Fairfield Community Primary School First Aid Medication Policy and Management Procedures

1. POLICY AIMS 2
2. KEY PRINCIPLES 2
3. GENERAL 2
4. ROLES AND RESPONSIBILITIES 3
5. PROCEDURE – SIMPLE, SHORT-TERM MEDICATION NEEDS (E.G. ANTIBIOTICS) 4
6. PROCEDURE - LONG TERM / MORE COMPLEX MEDICATION NEEDS 4
7. EDUCATIONAL VISITS 6
8. INDIVIDUAL HEALTH CARE PLAN (IHCP) 6
9. ADVICE ON MEDICAL CONDITIONS 8
10. SCHOOL ILLNESS EXCLUSION GUIDELINES 9

APPENDIX A – GENERAL CARE PLAN / INSTRUCTION TO ADMINISTER MEDICATION 11

APPENDIX A1 – RESIDENTIAL MEDICAL CONSENT AND EMERGENCY CONTACT FORM 12

APPENDIX B – INDIVIDUAL HEALTH CARE PLAN (COMPLETE IN SCHOOL) 14

APPENDIX C – EPILEPSY HEALTH AND RECORD FORMS FROM HEALTH PROFESSIONALS 16

APPENDIX D – EMERGENCY ACTION PLANS FOR ANAPHYLAXIS FROM HEALTH PROFESSIONALS 46

APPENDIX E – DIABETES HEALTH FORMS FROM HEALTH PROFESSIONALS 56

APPENDIX F – STATUTORY GUIDANCE ON SUPPORTING PUPILS AT SCHOOL WITH MEDICAL CONDITIONS (DFE DOCUMENT) 71

This document is based on a template document produced in conjunction with the Leicestershire Partnership Trusts. We would like to acknowledge input from professional bodies and services with Leicestershire County, City and Rutland. This document is revised in line with the current Department for Education ‘Supporting pupils at School with medical conditions’ 2014, which replaces the previous Managing medicines in Schools and early years settings 2005.

1. POLICY AIMS

1.1. The aim of this policy is to ensure that children with medical needs receive appropriate care and support at school.

2. KEY PRINCIPLES

2.1. We believe it to be important that parents should not send a child to school if he or she is unwell. However, some children may be well enough to attend school provided they receive the appropriate medication.

2.2. Where a child has a long term medical need a written health care plan will be drawn up with the parents and health professionals. It is crucial that parents inform the school about any particular medical needs before a child is admitted or when a child first develops a medical need.

2.3. The Head Teacher will accept responsibility for members of the school staff giving or supervising pupils taking prescribed medication during the school day.

2.4. Where possible children should be encouraged to self-administer under supervision.

2.5. It must be stressed that where prescription drugs are administered, it shall be by those members of staff who have volunteered to do so, since the school does not employ any medically trained staff. It should **not** be assumed that a qualified first aider will fulfil this role. Non-prescription drugs will not be administered

2.6. Any staff who agree to administer medicines to pupils in school do so on an entirely voluntary basis: there is no obligation on staff to volunteer to administer medicines. The Governors of Fairfield Community Primary School acknowledge that staff who do agree to administer medicines are acting within the scope of their employment.

2.7. If a child refuses medication or treatment to be administered by school staff, then the school will:

- ***Not*** force the child to take the medicine / treatment;
- If considered necessary, call an ambulance to get the child to hospital;
- Inform the child's parents / carers immediately.

3. GENERAL

3.1. Non-Prescribed Medication
The school will not store or give medicines that have not been prescribed to a child (e.g. Calpol, Piriton or cough medicines). Parents need to make arrangements to come into school and administer these medicines if they are to be given.

3.2. Prescribed Medication
Prescribed medicine will NOT be administered by staff unless clear <u>written</u> instructions to do so have been provided from the child's parents or carers. Support is available for the completion of the relevant form (see Appendices A-E) for parents who have literacy problems or where English is not their first language.

3.3. All medicines must be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions.

3.4. They must be clearly labelled with:

- Name of child;
- Name of medicine;
- Dose;
- Method of administration;
- Time/frequency of administration;
- Any side effects;
- Expiry date.

4. Roles and Responsibilities

4.2. Parents / Carers

4.2.1. Parents / carers of children who require medication in school, whether on a short-term, long-term, routine or emergency basis, are required to:

a) Provide the school with written information about their child's condition and required medication, in the form of a General Care Plan and Consent Form (Appendix A) or Individual Care Plan, as appropriate;

b) Ensure that the school is supplied with reasonable quantities of in-date medication. Reasonable quantities shall normally be considered to be sufficient for a maximum of 4 weeks supply.

c) If the pupil travels on school transport with an escort, ensure that the escort has a copy of written instructions relating to medication for the individual;

d) Notify the school promptly, in writing, of any changes in prescription drug issued by the GP;

e) Collect and restock medication from the school at the start and end of every day / term;

f) Ensure that all medication supplied to the school is in a secure labelled container as originally dispensed.

4.3. School

4.3.1. The school is required to:

a) Store medication in a known safe secure place (not necessarily locked away), recognising that some drugs may require refrigeration;

b) Ensure that where emergency medication is prescribed it must remain with the pupil at all times (e.g. Epipens, asthma inhalers);

c) Maintain and record the dosage prescribed / administered;

d) Identify staff volunteers to administer medication and name them on the Individual Care Plan (or an attached document)

e) Identify any standard or additional training that may be required by staff, ensure that this is sourced / delivered in a timely manner and maintain training records;

f) If a medical emergency develops, activate the relevant procedures and call 999.

4.4. Medical Professional (e.g. GP, Consultant, Nurse, etc)

4.4.1. Medical professionals are required to:

a) Complete an Individual Care Plan for children with long term medical needs;

b) Provide training, as appropriate, for staff who will be administering prescribed medication;

c) Prescribe the appropriate medication. Prescriptive labelled drugs must display:

- Pupil's name;
- Name of medication;
- Dosage;
- Frequency of administration;
- Date of dispensing;
- Storage requirements (if important) e.g. refrigeration;
- Expiry date.

5. PROCEDURE – SIMPLE, SHORT-TERM MEDICATION NEEDS (E.G. ANTIBIOTICS)

5.3. Where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours.

5.4. Parents must complete a consent form / general care plan (Appendix A) on the first day that the medication is required in school. The completed form, together with the medication, should be handed in at the school office (note: for children in 4+ the form and medication should be passed to the child's teacher).

5.5. Medication will be kept in a safe secure place (not necessarily locked away). It is acknowledged that some drugs may require refrigeration.

5.6. Staff administering the medicine will record the following on the reverse of the authorisation form:

- Date administered
- Time administered
- Dose given
- Who administered the medicine?

5.7. Medicines must be collected from the office (or 4+ unit) at the end of each day, by a parent / carer.

6. PROCEDURE - LONG TERM / MORE COMPLEX MEDICATION NEEDS

6.2. General

6.2.1. The school acknowledges that medicines in this category are largely preventative in nature and that it is essential they be given in accordance with instructions, otherwise the management of the medical condition is hindered.

6.2.2. In the first instance the Head Teacher should be informed of an individual child's diagnosis and prescription medication.

6.2.3. An individual health care plan must be drawn up for the pupil (see section 8)

6.2.4. An appropriate volunteer(s) will be identified and, if necessary will meet and discuss the issues with the parents/carers of the pupil. The volunteer(s) will be offered professional training and support in relation to the needs of the individual child, as required. This will be provided by a suitably competent person (who may or may not be a qualified trained nurse)

6.2.5. The school may seek parents / carers permission to explain the use of medication to a number of pupils in their child's class so that peer support can be given. This will only occur where it is considered such action would be helpful and/or necessary.

6.2.6. Medication will be kept in a known safe secure place (not necessarily locked away). It is recognised

that some drugs may require refrigeration.

6.3. Injections

6.3.1. There are certain conditions (e.g. Diabetes Mellitus, bleeding disorders, or hormonal disorders) which are controlled by regular injections (see Appendix E). Children with these conditions are usually taught to give their own injections, or the injections are required outside of the school day. Where this is not the case an individual care plan will need to be developed before the child joins the school, and training provided to staff who agree to administer the injections. The care plan must include agreed back up procedures in the event of the absence of trained staff. Special arrangements may also need to be considered in the event of school trips.

6.4. Emergency Treatment

6.4.1. Where emergency medication is prescribed this must remain with the pupil at all times (e.g. Epipen, asthma inhalers)

6.4.2. a) No emergency medication should be kept in school except that specified for use in an emergency for an individual child.

b) A care plan must be in place in all cases where a child has been prescribed emergency medication / treatment. See Appendices A to E for guidance and template documentation.

c) Emergency medications must be clearly labelled with the child's name, action to be taken, delivery route, dosage and frequency (see paragraph 2.6).

d) In the event of the absence of all trained staff, parents / carers will be notified immediately and agreement reached on the most appropriate course of action.

e) If it is necessary to give emergency treatment, a clear written account of the incident will be recorded and retained by the school (Appendices B to E): a copy will be given to the parents / carers of the child.

f) In all circumstances, if the school feels concerned they will call an ambulance.

6.4.3. In accordance with paragraph 6.1 above:

a) When specifically prescribed, a supply of antihistamines or pre-prepared adrenalin injection should be used if it is known that an individual child is hypersensitive to a specific allergen (e.g. wasp stings, peanuts, etc). Immediate treatment will be given before calling an ambulance. See also Appendix B.

b) A supply of "factor replacement" for injections should be kept in school where it is required for a child suffering from a bleeding disorder. If injection is necessary it is usual for the child to be able to self-inject. If this is not the case the parents / carers will be contacted immediately. If contact cannot be made emergency advice will be taken from the Bleeding Disorders Clinic at Leicester Royal Infirmary (0116 258 6500) or an ambulance will be called.

c) For children who have repeated or prolonged fits and require the administration of rescue medication, a small supply of Buccal Midazolam or Rectal Diazepam may be kept in school for administration to a specifically identified child. Appendices C and D provide guidance and documentation relating to the administration of these rescue medications.

