for oxygen to be available at a given location, arrangements should be made via the supplier for any cylinders to be removed as soon as possible. Such a decision will be as a result of medical advice.

Oxygen Cylinders Should:

- Be stored in a dry, reasonably well ventilated area, but under cover, not in the open;
- Be stored in a locked area which should be clearly marked with an oxygen symbol as a warning of the contents and the need for caution;
- Be considered as a fire risk as the contents are stored under pressure, which increases

the risk of explosions in case of a fire. The setting must inform their insurer that they are using and/or storing oxygen on site;
- Be kept away from highly flammable liquids, readily combustible materials and sources of heat and ignition;
- Not be exposed to extremes of temperature;
- Not be allowed to become rusty or dirty. If this happens, arrangements should be made for the cylinders to be exchanged as soon as possible;
- Not be repainted or have their markings obscured or labels removed.

During use, care should be taken to ensure that an oxygen cylinder does not fall over and become damaged. Cylinders which are equipped with carrying devices or stands to keep them upright should be stored in these devices. If no device or stand is supplied, the cylinder should be stored and used on a flat stable surface

Cylinders should NOT be carried around a room as a child plays.

A manual handling assessment should be carried out to determine the safest method for moving cylinders. For example a cylinder trolley may be required, depending upon the size of the cylinder and the distance it has to be moved. The findings of the risk assessment should be brought to the attention of anyone who may have to move the cylinder.

Administration of Oxygen

Before a child can be accommodated in a setting it is ESSENTIAL that a full care plan is drawn up by a relevant health professional, eg community paediatrician, GP, school nurse, health visitor, specialist nurse or hospital consultant; in conjunction with the child's parents and the setting.

The care plan should include:

- The child's details and medical needs;
- The level of flow that is required;
- The frequency that oxygen needs to be administered;
- Detailed checking and counter signing procedures;
- Any maintenance procedures;
- Details of emergency procedures should the equipment fails or the child becomes ill;
- Details of provision should it be necessary to admit a child to hospital;
- Details of emergency contacts for parents.

Under no circumstances should instructions for the administration of oxygen be accepted solely from parents.

Oxygen must only be administered to a child as prescribed eg at the times and for the duration stated on the written documentation supplied by the health contact. The details must match any instruction provided by the pharmacist who has supplied the cylinder. If the oxygen is dependent on staff observation of a child's condition, the limits of staff responsibility has to be clearly stated in the care plan along with the action that is needed should these limits be passed.

Oxygen should only be administered to a child when it is supplied through a 'fixed' or 'set' delivery device eg the attachment to the oxygen supply will normally have a numbered or 'step' delivery. Also as a safeguard, two members of staff should witness the numbered setting of the regulator when the oxygen cylinder is switched on.

Administration of oxygen must not be based upon the need for staff observation of a child's condition, or upon the request of a child or parent.

Storage, administrative and recording systems relating to oxygen on the premises should be treated in the same way as any other medicine. Members of staff, who may be required to administer oxygen to a child as part of their duties, must be shown how to do so properly by the pharmacist supplying the cylinder or by the appropriate health professional. Where the administration of oxygen is a recognised part of staff duties,

they will be covered under Lancashire County Council's insurance arrangements.

Emergencies

Leaks

Any leakage of oxygen from a cylinder will usually be evident by a hissing noise. Staff should be aware that leaks commonly occur at points where attachments are connected to the cylinder.

It is important to observe absolute cleanliness when handling oxygen cylinders, as the transfer of grease to the connections could cause a serious fire in the event of a leak.

Never use any kind of sealing or jointing compound to cure a suspected leak, or use sticky tape of any kind on a cylinder.

Never attempt to repair any cylinder, other than gentle tightening of joints or attachments as necessary as shown in training.

In the event of a leak, turn the cylinder valve off. Follow the procedures as written in the care plan regarding the failure of oxygen supply.

If the cylinder is thought to be unsafe, do not attempt to use it. If this is not possible, clear the area of others and seek assistance. Any cylinder found to be leaking should be removed to a safe area, marked accordingly and the supplier contacted with a request that it is removed as soon as possible.

Fire

The presence of oxygen cylinders may increase the risk of fire at an establishment by supporting the combustion of other materials, or posing a risk of explosion if a cylinder is exposed to heat or damage in the event of a fire.
Storage of oxygen should be noted in the Fire Risk Assessment and be brought to the attention of the Fire Officer.

Cylinders should be kept away from all sources of ignition, particularly during use.

Smoking should not be allowed in the same room as oxygen cylinders, either during storage or use.

