North Ferriby C E Primary School

Managing Medicines in School Policy

Date of New Policy:	**Autumn 2018**
Review Date:	**Autumn 2020**
Policy Type:	**School**
Co-ordinator:	**Russ Orr**
Link Governor:	**Derek Shepherd**
Committee:	**Full Governors**

North Ferriby CE Primary School Mission Statement:

A Christian School with children at its heart.

Christian Values Statement:

At North Ferriby CE Primary School, we keep Christian values at the heart of our school community where we live, love and learn together.

Ethos Statement for North Ferriby CE VC Primary:

Recognising its historic foundation, the school will preserve its religious character in accordance with the principles of the Church of England and in partnership with the Church at parish and diocesan level.

The school aims to serve its community by providing an education of the highest quality within the context of Christian belief and practice.

It encourages an understanding of the meaning and significance of faith and promotes Christian values through the experience it offers to all its pupils.

YORK DIOCESAN BOARD OF EDUCATION

Aims of the policy:

- To help the school in providing equality of opportunity for all.
- To ensure that wherever possible and practical, medical needs do not become barriers to school attendance.
- To provide clear procedures which ensure the safe handling and administering of medicines when it is necessary to do so.

Introduction:

1. Children with medical needs have the same rights of admission to a school or setting as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis. *[extract from DfES document 'Managing Medicines in Schools and Early Years Setting]*

2. Parents/carers have the prime responsibility for their child's health and should provide schools and settings with information about their child's medical condition. Parents/carers, and the child if appropriate, should obtain details from their child's General Practitioner (GP) or paediatrician, if needed. The school doctor or nurse or a health visitor and specialist voluntary bodies may also be able to provide additional background information for staff. *[extract from DfES document 'Managing Medicines in Schools and Early Years Setting]*

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

4. The school will attempt to ensure that they have sufficient members of staff who are willing and appropriately trained to manage medicines.

5. **This policy attempts to address the following:**

- procedures for managing prescription medicines which need to be taken during the school 'day'
- procedures for managing prescription medicines on school visits
- a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
- a clear statement on parental responsibilities in respect of their child's medical needs
- the need for prior written agreement from parent/carer for any medicines to be given to a child
- the school or setting policy on assisting children with long-term or complex medical needs
- policy on children carrying and taking their medicines themselves
- staff training in managing medicines safely and supporting an identified individual child
- record keeping
- safe storage of medicines

CHAPTER 1: MANAGING MEDICINES POLICY:

Non-Prescription Medicines

6. Non-prescription medicines will not be administered or even self-administered at school unless clear medical evidence is provided demonstrating that the child's attendance at school would be affected by non-administration (*e.g. the use of calpol to relieve migraines and thus avoid the need to send a pupil home*).

7. In cases where the school *does agree* to administer non-prescription medicines, a **'Pupil Healthcare Plan'** [Form B] must be completed by parents/carers.

8. N.B. A child under 16 should never be given any 'aspirin-containing' medicine unless prescribed by a doctor.

Prescribed Medicines

9. When medicines are prescribed to children the desirable option is for the medicine to be administered outside of school hours. The **'MANAGING MEDICINES IN SCHOOLS AND EARLY YEARS SETTINGS' Document (**Department for Education and Skills & Department of Health) states:

> It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable it to be taken outside school hours. **Parents could be encouraged to ask the prescriber about this**. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.
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> The Medicines Standard of the National Service Framework (NSF) for Children[1] recommends that a range of options are explored including:
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> - Prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours

10. If the above option is not possible then the next desirable option is for a parent or other nominated adult to attend school at the time recommended by the prescription in order to administer the medicine to the child.

11. If a parent/carer provides clear proof in writing that neither of these options are available, then the school will enter into an agreement whereby staff will make every effort to administer the medicine according to the prescription.

12. The Medicines Standard of the National Service Framework (NSF) for Children[2] recommends:
    - **prescribers should consider providing two prescriptions for a child's medicines: one for home and one for use in the school or setting.**

13. Having considered all of the above points, medicines will still only be taken to school when essential; that is ***where it would be detrimental to a child's health if the medicine were not administered during the school 'day'***. Only medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber will be accepted. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration and dosage.

14. The parent/carer must fill out and sign a **'parental agreement'** [Form D]. The head must then complete, sign and return a **'Headteacher's agreement'** [Form E].

15. The school is advised to: ***never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions***.

Controlled Drugs

16. The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations (see Annex A). Some may be prescribed as medicine for use by children, e.g. methylphenidate.

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

18. The school will keep any controlled drugs in a locked non-portable container and only named staff will have access. A record will be kept for audit and safety purposes.

19. A controlled drug, as with all medicines, will be returned to the parent/carer when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it will be returned to the dispensing pharmacist (details should be on the label).

20. Misuse of a controlled drug, such as passing it to another child for use, is an offence. Please refer to our 'Misuse of Drugs' policy for further information.

Long-Term Medical Needs:

21. The most common long-term medical needs faced by schools are allergies, asthma and diabetes.

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

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

24. It is vital that we are made aware of any particular needs before a child is admitted, or when a child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. In these situations a written ***health care plan*** will be produced, involving the parents/carers and relevant health professionals.

25. For pupils with **allergies** the school will often be provided with a treatment Plan drawn up by the GP or specialist. If not then parents/carers will be required to complete the schools **'Allergy Treatment Plan'** [Form C]. In either case the school will be in possession of a clear course of action for staff to follow should an allergic reaction occur. All school staff will also receive regular and relevant training.

26. For pupils with **asthma** an '**Asthma Inhaler Form'** [Form G] must be completed by parents/carers. On it, the following will be stipulated:

    - The type of inhaler prescribed.
    - Whether a duplicate inhaler will be kept in school or not.
    - Whether the child or an adult will be responsible for the inhaler.