Where either of these rescue medicines have been administered an ambulance will be called to take the child to the nearest hospital receiving emergencies, unless the parent / carer or a healthcare professional indicates otherwise and this is acceptable to the school.

d) A supply of glucose (gel, tablets, drink, food etc) for treatment of hypoglycaemic attaches should be provided by parents / carers of any child suffering from diabetes mellitus. If, after an initial recovery, a second attack occurs within 3 hours, the treatment will be repeated and the child

taken to the nearest hospital receiving emergencies. (See also appendix E)

7. Educational Visits

7.3. Any medical problems must by highlighted by parent / carers prior to their child's participation in an educational visit and must complete the Residential Medical Consent and Emergency Contact Form.

7.4. Where insurance cover is obtained by or through the school, medical conditions must be disclosed, otherwise insurance cover may be refused or be invalid.

7.5. A named person will be identified to supervise the storage and administration of all medication. See also section 2 of this policy.

7.6. Where medication needs to be kept refrigerated, parents / carers may be asked to supply a cool box / bag and ice packs for use on educational visits. Care must be taken to ensure that the mediation does not come into direct contact with the ice packs.

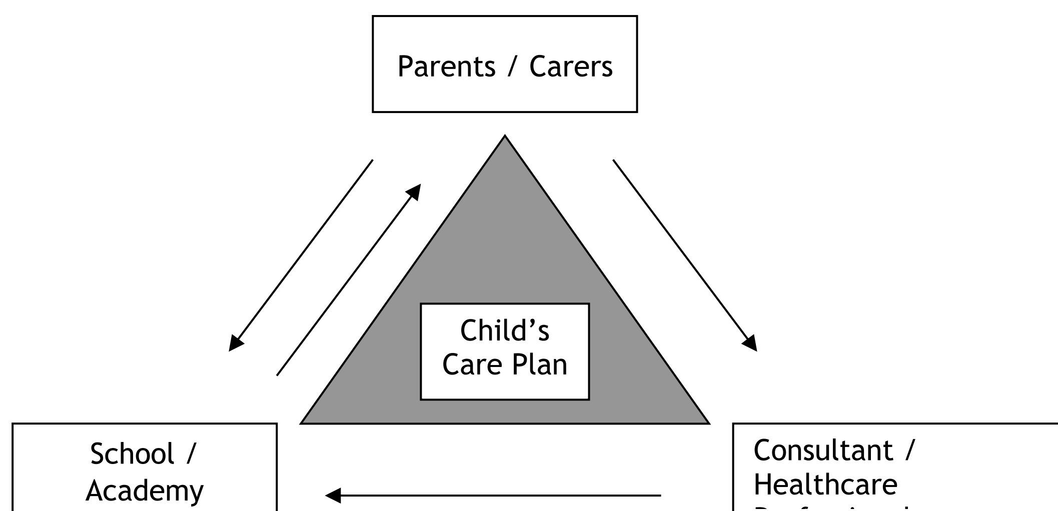
7.7. Wherever possible children should carry their own reliever inhalers or emergency treatment (see 2.7 above), but it is important that the named person is aware of this.

7.8. In the event that emergency medication or treatment is required whilst transporting a pupil, it may be deemed appropriate to stop and park the vehicle in the first instance, for safety reasons. A "999" call will then be made to summon emergency assistance.

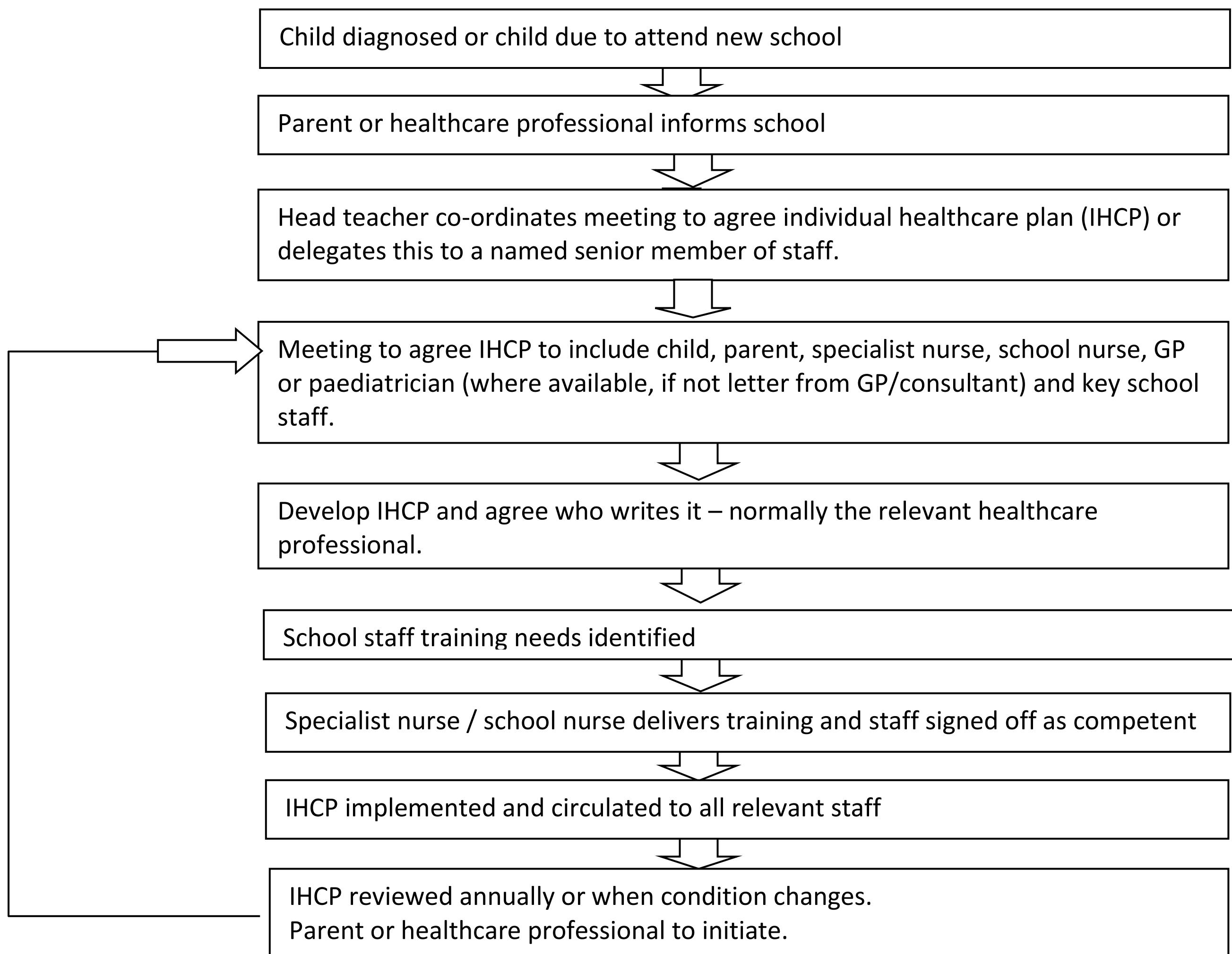
8. Individual Health Care Plan (IHCP)

8.3. An IHCP provides specific information on individual pupil requirements. A written recorded plan will ensure that their needs are met whilst in school and any treatment needed to be administered by members of staff will be fully understood. The plan is to be agreed by the Head Teacher and parents and ***must be formally recorded and reviewed at regular intervals*****.** A template/proforma can be found in Appendix B.

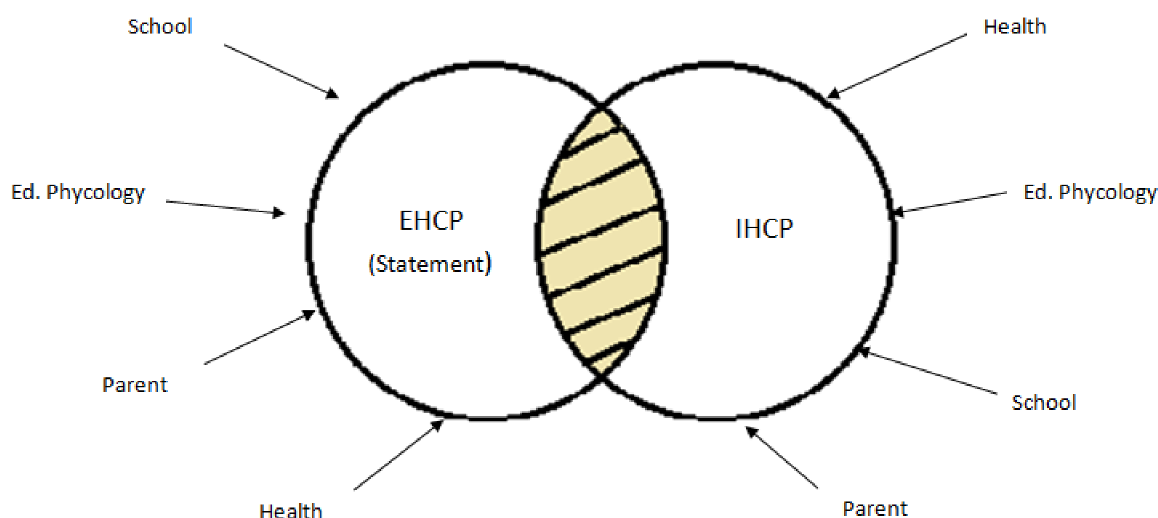
8.4.



8.5. The procedure for drawing up an Individual Health Care Plan is as follows:



8.6. Some children with medical conditions may have physical disabilities. Where this is the case governing bodies **must** comply with their duties under the Equality Act 2010. Some may have special educational needs (SEN) and may have a statement or Education Health Care Plan which will bring together health and social care needs, as well as their special education provision.



9.

EHCP "This is the new statement of educational needs and may incorporate the need for specialist medicines".	**IHCP** "Individual health care plans give direction for managing emergency or specialist medicines given".

9.3. The Community Paediatrician or Nurse may be asked to give advice regarding medical conditions to the school.

9.4. Parents / carers of children suffering for medical conditions, who require general information, are advised to seek advice from the GP, school health professionals (contact details available on request), or from the bodies detailed in Appendix F. These bodies can also supply leaflets regarding the conditions listed.