In the event of a fire, any oxygen cylinders should be removed from the premises, if it is safe to do so. If the cylinder is in use, it should be turned off before making any attempts to remove it.

Staff should follow the prescribed fire evacuation procedures for the establishment.

Training

All staff should be made aware of any oxygen cylinders located on site; the child for whom they are required; the location of the cylinders; and safety measures for their use and storage in accordance with these procedures.

A copy of the BOC Gases leaflet entitled 'Oxygen in the Home' (May 2000 edition) should be available at the establishment and the contents brought to the attention of all staff.

Any queries relating to these procedures must be brought to the attention of the Lancashire Early Years SEN service, Line Manager or Area Manager and where appropriate the Health and Safety Unit on telephone number **01772 535355** as soon as possible.

5.10 HIV

What is HIV?

HIV = human immune-deficiency virus.

HIV in Children and Young People

The vast majority of HIV-infected children and young people in this country have acquired HIV infection through mother to child transmission. Infection may pass from the

mother to the unborn child in the womb during pregnancy, during delivery of the baby or after birth through breastfeeding. Infants infected through mother to child transmission show few symptoms of acute HIV infection in the first weeks of life, but progression to serious disease or death is rapid, and up to 25% of these infants will progress to serious disease or death by their first birthday.

How is HIV Spread?

HIV infection is spread by blood-to-blood contact with an infected person's blood. Certain other body fluids may also be infectious eg semen, vaginal secretions and breast milk.

The Main Routes of Infection Are:

- By sexual intercourse with an infected person without a condom;
- By sharing blood-contaminated needles or other equipment for injection drug use;
- From an infected mother to her baby during pregnancy, whilst giving birth or through breastfeeding.

Other Less Common Routes by with the Infection may be Spread are:

- Through a blood transfusion in a country where blood donations are not screened for HIV (all blood donations in the UK are screened for HIV);
- By invasive medical/dental treatment abroad using non-sterile instruments/needles;
- By tattooing, cosmetic piercing (eg ear and body piercing) or acupuncture with unsterilised needles or equipment;
- By sharing razors and toothbrushes (Which may be contaminated with blood) with an infected person.

HIV Infection is Not Spread by Social Contact or Daily Activities such as:-

Coughing, sneezing, hugging, kissing, holding hands, or sharing bathrooms, swimming pools, toilets, food, cups, cutlery and crockery.

Implications for Settings

There is no obligation on parents, children and young people to disclose a diagnosis of HIV, nor is there any obligation for anyone to inform their employer of their HIV status.

It may be the case however that the person in charge of a setting may have to be informed; this may be if the child or young person is frequently absent due to the need to attend hospital appointments, or if medication has to be administered whilst the child or young person is attending the setting.

Those who are made aware should be strictly confined to those who need to know in order to ensure the proper care and any additional pastoral or educational support can be provided. Information should not be disclosed to or within settings solely on the basis that it might help protect those involved in the care or treatment of a child or young person with HIV infection.

The HIV status of any individual should only be disclosed with the informed consent of the individual concerned.

Disclosure

Disclosure concerning children and young people or adults may come about through a variety of sources, eg

- Child or young person and/or family;
- Playground or community gossip;
- Media attention.

The confidentiality policy should be followed at all times. The safety and well-being of the individual are paramount.

Under the Disability Discrimination Act 1995, schools have a duty not to discriminate against students on grounds relating to a disability in admissions, education and associated services, and exclusions from schools (see paragraphs 2.11-2.12 for discussion of HIV and disability).

In exceptional circumstances, where a child or young persons behaviour is thought to

pose a serious risk of infection to others, disclosure of the child or young persons HIV status may be warranted (eg if a child or young person is deliberately trying to harm other children by activities involving the direct exchange of fresh blood).

Links to Guidance Document:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4093509

Protection Against Infection

Standard hygiene precautions should be in use to protect against all infections. It is a requirement under COSHH for risk assessments to be undertaken in all settings to assess the risk and to control and minimise the risk of infection.

CHAPTER 6

6. Legal Framework

For ease of reading throughout the document the generic term "setting(s)" will be used to describe any of the above provision for Children and Young People.

The lead adult with overall responsibility in such a setting will be referred to as the 'Lead Adult'.

Where the term 'Parents' is used it should be taken as defined in Section 576 of the Education Act 1996, to include any person who is not a parent of a child but has parental responsibility for or care of a child.

6.1 Introduction

This section sets out the legal framework for settings and the local authority in the management of medicines.

It summarises:

- The main legal provisions that affect Lancashire County Council and settings' responsibilities for managing a child or young persons medical needs;
- The main legal provisions that affect early years settings' responsibilities for managing a child's medical needs.