27. If parents/carers do not wish for their child to take personal responsibility for their inhaler, the class teacher will make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers will always available during physical education, sports activities and educational visits.

Administering Medicines

28. The school will ensure that medicine is administered providing willing and trained staff are available at the time that the medicine is due to be administered.

29. No child will be given medicines unless the '**Parental agreement for school to administer medicine'** [Form D] has been completed.

30. The member of staff administering the medicine must read Form D first to ensure that they are complying with the instructions of the prescriber. They must also consult the '**Record of medicines administered'** [Form F] to ensure that administration has not already taken place. If they are in any doubt about any

procedure staff should not administer the medicines but check with the Headteacher before taking further action.

31. The school will keep a written record of medicine administration [Form F]**.** Staff will complete and sign the record each time medicines are given. [see also 'procedures for staff administering medicines' – appendix 1]

Self-Management

32. It is good practice to support and encourage children, who are able, to take responsibility to manage their own medicines from a relatively early age and schools should encourage this. The age at which children are ready to take care of, and be responsible for, their own medicines, varies.

33. If children can take their medicines themselves, staff may only need to supervise. This will be made clear on Form D.

Refusing Medicines

34. If a child refuses to take medicine, staff should not force them to do so, but should note this in the records and, in the case of a pupil with a health care plan, follow agreed procedures. Parents/carers should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the school or setting's emergency procedures should be followed.

Educational Visits

35. The schools will consider what reasonable adjustments to make to enable children with medical needs to participate fully and safely on visits. This might include reviewing and revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medical needs. It might also include risk assessments for such children.

36. Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor (TA or adult helper) might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions will always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans will be taken on visits in the event of the information being needed in an emergency.

37. If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek the views of parents/carers and take medical advice from the school health service or the child's GP. See DfES guidance on planning educational visits.

Sporting Activities

38. Most children with medical conditions can participate in physical activities and extra-curricular sport. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

39. Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures. [More details about specific health conditions can be found in the '**Supplementary Document to the Managing Medicines Policy**']

Safety Management

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

Storing Medicines

41. Large volumes of medicines should not be stored. The school will only store, supervise and administer medicine that has been prescribed for an individual child. Medicines will be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed.

42. Non-emergency medicines will be stored securely, out of reach of children. They will be kept together with copies of the '**Parental agreement for school to administer medicine**' [Form D] and the '**Record of medicines administered'** [Form F].

43. Where a child needs two or more prescribed medicines, each will be in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

44. The head is responsible for making sure that medicines are stored safely. All emergency medicines, such as asthma inhalers and adrenaline pens, will be readily available to children and not locked away. Other non-emergency medicines will be kept in a secure place not accessible to children.

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

46. Local pharmacists can give advice about storing medicines.

Disposal of Medicines

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

48. Sharps boxes will always be used for the disposal of needles. Sharps boxes can be obtained by parents/carers on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the Local Authority's environmental services.

Hygiene and Infection Control

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

Emergency Procedures

50. Guidance on calling an ambulance is provided in 'Appendix 4, Form A'. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent/carer arrives. Health professionals are responsible for any decisions on medical treatment when parents/carers are not available. Staff should never take children to hospital in their own car; it is safer to call an ambulance.

51. Individual health care plans will include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency.

CHAPTER 2: ROLES AND RESPONSIBILITIES:

Introduction

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

Parents and Carers

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

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

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

56. If a child is 'looked after' by a local authority, the child may either be on a care order or be voluntarily accommodated. A Care Order places a child in the care of a local authority and gives the Local Authority parental responsibility for the child. The local authority will have the power to determine the extent to which this responsibility will continue to be shared with the parents. A local authority may also accommodate a child under voluntary arrangements with the child's parents. In these circumstances the parents will retain parental responsibility acting so far as possible as partners of the local authority. Where a child is looked after by a local authority day-to-day responsibility may be with foster parents, residential care workers or guardians.

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

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

The Head Teacher

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

60. The employer **must** ensure that staff receive proper support and training where necessary. Equally, there is a contractual duty on head teachers to ensure that their staff receive the training. As the manager of staff it is likely to be the head teacher who will agree when and how such training takes place.

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

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

63. If staff follow documented procedures, they should be fully covered by their employer's public liability insurance should a parent/carer make a complaint.

Teachers and Other Staff

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

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

66. Many voluntary organisations specialising in particular medical conditions provide advice or produce packs advising staff on how to support children. Appendix 6 lists contact details.

School Staff Giving Medicines

67. Any member of staff who agrees to accept responsibility for administering prescribed medicines to a child should have appropriate training and guidance. They should also be aware of possible side affects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

Primary Care and NHS Trusts

68. PCTs have a statutory duty to purchase services to meet local needs. PCTs and NHS Trusts may provide these services. PCTs, Local Authorities and school governing bodies should work in cooperation to determine need, plan and co-ordinate effective local provision within the resources available.

69. PCTs **must** ensure that there is a medical officer with specific responsibility for children with special educational needs (SEN). Some of these children may have medical needs. PCTs and NHS Trusts, usually through the school health service, may provide advice and training for staff in providing for a child's medical needs.

Health Services

70. The health service can provide advice on health issues to children, parents, carers, teachers, education welfare officers and Local Authorities. The main health contact for our school is the school nurse. The school health service can also provide guidance on medical conditions and, in some cases, specialist support for a child with medical needs.

71. The school nurse or doctor can help us draw up individual health care plans for pupils with medical needs, and is be able to supplement information already provided by parents/carers and the child's GP. The nurse or doctor also gives advise on training for school staff on administering medicines.

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

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

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

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