Asthma at school – a guide for teachers	National Asthma Campaign www.asthma.org.uk Asthma Helpline: 0800 121 6244
Guidance for teachers concerning Children who suffer from fits	www.epilepsy.org.uk Helpline: Freephone 0808 800 5050 helpline@epilepsy.org.uk
Guidelines for Infections (e.g. HIV, AIDS and MRSA)	Public Health England Tel: 0344 225 4524
Haemophilia	info@haemophilia.org.uk Helpline: 0207 831 1020
Allergies Anaphylaxis Campaign	www.anaphylaxis.org.uk Helpline: 01252 542029
Thalassaemia	www.ukts.org office@ukts.org Tel: 0208 882 0011
Sickle Cell Disease	info@sicklecellsociety.org Tel: 0208 961 7795
Cystic Fibrosis and School (A guide for teachers and parents)	www.cftrust.co.uk Tel: 0208 464 7211
Children with diabetes - Guidance for teachers and school staff Leicester Royal Infirmary 9 am - 5 pm	www.diabetics.org.uk Diabetes Careline: 0345 123 2399 0116 258 6796 Diabetes Specialist Nurses

Diabetes Office	0116 258 7737 Consultant Paediatric
Insurance section Leicestershire County Council • Additional insurance • Concerns	David Marshall-Rowan: 0116 305 7658 James Colford: 0116 305 6516
County Community Nursing Teams – information on school nurses	East Region (Harborough/Rutland/ Melton) PA: Janet Foster 01858 138109 Clare Hopkinson 01664 855069 Locality Manager: Maureen Curley Jane Sansom West Region (Hinckley/Bosworth/Charnwood) PA: Sally Kapasi 01509 410230 Locality Manager: Chris Davies Teresa Farndon
Health, Safety & Wellbeing Service, Leicestershire County Council	healthandsafety@leics.gov.uk Tel: 0116 305 5515

10. School Illness Exclusion Guidelines

10.3. Parents / carers are asked to ensure their child knows how to wash his/her hands thoroughly to reduce risk of cross-infection. School attendance could be improved for all if children and families wash and dry their hands well 5 or more times a day.

10.4. Parents are expected to adhere to the following guidelines in the event of their child contracting particular illnesses / conditions:

Chickenpox	Until blisters have all crusted over or skin healed, usually 5-7 days from onset of rash.
Conjunctivitis	Parents/carers expected to administer relevant creams. Stay off school if unwell.
Nausea	Nausea without vomiting. Return to school 24 hours after last felt nauseous.
Diarrhoea and / or vomiting	Exclude for 48 hours after last bout (this is 24 hours after last bout plus 24 hours recovery time). Please check your child understands why they need to wash and dry hands frequently. Your child would need to be excluded from swimming for 2 weeks.
German measles / rubella	Return to school 5 days after rash appears but advise school immediately in case of a pregnant staff member .
Hand, foot and mouth disease	Until all blisters have crusted over. No exclusion from school if only have white spots. If there is an outbreak, the school will contact the Health Protection Unit.
Head lice	No exclusion, but please wet-comb thoroughly for first treatment, and then every three days for next 2 weeks to remove all lice.
Cold sores	Only exclude if unwell. Encourage hand-washing to reduce viral spread
Impetigo	Until treated for 2 days and sores have crusted over
Measles	For 5 days after rash appears
Mumps	For 5 days after swelling appears
Ringworm	Until treatment has commenced
Scabies	Your child can return to school once they have been given their first treatment although itchiness may continue for 3-4 weeks. All members of the household and those in close contact should receive treatment.
Scarletina	For 5 days until rash has disappeared or 5 days of antibiotic course has been completed

Slapped cheek	No exclusion (infectious before rash)
Threadworms	No exclusion. Encourage handwashing including nail scrubbing
Whooping cough	Until 5 days of antibiotics have been given. If mild form and no antibiotics, exclude for 21 days.
Viral infections	Exclude until child is well and temperature is normal (37 degrees).

Appendix A – General Care Plan / Instruction to Administer Medication

ADMINISTRATION OF MEDICINES

TO: Headteacher of FAIRFIELD PRIMARY SCHOOL

FROM: Parent/Guardian of ……………………………………….……….Full name of child

DATE…………………………………………………………….

My child has been diagnosed as suffering from ……………………………………………………
(name of illness)

He/She requires the following prescribed medicine to be administered

………………………………………………………………………………(name of medicine)

Could you please administer ………………………………………(dosage) at the following times:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

From………………………………………………………Until……………………………………..

The medicine should be administered by mouth*/in the ear*/nasally*/other*

*Delete as appropriate.

I understand that all staff are acting voluntarily in administering medicines and have the right to refuse to administer medication. I understand that the school staff cannot undertake to monitor the use of inhalers carried by children, and that the school is not responsible for loss or damage to any medication.

Signed ………………………………………………………………………………………………

Name of Parent/Guardian…………………………………………..……………………(Please print)

Signed: ………………………………………………………………………………… Date: ……………………………………...

RESIDENTIAL MEDICAL **CONSENT AND EMERGENCY CONTACT FORM**

Name of Pupil……………………………………………………………………………….

Medical Information

a) Does your son/daughter suffer from any conditions requiring medical treatment, including medication?
If **YES**, please give brief details

…….

…….

b) To the best of your knowledge, has your son/daughter been in contact with any contagious or infectious diseases or suffered from anything in the last four weeks that may be contagious or infectious.
If **YES**, please give details

………..

…….

c) Is your son/daughter allergic to any medication?
If **YES**, please specify

……….
…

……….

d) Has your son/daughter received a tetanus jab in the last five years?

YES/NO

e) Please outline any special dietary requirements of your child eg vegetarian, allergies.

I undertake to inform the co-ordinator/headteacher as soon as possible of any change in the medical circumstances between the data signed and the commencement of the journey.

Declaration

I agree to my son/daughter receiving emergency medical treatment, including anaesthetic and blood transfusions as considered necessary by the medical authorities present.

I may be contacted by telephoning the following numbers:

Work…………………………………………………………………………………………………

Home…………………………………………………………………………………………………..

My home address is:

……

……

If not available at above, please contact:

Name……………………………………………………………………………………………………..

Telephone Number……………………………………………………………………………….

Address

………

…….

Name, address and telephone number of family doctor:

……………………………………………………………………………………………………….

……………………………………………………………………………………………………….

Date ………………………………….……..Signed…………………………………………

(**Signed by the person with legal responsibility for the young person)**

APPENDIX B – INDIVIDUAL HEALTH CARE PLAN (COMPLETE IN SCHOOL)

Child Details

School:	Fairfield Community Primary School		
Child's Name:		**Date of Birth:**	
Home Address:			
Medical Diagnosis / Condition:			
Date:		**Review Date:**	

Family Contact Information

	Contact 1	**Contact 2**
Name		
Relationship to child		
Phone (work)		
(home)		
(mobile)		

Clinic / Hospital Contact

Name	
Phone	

GP

Name	
Phone	

Person Responsible for Providing Support in School

Name	

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

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

Daily care requirements

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

Arrangements for school visits/trips, etc.

Other information

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

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

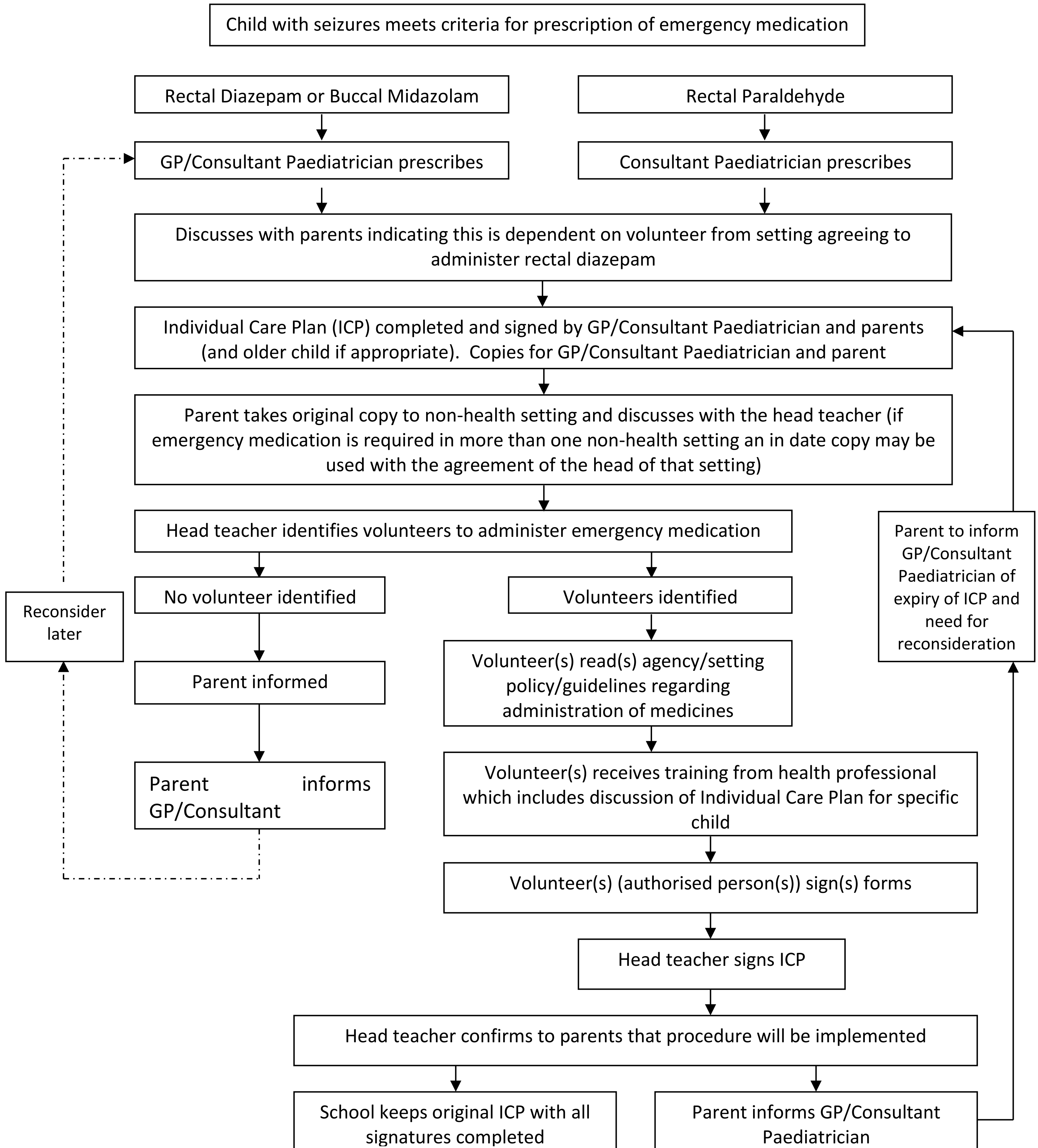
Plan developed with

Staff training needed / undertaken – who, what, when

Form copied to

APPENDIX C – EPILEPSY HEALTH AND RECORD FORMS FROM HEALTH PROFESSIONALS

C1 Protocol for health staff to support non-medical and non-nursing staff for the administration of Rectal Diazepam, Buccal Midazolam or Rectal Paraldehyde in response to epileptic seizures/fits/convulsions



C2a Example Individual Care Plan for the administration of rectal diazepam, as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: ………………………………………………… **DOB:** …………………………**Hosp No:** ……………………………….