It is to be noted that this section does not constitute an authoritative legal interpretation of the provisions of any enactments, regulations or common law – that is exclusively a matter for the courts. It remains for the Local Authority and the setting to develop their policies in the light of their statutory responsibilities and their own assessment of local needs and resources.

6.2 General Background

Where the Lancashire County Council acts 'in loco parentis' for any child or young person, procedures need to be in place for the administration of medication and to support the child or young person with medical needs. However, whilst all staff have a duty to take reasonable care for the health and safety of children and young people in settings there is no contractual requirement for staff to administer medication or support children and young people who have medical needs. Where staff do agree to participate in these duties it is important to recognise that their participation is of a voluntary nature.

Nevertheless, it is advisable for all settings to have in place up-to-date policies and procedures on the administration of medication and on the support of children and young people who have medical needs. All staff need to be made aware of the settings policies and procedures by the Lead Adult. In some cases the contracts for non-teaching staff or teaching assistants may include references to the administration of medication and/or the undertaking of medical procedures. These contracts will, of course, be agreed on an individual basis.

Staff who work in children's social care settings are required to adhere to the Children's Social Care policies and procedures.

6.3 Indemnity Policy (Applies to those employed by Lancashire County Council only)

All staff, including non-teaching staff, who are involved in the administration of medication and in the support of children and young people with medical needs, should be aware of Lancshire County Council's policy on indemnity. This policy is quoted in its entirety below.

If a member of staff administers medication to a child or young person, or undertakes a medical procedure to support that child or young person and, as a result expenses, liability, loss, claim or proceedings arise, the County Council as employer will indemnify the member of staff provided the following conditions apply:

- The member of staff is an employee of Lancashire County Council.

- The medication/procedure are administered by the member of staff in the course of or ancillary to their employment with Lancashire County Council.

- The member of staff follows:

(i) these procedures;

(ii) the setting's policy;

(iii) the procedure outlined in the individual child or young person's Health Care Plan and directions received through training in the appropriate procedures.

- The expenses, liability, loss, claim or proceedings are not directly or indirectly caused by and do not arise from fraud, dishonesty or a criminal offence committed by the member of staff.

NOTES: This indemnity is to be read together with the indemnity given to members and officers which was approved by Lancashire Full Council on 26 May 2005.

Exceptionally, this indemnity has been extended by the County Council to apply to members of staff in all schools maintained by the County Council including those who are employees of the governing body of the school rather than the County Council.

6.4 Action in Emergencies

Any individual can take action to preserve life provided that the action is carried out with the best of intentions and is performed in good faith. In law this is recognised as the issue of necessity and is used as a defence (successfully) for example in cases where blood transfusions may be given in life threatening situations against the religious wishes of the individual or the individual's parents/carers.

In failing to act in an emergency situation a teacher or other member of school staff may be found to be in breach of the statutory duty of care.

6.5 Children and Young People with Medical Needs

Children and young people with medical needs have the same rights of admission to a setting as others. Most children and young people will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some, however, have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children or young people with well-controlled epilepsy.

Others may require medicines in particular circumstances, such as those with severe allergies who may need an adrenaline injection. Children and young people with severe asthma may have a need for daily inhalers and additional doses during an attack.

Most children and young people with medical needs can attend a setting regularly and take part in normal activities, sometimes with some support. However, staff may need to take extra care in supervising some activities to make sure that these children and young people, and others, are not put at risk.

An individual Health Care Plan can help staff identify the necessary safety measures to support children and young people with medical needs and ensure that they and others are not put at risk. Detailed advice on how to develop a Health Care Plan is set out in Chapter 4.

6.6 Access to Education and Associated Services

Some children and young people with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA

defines a person as having a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their abilities to carry out normal day-to-day activities.

Under Part 4 of the DDA, responsible bodies for schools (including nursery schools) must not discriminate against disabled children and young people in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips and school clubs and activities[16]. Schools should be making reasonable adjustments for disabled children and young people including those with medical needs at different times of their life; and for the individual disabled child or young person in their practices and procedures and in their policies.

Early years settings not constituted as schools, including childminders and other private, voluntary and statutory provision are covered by Part 3 of the DDA. Part 3 duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child or young person[17]. This includes disabled children and young people with medical needs. Like schools, Early Years Settings should be making reasonable adjustments for disabled children and young people including those with medical needs. However, unlike schools, the reasonable adjustments by Early Years' Settings will include alterations to the physical environment as they are not covered by the Part 4 planning duties.

6.7 Health and Safety

Lancashire County Council schools and Governing Bodies are responsible for the health and safety of children and young people in their care. The legal framework for schools dealing with the health and safety of all their pupils derives from health and safety legislation. The law imposes duties on employers. Primary Care Trusts (PCTs) and NHS Trusts also have legal responsibilities for the health of residents in their area.
The Registered Person in Early Years Settings, which can legally be a management group rather than an individual, is responsible for the health and safety of the children in their care. The legal framework for registered early years settings is derived from both health and safety legislation and the National standards for under 8s day care.[18]

6.8 Staff administering medicine

There is no legal or contractual duty on staff to administer medicine or supervise a child or young person taking it. The only exceptions are set out in the paragraph below. Support staff may have specific duties to provide medical assistance as part of their contract. Of course, swift action needs to be taken by any member of staff to assist any child or young person in an emergency. Employers should ensure that their insurance policies provide appropriate cover.

6.9 Staff 'Duty of Care'

Anyone caring for children and young people including teachers, other school staff and day care staff in charge of children have a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children and young people are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities that take place off site, such as visits, outings or field trips.

16 The Code of Practice for Schools – DDA 1995: Part 4 (Disability Rights Commission, 2002) explains the duties: schools have and shows responsible bodies how they might meet the duties that apply to them. http://83.137.212.42/sitearchive/DRC/the_law/legislation__codes__regulation/codes_of_practice.html

17 The Disability Rights Commission (DRC) has issued a Code of Practice covering Rights of Access to Goods, Facilities, Services and Premises, under Part 3 of the DDA. 5

18 National standards for under 8s day care and childminding – Childminding (DCSF/0649/2003); Creches (DfES/0650/2003); Full day care (DfES/0651/2003); Out of school care (DfES/0652/2003); Sessional care (DCSF/0653/2003)

6.10 Admissions [19] [20]

Children and young people with medical needs have the same rights of admission to school as other children and young people, and cannot generally be excluded from school for medical reasons. In certain circumstances, eg where there is a risk to health and safety of staff or other pupils, children can be removed from school for medical reasons. This, however, is not exclusion.

6.11 The Law

Legislation, notably the Education Act 1996, the Disability Discrimination Act 1995, the Care Standards Act 2000 and the Medicines Act 1968 are also relevant to settings in dealing with children and young people's medical needs. The following paragraphs outline the provisions of these Acts that are relevant to the health and safety of children attending early years settings and schools.

6.12 SEN and Disability Act (SENDA) 2001

The SEN and Disability Act (SENDA) 2001 amended Part 5 of the Education Act 1996 making changes to the existing legislation, in particular strengthening the right of children and young people with SEN to be educated in mainstream schools.

Schools and early years settings are both required to take 'reasonable steps' to meet the needs of disabled children and young people.

6.13 Local Authority and Schools

SENDA also amended Part 4 of the Disability Discrimination Act (DDA) 1995 bringing access to education within the remit of the DDA, making it unlawful for schools and Local Authorities to discriminate against disabled pupils for a reason relating to their disability, without justification. This might include some children and young people with medical needs.

Part 4 duties apply to all schools; private or state maintained, mainstream or special and those early years settings constituted as schools.

Some medical conditions may be classed as a disability. The responsible body of a school will need to consider what arrangements can reasonably be made to help support a pupil (or prospective pupil) who has a disability. The Disability Rights Commission has produced a Code of Practice for Schools. Advice and training from local health professionals will help schools when looking at what arrangements they can reasonably make to support a pupil with a disability.

Schools are not, however, required to provide auxiliary aids or services or to make changes to physical features. Instead, schools and the Local Authority are under a duty to plan strategically to increase access, over time, to schools. This duty includes planning to increase access to the school premises, to the curriculum and providing written material in alternative formats to ensure accessibility.

Part 4 duties cover discrimination in admissions, the provision of education and associated services and exclusions.

The reasonable adjustments duty in Part 4 includes provision of:

- Auxiliary aids and services;
- Making physical alterations to buildings (from October 2004).

6.14 Early Years Settings

Early years settings, not constituted as schools, must comply with Part 3 of the DDA; this includes day nurseries, family centres, pre-schools, playgroups and childminders (including those in a childminding network). The duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child.

[19] School Admission Code of Practice (DfES/0031/2003). http://www.dfes.gov.uk/sacode/

[20] Improving Attendance & Behaviour: Guidance on Exclusion from Schools and Pupil Referral Units (DfES/0354/2004) http://www.behaviour4learning.ac.uk/viewarticle2.aspx?contentId=10612

Under Parts 3 and 4 of the DDA all settings are required not to treat a disabled child 'less favourably' than any other child for a reason relating to their disability. There may sometimes be justification for less favourable treatment, but it may not be possible to justify if there is a reasonable adjustment that might have been made but was not.