Address: ………

Description of type of fit/convulsions/seizure which requires rectal diazepam:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

The dose of Rectal Diazepam should be …………………………………………………………………mgs.

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **rectal diazepam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **Diazepam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

1. informing anyone who needs to know, if rectal diazepam has been given;
2. maintaining adequate and in-date supply of medication at the setting;
3. notifying the setting if there are any changes to medication dose / type;
4. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals):
………

Signature …………………………………………………………………………………… Date: ………………………………………………

PARENT/CARER (Block Capitals): ………………………………………………………… Tel No. ……………………………………………

Signature …………………………………………………………………………………… Date: ………………………………………………

OLDER CHILD/YOUNG PERSON (Block Capitals):

………….Signature ……………………………………………………………………………… Date: ………………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): ……………………………………………………………………………………………

Signature ……………………………………………………………………………… Date: ………………………………………………

AUTHORISED PERSON(S) TO ADMINISTER RECTAL DIAZEPAM

NAME (Block Capitals) ……

Signature …………………………………………………………………………………… Date: ……………………………………………

NAME (Block Capitals) ………

Signature …………………………………………………………………………………… Date: ………………………………………………

NAME (Block Capitals) ……

Signature …………………………………………………………………………………… Date: ………………………………………………

NAME (Block Capitals) ……

Signature …………………………………………………………………………………… Date: ………………………………………………

** delete as appropriate*

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

C2b Rectal Diazepam – Guidelines for Administration

Action	Rationale
Note time seizure begins	Preparation in case administration is needed
Request someone ring 999 or arrange for the child to be escorted to the nearest hospital receiving emergencies. Contact parent/carer	As per Individual Care Plan (ICP)
Locate and obtain, in a timely manner, child's Rectal Diazepam administration kit	
Check: • instruction on the individual care plan and its expiry date; • name and expiry date of medicine, strength and formulation and ensure this matches the care plan; • the name of the patient on the pharmacy label matches that on the care plan	To prevent error in administration from occurring
Put on gloves and apron	In accordance with infection control policies and guidelines
Place the child/young person on their left side if possible **Be sure to maintain your own safety**	To allow ease of access to the rectum, the left lateral position anatomically assists retention of medication. Laying an unconscious person on their side maintains the airways.
Loosen / remove items of clothing respecting privacy and dignity.	Allow access in a dignified manner
Note time Decide to administer the rectal diazepam	
Check medication and dose against individual care plan	To ensure accurate dose
Insert the rectal diazepam tube into the rectum in accordance with LPT training guidelines	To ensure correct position of the tube to enable administration and prevent injury
Squeeze the tube gently expelling the liquid Note: some liquid is designed to be left in the tube following administration	Te ensure the full dose is administered
Continue to squeeze the tube as removing from the rectum	To prevent the medication being sucked back into the tube
Gently hold the buttocks together If the child has their bowels open DO NOT re-administer the dose	To prevent seepage To prevent overdose

Action	Rationale
Record the time of administration	To know when the medication will start to take effect (rectal diazepam takes 5-10 minutes to take effect)
Remain with the child/young person until the seizure has stopped. Continue to observe breathing and the effects of the rectal diazepam.	Maintaining safety of the child/young person To monitor the effect of the rectal diazepam and if prescribed to determine the need for a second dose
Arrange for transfer to hospital	Maintaining safety of the child/young person (see individual care plan)
If seizure continues, if prescribed a second dose then administer as before	To continue with the individual's seizure procedure
Dispose of equipment as per agency guidelines and procedures	In line with LPT policies and guidelines
Complete report form – copies as indicated on form including to hospital with child if possible. Original to be kept in child's agency record	To enable monitoring of administration of rectal diazepam and update child's health records

C2c Rectal Diazepam – Administration Report Form

NAME OF CHILD:	**DOB:**
DATE OF SEIZURE / CONVULSION:	
TIME SEIZURE / CONVULSION STARTED: **ACTIVITY WHEN SEIZURE / CONVULSION BEGAN:** **DESCRIPTION OF SEIZURE / CONVULSION:**	
TIME RECTAL DIAZEPAM GIVEN **DOSE GIVEN** **MGS** **GIVEN BY** 1. ______________ ______________ ______________ ______________ 2. ______________ ______________ ______________ ______________ **ANY DIFFICULTIES IN ADMINISTRATION?** **TIME SEIZURE / CONVULSTION STOPPED:**	
TIME CHILD TAKEN TO HOSPITAL: **ANY OTHER NOTES ABOUT INCIDENT (e.g. injuries to child or other parties, child sleepy)**	
SIGNED (authorised person): **DATE:** **DESIGNATION:**	**NAME (print):**

C2d Training agreement for volunteers identified by head teacher to administer rectal diazepam

NAME: ………………………………………………………………………………

SETTING: ………………………………………………………………………………

Verbal and Written Instructions		Received
-	Epilepsy awareness	Y/N
-	First aid for epileptic seizures	Y/N
-	Awareness of child / young person's specific Agreement Form which includes:	
	The preparation of rectal diazepam	Y/N
	When to administer rectal diazepam	Y/N
	The dose to be given	Y/N
	Whether 2nd dose is indicated	Y/N
	What to include in the "kit"	Y/N
-	Procedure for administration of rectal diazepam	Y/N
-	Care following administration	Y/N
	Support to child	Y/N
	Transfer to hospital	Y/N
	Record of procedures – report form	Y/N
	Safe disposal of used equipment	Y/N

<u>Practical</u>

-	Demonstration from health professional on the administration of Rectal diazepam (using a placebo)	Y/N
-	Practice of the procedure until confident	Y/N

<u>Other (specify)</u>

Declaration

I …………………………………………………………………………… confirm that I have been trained to use rectal diazepam as detailed overleaf.

Signed: ………………………………………………………………………………

Date: ………………………………………

Training given by:

Name: ………………………………………………………………………………

Designation: ………………………………………………………………………………

Agency: ………………………………………………………………………………

Date: ………………………………………………………………………………

Review date: ………………………………………………………………………………

Copies to: Authorised person
Health professional
Head of setting

C3a Example individual care plan for the administration of buccal midazolam, as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: ………………………………………………… **DOB:** …………………………… **Hosp No:** …………………………………   **Address:** ……
Description of type of fit/convulsions/seizure which requires Buccal Midazolam:-   Insert description   * lasting …………… minutes ☐   or * repetitive over …………… minutes ☐   without regaining consciousness   * delete as appropriate

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

The dose of Buccal Micazolam should be ……………………… milligrams   = ……………………… ml of Buccal Midazolam   This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop   This should occur in 5-10 minutes.   **If the seizure does not stop, then phone 999 for ambulance.**   Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **buccal midazolam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **buccal midazolam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

1. informing anyone who needs to know, if buccal midazolam has been given;
2. maintaining adequate and in-date supply of medication at the setting;
3. notifying the setting if there are any changes to medication dose / type;
4. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): ……………………………………………………………………………………………

Signature ……………………………………………………………………………… Date: …………………………………………

PARENT/CARER (Block Capitals): ………………………………………………… Tel No. ……………………………………….

Signature ……………………………………………………………………………… Date: …………………………………………

OLDER CHILD/YOUNG PERSON (Block Capitals): ……………………………………………………………………………….

Signature ………………………………………………………………………… Date: ………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): ……………………………………………………………………………

Signature ……………………………………………………………………… Date: ………………………………………

AUTHORISED PERSON(S) TO ADMINISTER BUCCAL MIDAZOLAM

NAME (Block Capitals) ……….

Signature …………………………………………………………………………… Date: ………………………………………

NAME (Block Capitals) ……….

Signature ……………………………………………………………………… Date: ………………………………………

NAME (Block Capitals) ……….

Signature ………………………………………………………………………… Date: ………………………………………

NAME (Block Capitals) ……….