6.15 Health and Safety at Work Act 1974

http://www.healthandsafety.co.uk/haswa.htm

The Health and Safety at Work Act (HSWA) 1974 places duties on employers for the health and safety of their employees and anyone else on the premises. This covers the head teacher and teachers, non-teaching staff, children and visitors.[21]
Who the employer is depends on the type of school:

- For community schools, community special schools, voluntary controlled schools, maintained nursery schools and pupil referral units the employer is the Lancashire County Council;
- For foundation schools, foundation special schools and voluntary-aided schools the employer is the governing body;
- For academies and city technology colleges the employer is the governing body;
- For non-maintained special schools the employer is the trustees;
- For other independent schools the employer is usually the governing body, proprietor or trustees.

The employer for registered day care will depend on the way it has been set up. Settings may be run by private individuals, charities, voluntary committees, Lancashire County Council, School Governors, the proprietor or the trustees in some independent schools, and companies that provide day care as an additional service to customers (eg crèches in shops or sports clubs).

The employer of staff at the setting must do all that is reasonably practicable to ensure the health, safety and welfare of employees. The employer must also make sure that others, such as pupils and visitors, are not put at risk. The main actions employers must take under the Health and Safety at Work etc Act are to:

- Prepare a written Health and Safety policy;
- Make sure that staff are aware of the policy and their responsibilities within that policy;
- Make arrangements to implement the policy;
- Make sure that appropriate safety measures are in place;
- Make sure that staff are properly trained and receive guidance on their responsibilities as employees.

Most settings will at some time have children on roll with medical needs. The responsibility of the employer is to make sure that safety measures cover the needs of all children at the setting.

6.16 Management of Health and Safety at Work Regulations 1999

The Management of Health and Safety at Work Regulations 1999, made under the HSWA, require employers of staff at a school or early years setting to:

- Make an assessment of the risks of activities;
- Introduce measures to control these risks;
- Tell their employees about these measures.

The National standards for day care settings make it clear that the registered person must comply with all relevant health and safety legislation. Registered persons in Early Years Settings are also required under the National standards to take positive steps to promote safety. Supporting criteria under the safety standard includes undertaking risk assessments.

[21] Health and Safety: Responsibilities and Powers (DfES/0803/ 2001) http://www.teachernet.gov.uk/_doc/4017/Responsibilites%20and%20Powers.doc

HSWA and the Management of Health and Safety at Work Regulations 1999 also apply to employees. Employees must:

- Take reasonable care of their own and others' health and safety;
- Co-operate with their employers;
- Carry out activities in accordance with training and instructions;
- Inform the employer of any serious risk.

In some cases children and young people with medical needs may be more at risk than other children. Staff may need to take additional steps to safeguard the health and safety of such children. In a few cases individual procedures may be needed. The employer is responsible for making sure that all relevant staff know about and are, if necessary, trained to provide any additional support these children require.

6.17 Control of Substances Hazardous to Health Regulations 2002

The Control of Substances Hazardous to Health Regulations 2002 (COSHH) requires employers to control exposures to hazardous substances to protect both employees and others. Some medicines may be harmful to anyone for whom they are not prescribed. Where a school or setting agrees to administer this type of medicine the employer must ensure that the risks to the health of staff and others are properly controlled.

Legislation, notably the Education Act 1996
http://www.opsi.gov.uk/ACTS/acts1996/ukpga_19960056_en_1
The Disability Discrimination Act 1995
http://www.opsi.gov.uk/acts/acts1995/ukpga_19950050_en_1
The Care Standards Act 2000
http://www.opsi.gov.uk/acts/acts2000/en/ukpgaen_20000014_en_1
and the Medicines Act 1968
http://www.opsi.gov.uk/si/si1989/Uksi_19890192_en_1.htm
are also relevant to settings in dealing with children's medical needs.

6.18 Misuse of Drugs Act 1971 and associated regulations

The supply, administration, possession and storage of certain drugs are controlled by the Misuse of Drugs Act 1971 and associated regulations. This is of relevance to settings because they may have a child or young person that has been prescribed a controlled drug. The Misuse of Drugs Regulations 2001 allows 'any person' to administer the drugs listed in the Regulations.

6.19 Medicines Act 1968

The Medicines Act 1968 specifies the way that medicines are prescribed, supplied and administered within the UK and places restrictions on dealings with medicinal products, including their administration. Anyone may administer a prescribed medicine, with consent, to a third party, so long as it is in accordance with the prescriber's instructions. This indicates that a medicine may only be administered to the person for whom it has been prescribed, labelled and supplied; and that no-one other than the prescriber may vary the dose and directions for administration.

The administration of prescription-only medicine by injection may be done by any person but must be in accordance with directions made available by a doctor, dentist, nurse prescriber or pharmacist prescriber in respect of a named patient.

6.20 The Education (School Premises) Regulations 1999 [22]

The Education (School Premises) Regulations 1999 require every school to have a room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. It must contain a washbasin and be reasonably near a water closet. It must not be teaching accommodation. If this room is used for other purposes as well as for medical accommodation, the body responsible must consider whether dual use is satisfactory or

[22] Standards for School Premises (DFEE/0029/2000) http://www.opsi.gov.uk/si/si1999/19990002.htm

has unreasonable implications for its main purpose.

The responsibility for providing these facilities in all maintained schools rests with the Local Authority.

6.21 National Standards for under 8s day care and childminding – Premises

The National standards do not require day care settings to have a separate first aid room but they do cover the promotion of good health and taking positive steps to prevent the spread of infection. Such settings should also have one washbasin for every ten children over two years of age.

The National standards also require premises to be safe, secure and suitable for their purpose. They must provide adequate space in an appropriate location, be welcoming to children and offer all the necessary facilities for a range of activities that promote their development. Supporting criteria under the standard includes space standards, outdoor play areas, toilets, staff facilities, kitchens and laundry facilities. The standards do not require settings to have a separate first aid room but they do cover the promotion of good health and taking positive steps to prevent the spread of infection.

6.22 The Education (Independent Schools Standards) (England) Regulations 2003

The Education (Independent Schools Standards) (England) Regulations 2003 require that independent schools have and implement a satisfactory policy on First Aid and have appropriate facilities for pupils in accordance with the Education (School Premises) Regulations 1999.

6.23 Special Educational Needs – Education Act 1996

Section 312 of the Education Act 1996 sets out that a child has special educational needs if he has a learning difficulty that calls for special educational provision to be made for him. Children with medical needs will not necessarily have special educational needs (SEN). For those who do, schools should refer to the DCSF SEN guidance.

Section 322 of the Education Act 1996 requires that local health services must provide help to the Local Authority (LA) for a child with SEN (which may include medical needs), unless the health services consider that the help is not necessary to enable the LA to carry out its duties or that it would not be reasonable to give such help in the light of the resources available to the local health services to carry out their other statutory duties. This applies whether or not a child attends a special school. Help from local health services could include providing advice and training for staff in procedures to deal with a child's medical needs if that child would otherwise have limited access to education. Local Authorities, schools and early years' settings should work together, in close partnership with parents, to ensure proper support for children with medical needs.

6.24 Care Standards Act 2000

Schools

Residential special schools are required to register with the Commission for Social Care Inspection (CSCI) and are subject to the requirements set out in the Children's Homes Regulations 2001. In respect of medicines, this is set out in Regulation 21 and places a duty on the registered person to make 'suitable arrangements for the recording, handling, safekeeping, safe administration and disposal of medicines'. The Department of Health has also published National Minimum Standards (NMS) that set out guidance of how the Regulations may be met (Standard 13).

CSCI also works in conjunction with Ofsted to monitor health and social welfare in boarding schools. There are also NMS for boarding schools although such schools are not

subject to Regulations under the Care Standards Act.

Day Care Provision

The Children Act 1989 was amended by the Care Standards Act 2000 by the introduction of Part XA. In accordance with 79B in Part XA of the Children Act, the Office for Standards in Education (Ofsted) registers day care provision (day nurseries, crèches, out of school clubs and pre-school provision) and childminders. As regulator, Ofsted ensures that those who provide day care or childminding services are suitable and that the requirements set out in the National standards for under 8s day care and childminding are met. The registered person in early years settings in the private and voluntary sectors must meet the requirements of the national standards for under 8s day care and childminding.
The National standards for under 8s day care and childminding require that the Registered Person in an early years setting promotes the good health of children and takes positive steps to prevent the spread of infection and appropriate measures when they are ill (Standard 7).

The criteria for this standard sets out that the registered person has a clear policy, understood by all staff and discussed with parents, regarding the administration of medicines. If the administration of prescription medicine requires technical/medical knowledge then individual training must be provided for staff from a qualified health professional and that training must be specific to the individual child or young person concerned.

There is a requirement in the National standards for under 8s day care and childminding that the registered person must take positive steps to promote safety within the setting and on outings and ensure proper precautions are taken to prevent accidents (Standard 6).