Signature ……………………………………………………………………… Date: ………………………………………

** delete as appropriate*

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

C3b Buccal Midazolam - Guidelines for the administration (liquid preparation 10mgs per 1ml or 10mgs per 2mls)

Action	Rationale
Note time seizure begins	Preparation in case administration is needed
Request someone ring 999 or arrange for the child to be escorted to the nearest hospital receiving emergencies. Contact parent/carer	As per Individual Care Plan (ICP) between consultant, parent and agency
Locate and obtain, in a timely manner, the child's buccal midazolam administration kit	
Check: • instruction on the individual care plan and its expiry date; • name and expiry date of medicine, strength and formulation and ensure this matches the care plan; • the name of the patient on the pharmacy label matches that on the care plan	To prevent error in administration from occurring
Put on gloves and apron	In accordance with infection control policies and guidelines
Remove the lid from the bottle containing the midazolam liquid	To ensure access to the liquid
User the **oral** syringe to draw up the prescribed amount of midazolam liquid Get dosage checked	To ensure correct dose
Child/young person should ideally be laying on his/her side. However if the child is in a wheelchair it may be more prudent for the child to be given buccal midazolam whilst sitting	To reduce leakage of drug from the mouth The safest place for a child having a seizure is on the floor or a bed.
Insert the syringe into the child's mouth between the cheek and the teeth/gums	The medicine is absorbed from the lining of the cheek
Slowly push half of the dose Remove the syringe from mouth and rub cheek Add other half as above in other side	Leakage likely to be reduced if administered slowly More likely to remain in correct location Prevent swallowing or retention of syringe
Arrange for transfer to hospital	Maintaining safety of the child/young person (see individual care plan)
Complete report form – copies as indicated on form including to hospital with child if possible. Original to be kept in child's agency record	To enable monitoring of administration of buccal midazolam and update child's health records

C3c Buccal Midazolam – Administration Report Form

NAME OF CHILD:	**DOB:**
DATE OF SEIZURE / CONVULSION:	
TIME SEIZURE / CONVULSION STARTED: **ACTIVITY WHEN SEIZURE / CONVULSION BEGAN:** **DESCRIPTION OF SEIZURE / CONVULSION:**	
TIME BUCCAL MIDAZOLAM GIVEN **DOSE GIVEN** **GIVEN BY** 1. ________ ________ ________ 2. ________ ________ ________ **ANY DIFFICULTIES IN ADMINISTRATION?** **TIME SEIZURE / CONVULSTION STOPPED:**	
TIME CHILD TAKEN TO HOSPITAL: **ANY OTHER NOTES ABOUT INCIDENT (e.g. injuries to child or other parties, child sleepy)**	
SIGNED (authorised person): **DATE:** **DESIGNATION:**	**NAME (print):**

C3d Training agreement for volunteers identified by head teacher to administer buccal midazolam

NAME: ……………………………………………………………………………………

SETTING: ……………………………………………………………………………………

Verbal and Written Instructions	Received
- Epilepsy awareness	Y/N
- First aid for epileptic seizures	Y/N
- Awareness of child / young person's specific Agreement Form which includes	
The preparation of buccal midazolam	Y/N
When to administer buccal midazolam	Y/N
The dose to be given	Y/N
Whether 2nd dose is indicated	Y/N
What to include in the "kit"	Y/N
- Procedure for administration of buccal midazolam	Y/N
- Care following administration	Y/N
Support to child	Y/N
Transfer to hospital	Y/N
Record of procedures – report form	Y/N
Safe disposal of used equipment	Y/N

Practical

- Demonstration from health professional on the administration of buccal midazolam (using a placebo)	Y/N
- Practice of the procedure until confident	Y/N

-

Other (specify)

-

Declaration

I ……………………………………………………………………… confirm that I have been trained to use buccal midazolam as detailed overleaf.

Signed: ………………………………………………………………………………

Date: ……………………………………

Training given by:

Name: ………………………………………………………………………………

Designation: ………………………………………………………………………………

Agency: ………………………………………………………………………………

Date: ………………………………………………………………………………

Review date: ………………………………………………………………………………

Copies to: Authorised person
Health professional
Head of setting

C4a Example individual care plan for the administration of Buccolam Oromucosal Solution (2.5mgs), as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: ………………………………………………… **DOB:** …………………………… **Hosp No:** …………………………………

Address: ……

Description of type of fit/convulsions/seizure which requires Buccolam:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

Buccolam (oro-mucosal solution) 2.5mgs in the pre-filled YELLOW labelled syringe

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **Buccolam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **Buccolam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

1. informing anyone who needs to know, if Buccolam has been given;
2. maintaining adequate and in-date supply of medication at the setting;
3. notifying the setting if there are any changes to medication dose / type;
4. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): ……………………………………………………………………………………………

Signature ……………………………………………………………………………   Date: ………………………………………..

PARENT/CARER (Block Capitals): ………………………………………………   Tel No. ……………………………………..

Signature …………………………………………………………….………   Date: …………………………………………

OLDER CHILD/YOUNG PERSON (Block Capitals): …………………………………………………………..………………….

Signature ………………………………………………………………………   Date: ……………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): ………………………...……………………………………………

Signature ………………………………………………………………………   Date: ……………………………………………

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM

NAME (Block Capitals) ………..

Signature ……………………………………………………………………………   Date: ……………………………………………

NAME (Block Capitals) ……

Signature ……………………………………………………………………………   Date: …………………………………………

NAME (Block Capitals) ………

Signature ……………………………………………………………………………   Date: …………………………………………

NAME (Block Capitals) ………

Signature ………………………………………………………………………………   Date: …………………………………………

** delete as appropriate*

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

C4b Example individual care plan for the administration of Buccolam Oromucosal Solution (5mgs), as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: …………………………………………………………**DOB:** ……………………………**Hosp No:** …………………………………

Address: ………

Description of type of fit/convulsions/seizure which requires Buccolam:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

Buccolam (oro-mucosal solution) 5mgs in the pre-filled BLUE labelled syringe

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **Buccolam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **Buccolam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

5. informing anyone who needs to know, if Buccolam has been given;
6. maintaining adequate and in-date supply of medication at the setting;
7. notifying the setting if there are any changes to medication dose / type;
8. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): ……………………………………………………………………………………

Signature …………………………………………………………………………… Date: ……………………………………….

PARENT/CARER (Block Capitals): ………………………………………………… Tel No. …………………………………….

Signature …………………………………………………………………………… Date: ……………………………………….

OLDER CHILD/YOUNG PERSON (Block Capitals): ……………………………………………………………………………

Signature …………………………………………………………………………… Date: ……………………………………….

HEAD OF ADMINISTERING SETTING (Block Capitals): ……………………………………………………………………

Signature …………………………………………………………………………… Date: ……………………………………….

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM

NAME (Block Capitals) ………

Signature …………………………………………………………………………… Date: ……………………………………….

NAME (Block Capitals) ………

Signature …………………………………………………………………………… Date: ……………………………………….

NAME (Block Capitals) ………

Signature …………………………………………………………………………… Date: ……………………………………….

NAME (Block Capitals) ………

Signature …………………………………………………………………………… Date: ……………………………………….

** delete as appropriate*

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

C4c Example individual care plan for the administration of Buccolam Oromucosal Solution (7.5mgs), as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: ……………………………………………………**DOB:** …………………………… **Hosp No:** …………………………………

Address: ………

Description of type of fit/convulsions/seizure which requires Buccolam:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

Buccolam (oro-mucosal solution) 7.5mgs in the pre-filled PURPLE labelled syringe

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **Buccolam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **Buccolam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

9. informing anyone who needs to know, if Buccolam has been given;
10. maintaining adequate and in-date supply of medication at the setting;
11. notifying the setting if there are any changes to medication dose / type;
12. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): …………………………………………………………………………………………

Signature ………………………………………………………………………… Date: ………………………………………..

PARENT/CARER (Block Capitals): ……………………………………………… Tel No. ……………………………………..

Signature ……………………………………………………………………… Date: ………………………………………….

OLDER CHILD/YOUNG PERSON (Block Capitals): ………………………………………………………………………………….

Signature ……………………………………………………………………… Date: ……………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): …………………………………………………………………………

Signature ……………………………………………………………………… Date: ……………………………………………

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM

NAME (Block Capitals) ……

Signature ………………………………………………………………………… Date: ……………………………………………

NAME (Block Capitals) …….

Signature ………………………………………………………………………… Date: …………………………………………

NAME (Block Capitals) ………

Signature ………………………………………………………………………… Date: …………………………………………

NAME (Block Capitals) ……….

Signature ……………………………………………………………………………… Date: …………………………………………

** delete as appropriate*

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

C4d Example individual care plan for the administration of Buccolam Oromucosal Solution (10mgs), as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: …………………………………………… **DOB:** …………………………… **Hosp No:** ………………………………

Address: ………

Description of type of fit/convulsions/seizure which requires Buccolam:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

Buccolam (oro-mucosal solution) 10mgs in the pre-filled ORANGE labelled syringe

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **Buccolam** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **Buccolam** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

13. informing anyone who needs to know, if Buccolam has been given;
14. maintaining adequate and in-date supply of medication at the setting;
15. notifying the setting if there are any changes to medication dose / type;
16. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): ………………………………………………………………………………………

Signature ……………………………………………………………………… Date: ……………………………………….

PARENT/CARER (Block Capitals): ……………………………………………… Tel No. …………………………………….

Signature ……………………………………………………………………. Date: ……………………………………….

OLDER CHILD/YOUNG PERSON (Block Capitals): ……………………………………………………………………………..

Signature ……………………………………………………………………. Date: …………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): ………………………………………………………………………

Signature ……………………………………………………………………. Date: …………………………………………

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM

NAME (Block Capitals) ……

Signature ………………………………………………………………………… Date: …………………………………………

NAME (Block Capitals) …….

Signature ………………………………………………………………………… Date: ………………………………………

NAME (Block Capitals) ……

Signature ………………………………………………………………………… Date: ………………………………………

NAME (Block Capitals) ………..

Signature ……………………………………………………………………………… Date: ………………………………………

** delete as appropriate*

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

C4e Guidelines for the administration of Buccolam (pre-filled syringes 5mg per ml)

Action	Rationale
Note time seizure begins	Preparation in case administration is needed
Request someone ring 999 or arrange for the child to be escorted to the nearest hospital receiving emergencies. Contact parent/carer	As per Individual Care Plan (ICP) between consultant, parent and agency
Locate and obtain, in a timely manner, the child's buccolam administration kit	
Check: • instruction on the individual care plan and its expiry date; • name and expiry date of medicine, strength and formulation and ensure this matches the care plan; • the name of the patient on the pharmacy label matches that on the care plan	To prevent error in administration from occurring
Put on gloves and apron	In accordance with infection control policies and guidelines
Always make sure tamper proof seal is not broken. Take one plastic tube, break the tamper proof seal and remove syringe containing Buccolam	To ensure access to the liquid
Remove and discard the red syringe cap before use to avoid choking. **Do not** put a needle on the syringe – Buccolam must NOT be injected	To avoid choking
Check syringe label	To ensure correct does is administered
Child/young person should ideally be laying on his/her side. However if the child is in a wheelchair it may be more prudent for the child to be given buccolam whilst sitting	To reduce leakage of drug from the mouth The safest place for a child having a seizure is on the floor or a bed.
Insert the syringe into the child's mouth between the cheek and the teeth/gums	The medicine is absorbed from the lining of the cheek
Slowly push half of the dose Remove the syringe from mouth and rub cheek Add other half as above in other side	Leakage likely to be reduced if administered slowly More likely to remain in correct location Prevent swallowing or retention of syringe
Arrange for transfer to hospital	Maintaining safety of the child/young person (see individual care plan)
Complete report form – copies as indicated on form including to hospital with child if possible. Original to be kept in child's agency record	To enable monitoring of administration of buccolam and update child's health records

C5a Example individual care plan for the administration of rectal paraldehyde, as treatment for epileptic seizures / fits / convulsions, by non-health staff.