For day care settings, the criteria sets out that the Registered Person must take reasonable steps to ensure that hazards to children on the premises, both inside and outside, are minimised and is aware of, and complies with, health and safety regulations. Staff must be trained to have an understanding of health and safety requirements for the environment in which they work.

The national standards do not override the need for providers to comply with other legislation such as that covering health and safety, food hygiene and so on.

CHAPTER 7

7. Related Documents

DfES unpriced documents can be ordered from DfES Publications,
Tel: 0845 6022260.
Email: dfes@prolog.uk.com.
Please quote the publication reference when ordering.

7.1 Early Years Settings

Disability Discrimination Act 1995 – Code of Practice – Rights of Access – Goods, Facilities, Services and Premises (Disability Rights Commission, 2002). Price: £13.95
Order: The Stationery Office Tel: 0870 600 5522 DRC Code of Practice webpage:
www.drc-gb.org/the law/practice. asp

Early Support Family Support Pack and Early Support Professional Guidance (DfES, 2004).
Ref: ESPP1. Website:
www.earlysupport.org.uk

Including Me – Managing Complex Health Needs in Schools and Early Years Settings (Council for Disabled Children, due for publication in summer 2005). Council for Disabled Children. Tel: (020) 7843 1900.

National standards for under 8s day care and childminding – (DfES/DWP, 2003) –
Childminding Ref: DfES/0649/2003.
Créches Ref: DfES/0650/2003.
Full day care Ref: DfES/0651/2003.
Out of school care Ref: DfES/0652/2003.
Sessional care Ref: DfES/0653/2003.
http://www.surestart.gov.uk/improvingquality/ensuringquality/inspectionandregulation/

7.2 Schools

Code of Practice for Schools – Disability Discrimination Act 1995: Part 4 (Disability Rights Commission, 2002). Ref: COPSH
www.drc-gb.org/thelaw/practice.asp
Order: Disability Rights Commission Tel: 08457 622 633
Drugs: Guidance for Schools (DfES, 2004)
Ref: DfES/0092/2004
www.teachernet.gov.uk/drugs/

Guidance on First Aid for Schools: a good practice guide (DfES, 1998)
Ref: GFAS98. www.teachernet.gov.uk/firstaid

Health and Safety: Responsibilities and Powers (DfES, 2001)
Ref: DfES/0803/2001.
www.teachernet.gov.uk/responsibilities/

Health and Safety of Pupils on Education Visits: a good practice guide (DfES, 1998)
Ref: HSPV
http://www.teachernet.gov.uk/wholeschool/healthandsafety/visits/

Also three part supplement:
Part 1 – Standards for LEAs in Overseeing Educational Visits (DfES, 2002)
Ref: DfES/0564/2002;
Part 2 – Standards for Adventure (DfES, 2002) Ref: DfES/0565/2002;
Part 3 – Handbook for Group Leaders (DfES, 2002) Ref: DfES/0566/2002.

Home to school travel for pupils requiring special arrangements (DfES, 2004)
Ref: LEA/0261/2004
www.teachernet.gov.uk/wholeschool/sen/sentransport/

Improving Attendance and Behaviour: Guidance on Exclusion from Schools and Pupil Referral Units (DfES, 2004) Ref: DfES/0354/2004
http://www.teachernet.gov.uk/management/resourcesfinanceandbuilding/schoolbuildings/schooldesign/Pupil_Referral_Units/

Insurance – A guide for schools (DfES, 2003)
Ref: DfES/0256/2003
www.teachernet.gov.uk/management/atoz/i/insurance/index.cfm?code=keyd

School Admissions Code of Practice (DfES, 2003)
Ref: DfES/0031/2003
www.dfes.gov.uk/sacode/

Special Educational Needs Code of Practice (DfES, 2001)
Ref: DfES/0581/2001
www.teachernet.gov.uk/teachinginengland/detail.cfm?id=390

Standards for School Premises (DfEE, 2000)
Ref: DFEE/0029/2000
www.teachernet.gov.uk/sbregulatoryinformation

Work Related Learning and the Law (DfES, 2004)
Ref: DfES/0475/2004
http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DFES-0340-2006&

7.3 Department of Health (including joint publications)

Guidance on infection control in schools and nurseries (Department of Health/Department for Education and Employment/Public Health Laboratory Service, 1999) Download only from: Wired for Health at:
www.wiredforhealth.gov.uk/

National Service Framework for Children and Young People and Maternity Services: Medicines and Children and Young People website: www.dh.gov.uk/healthtopics
(Click on Children's Services). Order: DH Publications Tel: 08701 555 455

7.4 Ofsted

Inspecting schools – Handbook for inspecting nursery and primary schools Ref: HMI 1359. Inspecting schools – Handbook for inspecting secondary schools Ref: HMI 1360. Inspecting schools – Handbook for inspecting special schools and pupil referral units
Ref: HMI 1361. All Ofsted 2003. Priced.
Order: The Stationery Office Tel: 0870 600 5522 or view online at
http://www.ofsted.gov.uk/

LEA Framework 2004 – Support for health and safety, welfare and child protection (Ofsted, 2004)
http://www.ofsted.gov.uk/portal/site/Internet/menuitem.eace3f09a603f6d9c3172a8a08c08a0c/?vgnextoid=4f4ac30f8636c010VgnVCM1000003507640aRCRD

7.5 Useful Contacts

Allergy UK
Allergy Help Line: (01322) 619864
Website: www.allergyfoundation.com

The Anaphylaxis Campaign
Helpline: (01252) 542029
Website: www.anaphylaxis.org.uk and www.allergyinschools.co.uk

Association for Spina Bifida and Hydrocephalus
Tel: (01733) 555988 (9 am to 5 pm)
Website: www.asbah.org

Asthma UK (formerly the National Asthma Campaign)
Adviceline: 08457 01 02 03
(Mon-Fri 9 am to 5 pm)
Website: www.asthma.org.uk

Council for Disabled Children
Tel: (020) 7843 1900
Website: www.ncb.org.uk/cdc/

Contact a Family
Helpline: 0808 808 3555
Website: www.cafamily.org.uk

Cystic Fibrosis Trust
Tel: (020) 8464 7211
(Out of hours: (020) 8464 0623)
Website: www.cftrust.org.uk
Diabetes UK
Careline: 0845 1202960
(Weekdays 9 am to 5 pm)
Website: www.diabetes.org.uk

Department for Education and Skills
Tel: 0870 000 2288
Website: www.dfes.gov.uk

Department of Health
Tel: (020) 7210 4850
Website: www.dh.gov.uk

Disability Rights Commission (DRC)
DRC helpline: 08457 622633
Textphone: 08457 622 644
Fax: 08457 778878
Website: www.drc-gb.org

Epilepsy Action
Free phone Helpline: 0808 800 5050
(Monday – Thursday 9 am to 4.30 pm, Friday 9 am to 4 pm)
Website: www.epilepsy.org.uk

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

Health Education Trust
Tel: (01789) 773915
Website: www.healthedtrust.com

Hyperactive Children's Support Group
Tel: (01243) 551313
Website: www.hacsg.org.uk

MENCAP
Telephone: (020) 7454 0454
Website: www.mencap.org.uk

National Eczema Society
Helpline: 0870 241 3604
(Mon-Fri 8 am to 8 pm)
Website: www.eczema.org

National Society for Epilepsy
Helpline: (01494) 601400
(Mon-Fri 10 am to 4 pm)
Website: www.epilepsynse.org.uk

Psoriasis Association
Tel: 0845 676 0076 (Mon-Thurs 9.15 am to 4.45 pm Fri 9.15 am to 16.15 pm)
Website: www.psoriasis-association.org.uk/

Sure Start
Tel: 0870 000 2288
Website: www.surestart.gov.uk
You can download this publication or order copies online at:
www.teachernet.gov.uk/publications
Search using ref: 1448-2005DCL-EN.

7.6 The Law

SEN and Disability Act 2001
http://www.opsi.gov.uk/ACTS/acts2001/ukpga_20010010_en_1

Health and Safety at Work etc Act 1974
http://www.hse.gov.uk/legislation/hswa.pdf

The Management of Health and Safety at Work Regulations 1999
http://www.opsi.gov.uk/si/si1999/19993242.htm

Control of Substances Hazardous to Health Regulations 2002
http://www.opsi.gov.uk/si/si2002/20022677.htm

Misuse of Drugs Act 1971
http://www.ukcia.org/pollaw/lawlibrary/misuseofdrugsact1971.php
And associated regulations Medicines Act 1968
http://www.the-shipman-inquiry.org.uk/4r_page.asp?id=3116

The Education (School Premises) Regulations 1999
http://www.england-legislation.hmso.gov.uk/si/si1999/99000202.htm

The Education (Independent Schools Standards) (England) Regulations 2003
http://www.opsi.gov.uk/si/si2003/20031910.htm

National Standards for under 8s day care and childminding – Premises
http://www.opsi.gov.uk/si/si2003/20031996.htm

Special Educational Needs – Education Act 1996
http://www.opsi.gov.uk/ACTS/acts1996/ukpga_19960056_en_1

Care Standards Act 2000
http://www.opsi.gov.uk/acts/acts2000/en/ukpgaen_20000014_en_1