1. TO BE COMPLETED BY A PRESCRIBER (CLINICIAN), PARENT, HEAD OF THE ADMINISTERING SETTING AND THE AUTHORISED PERSON
2. THE HEAD OF THE SETTING AND PARENT MUST FACILITATE A REVIEW OF THIS ICP WITH THE PRESCRIBER AFTER 12 MONTHS FROM THE PRESCRIBER'S LAST SIGNATURE. THIS MUST OCCUR WITHIN 30 DAYS OF THE INTENDED REVIEW DATE.

NAME OF CHILD: ……………………………………………… **DOB:** …………………………… **Hosp No:** ……………………………….

Address: ……

Description of type of fit/convulsions/seizure which requires Rectal Paraldehyde:-
Insert description

* lasting ………….. minutes ☐
or * repetitive over ………….. minutes ☐
without regaining consciousness
* delete as appropriate

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

The dose of Rectal Paraldehyde should be …………..mls 50/50 ready mixed paraldehyde and olive oil.

This should be prepared and administered by an authorised person (see over) in accordance with the procedure endorsed by the indemnifying agency, which would normally be the Local Education Authority.

The normal reaction to this dose is that the seizure should stop
This should occur in 5-10 minutes.

If the seizure does not stop, then phone 999 for ambulance.

Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

After **rectal paraldehyde** has been given the child must be assessed by a healthcare professional (e.g. paramedic or school nurse). The health care professional (or parent or someone with parental responsibility if present) will decide if there is a need to transfer to a hospital. If a healthcare professional is not available, the establishment must call 999 for an ambulance. Remember to tell the ambulance staff the exact time and dose of medication given (see the report form)

After **rectal paraldehyde** is given, please complete the report form giving a clear account of the incident. Copies should go with the child to the Emergency Department and to the parent. The original should be kept by the administering agency.

The parents will be responsible for:

17. informing anyone who needs to know, if Buccolam has been given;
18. maintaining adequate and in-date supply of medication at the setting;
19. notifying the setting if there are any changes to medication dose / type;
20. sorting out the review of the Individual Care Plan (ICP)

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAL) (Block Capitals): ………………………………………………………………………………………

Signature ……………………………………………………………………………… Date: …………………………………………..

PARENT/CARER (Block Capitals): ………………………………………………… Tel No. ……………………………………..

Signature ………………………………………………………………………… Date: ………………………………………….

OLDER CHILD/YOUNG PERSON (Block Capitals): ……………………………………………………………………..……………….

Signature ……………………………………………………………………… Date: ……………………………………………

HEAD OF ADMINISTERING SETTING (Block Capitals): ………………………….……………………………………….………

Signature ……………………………………………………………………… Date: ……………………………………………

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM

NAME (Block Capitals) ………

Signature ………………………………………………………………………… Date: ……………………………………………

NAME (Block Capitals) ……….

Signature ………………………………………………………………………… Date: …………………………………………

NAME (Block Capitals) ……

Signature ………………………………………………………………………… Date: …………………………………………

NAME (Block Capitals) ………..

Signature ……………………………………………………………………………… Date: …………………………………………

** delete as appropriate*

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

C5b Rectal Paraldehyde – Guidelines for Administration

Action	Rationale
Note time seizure begins	Preparation in case administration is needed
Request someone ring 999 or arrange for the child to be escorted to the nearest hospital receiving emergencies. Contact parent/carer	As per Individual Care Plan (ICP)
Locate and obtain, in a timely manner, the child's rectal paraldehyde administration kit	
Check: • instruction on the individual care plan and its expiry date; • name and expiry date of medicine, strength and formulation and ensure this matches the care plan; • the name of the patient on the pharmacy label matches that on the care plan	To prevent error in administration from occurring
Put on gloves and apron	In accordance with infection control policies and guidelines
Obtain Rectal Paraldehyde and olive oil, draw up correct amount of Paraldehyde by attaching kwill to the syringe and mix with equal volume of oil. If ready mixed, draw up correct volume in syringe, no need for mixing. Gently mix the contents in the syringe.	
Check syringe contains the correct amount of paraldehyde according to the seizure procedure	To ensure correct does is administered
Place the child/young person on their left side if possible **Be sure to maintain your own safety**	To allow ease of access to the rectum, the left lateral position anatomically assists retention of medication. Laying an unconscious person on their side maintains the airways.
Loosen / remove items of clothing respecting privacy and dignity.	Allow access in a dignified manner
Note time Decide to administer the rectal paraldehyde	
Check medication against individual care plan	To ensure accurate dose
Squeeze the syringe gently expelling the liquid Note: some liquid is designed to be left in the tube following administration	Te ensure the full dose is administered
Gently hold the buttocks together If the child has their bowels open DO NOT re-administer the dose	To prevent seepage To prevent overdose

Action	Rationale
Record the time of administration	To know when the medication will start to take effect
Remain with the child/young person until the seizure has stopped. Continue to observe breathing and the effects of the rectal paraldehyde.	Maintaining safety of the child/young person. To monitor the effect of the rectal paraldehyde
Arrange for transfer to hospital	Maintaining safety of the child/young person (see individual care plan)
Dispose of equipment as per agency guidelines and procedures	In line with LPT policies and guidelines
Complete report form – copies as indicated on form including to hospital with child if possible. Original to be kept in child's agency record	To enable monitoring of administration of rectal paraldehyde and update child's health records

C5c Rectal Paraldehyde – Administration Report Form

NAME OF CHILD:	**DOB:**
DATE OF SEIZURE / CONVULSION:	
TIME SEIZURE / CONVULSION STARTED: **ACTIVITY WHEN SEIZURE / CONVULSION BEGAN:** **DESCRIPTION OF SEIZURE / CONVULSION:**	
TIME RECTAL PARALDEHYDE GIVEN **DOSE GIVEN** **MLS** **GIVEN BY** 1. ______ ______ ______ ______ 2. ______ ______ ______ ______ **ANY DIFFICULTIES IN ADMINISTRATION?** **TIME SEIZURE / CONVULSTION STOPPED:**	
TIME CHILD TAKEN TO HOSPITAL: **ANY OTHER NOTES ABOUT INCIDENT (e.g. injuries to child or other parties, child sleepy)**	
SIGNED (authorised person): **NAME (print):** **DATE:** **DESIGNATION:**	

C5d Training agreement for volunteers identified by head teacher to administer rectal paraldehyde

NAME: ……………………………………………………………………………………

SETTING: ……………………………………………………………………………………

Verbal and Written Instructions	Received
- Epilepsy awareness	Y/N
- First aid for epileptic seizures	Y/N
- Awareness of child / young person's specific Agreement Form which includes	
The preparation of rectal paraldehyde	Y/N
When to administer rectal paraldehyde	Y/N
The dose to be given	Y/N
Whether 2nd dose is indicated	Y/N
What to include in the "kit"	Y/N
- Procedure for administration of rectal paraldehyde	Y/N
- Care following administration	Y/N
Support to child	Y/N
Transfer to hospital	Y/N
Record of procedures – report form	Y/N
Safe disposal of used equipment	Y/N

Practical

- Demonstration from health professional on the administration of rectal paraldehyde (using a placebo)	Y/N
- Practice of the procedure until confident	Y/N

-

Other (specify)

-

Declaration

I ………………………………………………………………………… confirm that I have been trained to use rectal paraldehyde as detailed overleaf.

Signed: ……………………………………………………………………………

Date: ……………………………………

Training given by:

Name: ……………………………………………………………………………

Designation: ……………………………………………………………………………

Agency: ……………………………………………………………………………

Date: ……………………………………………………………………………

Review date: ……………………………………………………………………………

Copies to: Authorised person
Health professional
Head of setting

APPENDIX D – EMERGENCY ACTION PLANS FOR ANAPHYLAXIS FROM HEALTH PROFESSIONALS

D1 Types of Adrenaline Auto-injectors

Epipen

Old Style Epipen

Jext

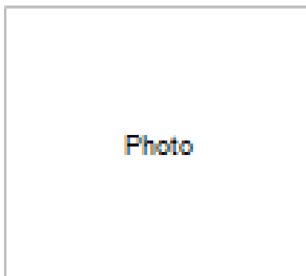
Allergy: Emergency Action Plan with ***Antihistamine***

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:



Parent / Carer details:

1)

2)

Mild to Moderate Reaction:

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

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- Contact parent / carer

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

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

If ANY ONE of these signs are present:

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

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

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

<u>Allergy: Emergency Action Plan with Antihistamines</u>

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

PARENT/GUARDIAN

NAME: ……………………………………………. **Tel No:** ………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

Emergency telephone contact number ………………………………………………………………

HEAD OF ADMINISTERING SETTING

NAME: …………………………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE

NAME: …………………………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME: ……………………………………………. **Tel No:** ………………………….

Signature: …………………………………………… Date ____ / ____ / 20______

Designation: ………………………………………………………………………………

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan

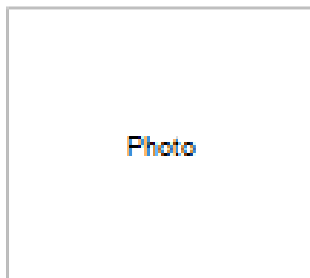
Allergy: Emergency Action Plan with *EpiPen®*

KNOWN ALLERGIES:

Name:

Preferred Name:

Date of Birth:



Parent / Carer details:

1)

2)

Mild to Moderate Reaction:

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

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- Contact parent / carer
- Locate EpiPen®

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

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

If ANY ONE of these signs are present:

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

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

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

How to give EpiPen®

Step 1

Step 1. Lie down with your leg slightly elevated or sit up if breathing is difficult

Step 2

Step 2. Grasp your EpiPen® in your dominant hand with the blue safety cap closest to your thumb and remove cap

Step 3

Step 3. Hold the EpiPen® about 10cm away from your leg, swing and jab the orange tip into the outer thigh. Hold in place for 10 seconds. Remove EpiPen®

Step 4

Step 4. Massage the injection area for 10 seconds. You must dial 999 immediately, ask for an ambulance and state anaphylaxis.

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

Please complete Report Form (appendix B3), giving clear

Allergy: Emergency Action Plan with Epipen®

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

PARENT/GUARDIAN

NAME: ……………………………………………. **Tel No:** ………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

Emergency telephone contact number ……………………………………………………………

HEAD OF ADMINISTERING SETTING

NAME: …………………………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND EPIPEN®

NAME: …………………………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

NAME: …………………………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME: ……………………………………………. **Tel No:** ………………………….

Signature: ……………………………………………. Date ____ / ____ / 20______

Designation: ……………………………………………………………………………

I have prescribed a second EpiPen® to be given (circle) Yes No

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan

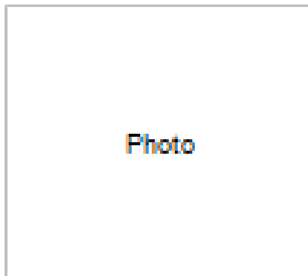
Allergy: Emergency Action Plan with *Jext®*

KNOWN ALLERGIES:

Name:

Preferred Name:

Date of Birth:



Parent / Carer details:

1)

2)

Mild to Moderate Reaction:

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

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- Contact parent / carer
- Locate Jext®

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

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

If ANY ONE of these signs are present:

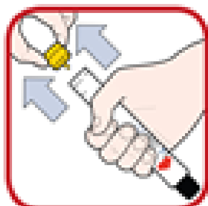
- **Lie child flat.** If breathing is difficult, allow to sit
- **Give Jext®** (circle) **150 micrograms 300 micrograms**
- **Dial 999 for an ambulance* and say ANAPHYLAXIS ("ANA-FIL-AX-IS")**
- **Stay with the child**
- **If no improvement after 5-10 minutes, give a further Jext® dose** (if prescribed)

(please check overleaf)

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

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

How to give Jext®



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

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

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

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

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

Please complete Report Form (appendix B3), giving clear

Allergy: Emergency Action Plan with Jext®

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

PARENT/GUARDIAN

NAME: ………………………………………….. **Tel No:** ………………………….

Signature: ………………………………………….. Date ____ / ____ / 20______

Emergency telephone contact number ……………………………………………………………

HEAD OF ADMINISTERING SETTING

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND JEXT®

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME: ………………………………………….. **Tel No:** ………………………….

Signature: ………………………………………….. Date ____ / ____ / 20______

Designation: ……………………………………………………………………………

I have prescribed a second Jext® to be given (circle) **Yes** **No**

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan

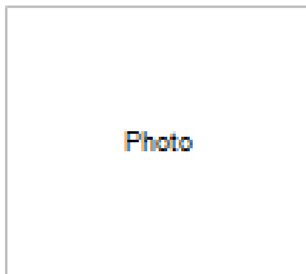
Allergy: Emergency Action Plan with *old style EpiPen®*

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:



Parent / Carer details:

1)

2)

Mild to Moderate Reaction:

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

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- Contact parent / carer
- Locate EpiPen®

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS

(Severe allergic reaction):

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

If ANY ONE of these signs are present:

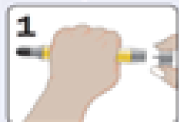
- **Lie child flat.** If breathing is difficult, allow to sit
- **Give EpiPen®** (circle) EpiPen® Jr EpiPen®
- **Dial 999 for an ambulance* and say ANAPHYLAXIS ("ANA-FIL-AX-IS")**
- **Stay with the child**
- **If no improvement after 5-10 minutes, give a further EpiPen® dose** (if prescribed)

(please check overleaf)

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

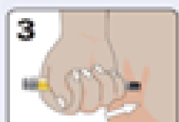
*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

How to give EpiPen® or EpiPen® Jr

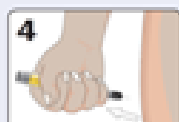


Form fist around EpiPen® and PULL OFF GREY SAFETY CAP.

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



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



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

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

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

Please complete Report Form (appendix B3), giving clear

Allergy: Emergency Action Plan with old style Epipen®

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

PARENT/GUARDIAN

NAME: ………………………………………….. **Tel No:** ………………………….

Signature: ………………………………………….. Date ____ / ____ / 20______

Emergency telephone contact number ……………………………………………………………

HEAD OF ADMINISTERING SETTING

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND EPIPEN®

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

NAME: …………………………………………..

Signature: ………………………………………….. Date ____ / ____ / 20______

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME: ………………………………………….. **Tel No:** ………………………….

Signature: ………………………………………….. Date ____ / ____ / 20______

Designation: …………………………………………………………………………

I have prescribed a second EpiPen® to be given (circle) Yes No

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND PRE-PREPARED ADRENALINE.

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: **……………………………………………**

Signature: …………………………………………… Date ____ / ____ / 20______

NAME: ***……………………………………………***

Signature: …………………………………………… Date ____ / ____ / 20______

APPENDIX E – DIABETES HEALTH FORMS FROM HEALTH PROFESSIONALS

Guidance for Settings on the Management of Diabetes Mellitus

Authors: James Greening Consultant Paediatric Diabetologist
Michelle Mottershaw Children's Diabetic Specialist Nurse
Maureen Burnett Medical Adviser to CYPS (Education),
Leicester, Leicestershire and Rutland

May 2010.

Introduction

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

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

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

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

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

Background

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

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

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

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

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

In order for a patient to have blood glucose testing, results recording and insulin administered by a setting's volunteer, all documentation as specified, i.e. the Individual Care Plan, Blood Glucose Testing and Insulin Injection 'update forms' and the Record of Completion of Training, will have to be completed in full, signed and up to date.

An ICP will be developed during consultation **with the doctor at the diabetes clinic**. Blood glucose testing times and result reporting requirements will be stated. The type of insulin injector equipment, dose and times of insulin and injection site will be stated. **Any changes to the regime agreed between the patient and the doctor will be documented by the doctor in an updated ICP, using the signed 'update forms' and the doctor or diabetes specialist nurse** (Diabetes Support Team) **will inform the authorised volunteers.** The ICP will be reviewed at least yearly to see if it continues to be appropriate e.g. discontinued if self administering (use Appendices E1 and E2).

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

Setting **staff** managing the blood testing or administration of insulin should receive appropriate **training** and support from health professionals. To support setting staff with this it is envisaged that the local Diabetes Support Team and Diabetes UK: East Midlands[5] will hold regular training and awareness sessions for setting staff working with children with diabetes[4]. Once the head of the setting has identified volunteers the school should contact the Diabetes Specialist Nurse[3] who will arrange the training. This would also be the process for training of new staff. Refresher sessions should be planned annually to keep staff up to date (Appendix E8).

Volunteers will be trained to the standard **to carry out the protocol** (see Appendices E6 and E7). They will keep a **copy of the appropriate protocols after their training** and their training will be **confirmed by signature by the authorised trainer and the prescribing doctor** (Appendix E9).

Notes

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

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

3) Contact telephone numbers at Leicester Royal Infirmary 9 am – 5 pm
   0116 258 6796 Diabetes Specialist Nurses Office
   0116 258 7737 Consultant Paediatric Diabetologists Office

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

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

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

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

References

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

E1 Agreement for self-testing of blood glucose in the school

Child or Young Person's Name: ……………………………………………………………………………………

Child or Young Person's DOB: …………………………………………………

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

1) All test equipment is supplied from home.

2) The school staff are aware of approximate times for testing.

Time(s): ……………………………………………………………………………………………..

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

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

5) Standard hygiene procedures are applied at all times.

6) * The child or young person self tests independently

* The child or young person self tests with minimal supervision

* (*insert details*)…………………………………………………………………………will attend the setting to do the tests

7) The child or young person will independently or with minimal supervision store all sharp objects and contaminated materials used for testing in a designated biohazard container (sharps bin) for which intermittent disposal and replacement arrangements are made in advance by the family[1].

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

9) The child or young person independently

* interprets the results and acts accordingly or

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

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

* delete as appropriate.

pto

[1] discuss with School Nurse or local Diabetes Support Team

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

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

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

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

Name of child: ……

Signed: ……………………………………………………………………………… Date: …………………………………………

Name of Parent: ………..

Signed: ……………………………………………………………………………. Date: …………………………………………

Emergency Contact Details:

Name: ……………………………………………………………………………… **Tel Home:** …………………………………….

Tel Work: …………………………………….

Name of Head teacher: ……

Signed: ……………………………………………………………………………… Date:…………………………………………….

Setting has original
cc Parents

As a minimum updated annually

E2 Agreement to self- injection of insulin for children with diabetes mellitus

Full Name of Child: ………………………………………………………………… Date of birth: ……………………………

This person has been diagnosed as having Diabetes Mellitus and requires insulin injections during school hours at the following times:

………

* He/she can carry their equipment and independently self administer the injections.

* He/she needs to store their equipment but can independently self administer the injections.

* He/she can carry their equipment but needs minimal supervision to self administer the injections

* He/she needs to store their equipment and *(insert name)* …………………………………………………… will attend the setting to give the injections.

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

Staff are acting voluntarily in this and cannot undertake to monitor equipment carried by the child. The school is not responsible for loss or damage to any medication or equipment.

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

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

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

Name of child: ………

Signed: ……………………………………………………………………… Date: ………………………………………

Name of Parent: ……..

Signed: ……………………………………………………………………. Date: ………………………………………

Emergency Contact Details:

Name: ……………………………………………………………………… **Tel Home:** ………………………………………

Tel Work: ………………………………………

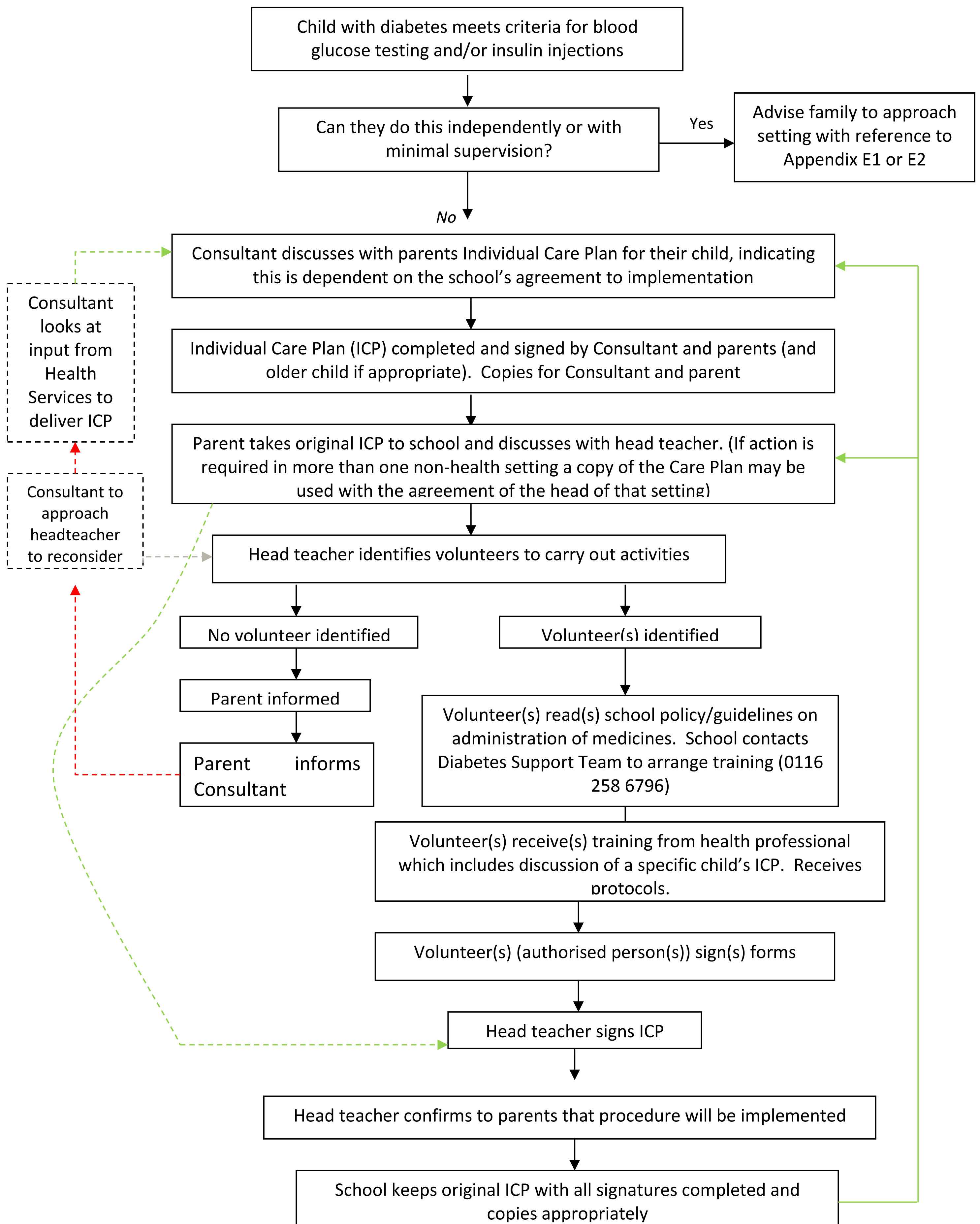
Name of Head teacher: ………

Signed: ……………………………………………………………………… Date:…………………………………………

Setting has original
cc Parents

As a minimum updated annually

E3 Process for establishing or revising an individual care plan for the management of diabetes mellitus in non-health settings



E4 *Example individual care plan for the management of diabetes mellitus by non-medical and non-nursing staff*

TO BE COMPLETED BY A CONSULTANT, PARENT, HEAD TEACHER AND THE AUTHORISED PERSON

NAME OF CHILD:	DOB:

This plan has been agreed by the following:

CONSULTANT (Block Capitals)…….

Signature: ……………………………………………………………………… Date: ……………………………………….....

PARENT/CARER(Block Capitals) ……

Signature: ………………………………………………………………………….. Date: ……………………………………….....

Emergency contact number: ………………………………………………………………………………………………………

OLDER CHILD/YOUNG PERSON *(if appropriate)* …………………………………………………………………………………….

Signature: ………………………………………………………………………….. Date: ………………………………………….....

HEAD TEACHER (Block Capitals)……………………………………………………………………………………………………….....

Signature: ……………………………………………………………………….. Date: ………………………………………….....

AUTHORISED PERSON(S) TO *TEST BLOOD GLUCOSE AND/OR *ADMINISTER PRE-PREPARED INSULIN INJECTION

NAME (Block Capitals): ……….

Signature: ……………………………………………………………………………. Date: ………………………………………….....

NAME (Block Capitals): ……….

Signature: ……………………………………………………………………………. Date: ………………………………………….....

NAME (Block Capitals): ……….

Signature: ……………………………………………………………………………. Date: ………………………………………….....

* delete as appropriate

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

SAMPLE

E5 Blood Glucose Testing

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and supplies at the school.
Staff should be aware of the emergency care for this child in response to a hypoglycaemic episode (hypo).
If the child refuses testing to not progress but immediately inform their parent /carer.

<u>BLOOD GLUCOSE TESTING</u>

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

o Check the blood glucose level at (*insert times or activities*) ………………………………………………………………
………
…
Dispose of test strip and pricker into sharps bin.
Record on the Record Sheet

* Report result to ……………………………………………………………………………… Tel: …………………………………………………

o Check the blood glucose level prior to insulin being given.
Dispose of test strip and pricker into sharps bin
Record on the Record Sheet
Within the range ……………………………… give insulin dose recorded in the ICP.

Outside the range immediately report result to: ………………………………………………………………………………
Tel: ………………………………………………………………………………

Give insulin dose advised by the above person <u>on this occasion only.</u>

Record dose on Record Sheet.

o If testing required tick one only.

* Delete as appropriate

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

SAMPLE

E6 Insulin Injection

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and medication at the school.
Staff should be aware of the emergency care for this child in response to a hypoglycaemic episode (hypo).
If the child refuses injection to not progress but immediately inform their parent /carer.

INSULIN INJECTION

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

The type of insulin is prescribed as:

Penfill cartridge injection ☐
Insulin bolus via pump ☐

TYPE OF INSULIN	INJECTION SITE	The subcutaneous **DOSE OF INSULIN** is			
		Breakfast	***Lunch***	***Dinner***	***Other*** *Enter time or activity*

Particular things to note are:

Action to take:

Dispose of needle into sharps bin

After administration of insulin, please complete the Record Sheet.

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

SAMPLE

E7 *Blood glucose test and/or insulin administration record sheet*

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

SAMPLE
FAIRFIELD COMMUNITY PRIMARY SCHOOL

* delete as appropriate

Original retained at setting

cc: Parent on request
Diabetes Support Team on request

E8 Protocol for Blood Glucose Testing

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

SAMPLE

E9 Protocol for Administration of Insulin

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

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

SAMPLE

E10 Example of Diabetes Awareness Training for School Staff

Programme

09.00 - 09.05	Welcome and Introduction Julie Orrey, East Midlands Regional Manager, Diabetes UK
09.05 - 09.20	Disability Equality Duty update Liz Mangle, Assistant SEN Officer, Nottinghamshire LEA
09.20 - 09.40	Basic overview of diabetes in children Josie Drew, Paediatric Consultant
09.40 - 10.00	What support is available to schools Helen Marsh, Paediatric Diabetes Specialist Nurse
10.00 - 10.20	Refreshments
10.20 - 10.40	Hypo management Vreni Verhoeven, Paediatric Diabetes Specialist Nurse
10.40 - 11.00	Food & activity Anna Clark, Dietician

Split into 2 groups for practical demonstrations

11.00 - 12.00	Pens & insulin administration Helen Marsh, Paediatric Diabetes Specialist Nurse
(30 minutes each session)	Meters & blood testing Vreni Verhoeven, Paediatric Diabetes Specialist Nurse
12.00 - 12.30	Panel Q & A session
Close	

SAMPLE
FAIRFIELD COMMUNITY PRIMARY SCHOOL

E11 Example record of completion of training for blood glucose testing and/or insulin administration by non-medical and non-nursing staff

To: Head of Setting

RE: Name of person………

Date of Birth:……………………………………………………………………………………

Name of setting working at………

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

……………..…………….…..............

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

AUTHORISED TRAINER

(Block Capitals)………………………………….................. Designation……………………………………………

Signature ……………………………………………….............. Date…………………………………………………........

Agency………………………………………………………………… Contact Number………………………………………

CONSULTANT

(Block Capitals)…………………………………………………………………….....................................………….

Signature ………………………………………………………........... Date…………………………………………........

I confirm I have attended the training as recorded above:

AUTHORISED PERSON(S) NAME

(Block Capitals)……………………………………………………………………………………………….........……………

Signature………………………………………………………………….. Date……………………………………………

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

TRAINING SHOULD BE UPDATED ANNUALLY

APPENDIX F – STATUTORY GUIDANCE ON SUPPORTING PUPILS AT SCHOOL WITH MEDICAL CONDITIONS (DFE DOCUMENT)

Double click the icon to view this document

Appendix F -
Statutory guidance o

Policy	*Medication Policy and Management Procedures*
Reviewing Committee	*Health & Safety*
Last Reviewed	
Ratified by Governing Body	