BATH & WELLS
Multi Academy Trust
'That they may have life, life in all its fullness' John 10:10

SUPPORTING STUDENTS WITH MEDICAL CONDITIONS

ABBAS AND TEMPLECOMBE CHURCH SCHOOL

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Contents

As a proprietor of one or more academies, the Bath and Wells Multi Academy Trust (BWMAT) has a legal duty to make arrangements for supporting pupils at the academy with medical conditions. The board of BWMAT has delegated this responsibility to the academy (school).

The academy (school) has adopted this policy to set out the arrangements it has put in place for its pupils with medical conditions.

Overriding principles

Children and young people with medical conditions are entitled to a full education. The academy is committed to ensuring that pupils with medical conditions are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential. We want all pupils, as far as possible, to access and enjoy the same opportunities at school as any other child. This will include actively supporting pupils with medical conditions to participate in school trips/visits and/or in sporting activities.

1 Definition of "medical condition"

1.1 For the purposes of this policy, a medical condition is any illness or disability which a pupil has. It can be:

- physical or mental
- a single episode or recurrent
- short-term or long-term
- relatively straightforward (e.g. the pupil can manage the condition themselves without support or monitoring) or complex (requiring on-going support, medicines or care whilst at school to help the pupil manage their condition and keep them well)
- involving medication or medical equipment
- affecting participation in school activities or limiting access to education
- affecting use of a defibrillator

1.2 Medical conditions may change over time, in ways that cannot always be predicted.

2 Policy implementation

2.1 The person with overall responsibility for the successful administering and implementation of this policy is the Headteacher.

2.2 The Headteacher has overall responsibility for ensuring:

- that sufficient staff are suitably trained to meet the known medical conditions of pupils at the academy
- all relevant staff are made aware of the pupil's medical condition and supply teachers are properly briefed
- cover arrangements are in place to cover staff absences/turnover to ensure that someone is always available and on site
- risk assessments for school visits, holidays and other school activities outside of the normal timetable are completed
- individual healthcare plans are prepared where appropriate and monitored
- all medications are stored safely (special consideration for controlled drugs)

3 Notification that a pupil has a medical condition

3.1 Ordinarily, the pupil's parent/carer will notify the academy that their child has a medical condition, or of any changes to their condition. Parents/carers should ideally provide this information in writing addressed to the Headteacher. However, they may sometimes pass this information on to a class teacher or another member of staff. Any staff member receiving notification that a pupil has a medical condition, or any changes to that condition, should notify the Headteacher as soon as practicable.

3.2 A pupil themselves may disclose that they have a medical condition. The staff member to whom the disclosure is made should notify the Headteacher as soon as practicable.

3.3 Notification may also be received direct from the pupil's healthcare provider or from a school from which a child may be joining the academy. The academy may also instigate the procedure themselves where the pupil is returning to the academy after a long-term absence.

3.4 Where a child has an allergy or food intolerance it is the responsibility of parents to notify the school. For allergies or intolerances to food, medical documentation needs to be provided to the school so that all staff can be informed and catering staff can provide an alternative menu as applicable. The Schools Allergy Code is a free guide to best practice for all schools.

4 Procedure following notification that a pupil has a medical condition

4.1 Except in exceptional circumstances where the pupil does not wish their parent/carer to know about their medical condition, the pupil's parents/carers will be contacted by the Headteacher or someone designated by them, as soon as practicable to discuss what, if any, arrangements need to be put into place to support the pupil. Every effort will be made to encourage the child to involve their parents while respecting their right to confidentiality.

4.2 Unless the medical condition is short-term and relatively straightforward (e.g. the pupil can manage the condition themselves without any support or monitoring), a meeting will normally be held to:

- discuss the pupil's medical support needs
- identify a member of school staff who will provide support to the pupil where appropriate
- determine whether an individual healthcare plan (IHP) is needed and, if so, what information it should contain
- agree when a future review meeting is needed to ensure the school's information about the pupil's health needs remains current

4.3 Where possible, the pupil will be enabled and encouraged to attend the meeting and speak on his/her own behalf, taking into account the pupil's age and understanding. Where this is not appropriate, the pupil will be given the opportunity to feed in his/her views by other means, such as setting their views out in writing.

4.4 The healthcare professional(s) with responsibility for the pupil may be invited to the meeting or be asked to prepare written evidence about the pupil's medical condition for consideration. Where possible, their advice will be sought on the need for, and the contents of, an IHP.

4.5 In cases where a pupil's medical condition is unclear, or where there is a difference of opinion, the Headteacher will exercise his/ her professional judgement based on the available evidence to determine whether an IHP is needed and/or what support to provide.

4.6 In exceptional circumstances, for instance in the event a pupil has a serious medical condition where recovery is the priority, it may be appropriate and in their best interests to place them on a reduced timetable. Further information about such circumstances and the process can be found in the Reduced Timetables Policy available at: Bath and Wells Multi Academy Trust - Policies (bwmat.org).

4.7 For children joining the academy at the start of the school year any support arrangements will be made in time for the start of the school term where possible. In other cases, such as a new diagnosis or a child moving to the academy mid-term, every effort will be made to ensure that any support arrangements are put in place within two weeks.

4.8 In line with our safeguarding duties, the academy will ensure that pupil's health is not put at unnecessary risk from, for example, infectious diseases. The academy follows and adheres to, the UK Health Security Agency guidelines on managing cases of infectious diseases in children and young people settings, including education. This guidance indicates the time period an individual should not attend a setting to reduce the risk of transmission during the infectious stage. The academy will not accept a pupil into the school at times where it will be detrimental to the health of that child or others.

5 Pupils with health needs who cannot attend school

5.1 Where a pupil cannot attend school because of health needs, unless it is evident at the outset that the pupil will be absent for 15 or more days, the academy will initially follow the usual process around attendance and mark the pupil as ill for the purposes of the register.

5.2 The academy will provide support to pupils who are absent from school because of illness for a period shorter than 15 days. This may include providing pupils with relevant information, curriculum materials and resources.

5.3 In accordance with the Department for Education's statutory guidance[1], where a pupil is unable to attend school for more than 15 days due to illness:

(i) the local authority should be ready to take responsibility for arranging suitable full-time education for that pupil; and

(ii) the local authority should arrange for this provision to be in place as soon as it is clear that the absence will last for more than 15 days.

The academy will inform and work collaboratively with the local authority to support these responsibilities.

5.4 The academy will work collaboratively with the local authority, relevant medical professionals, relevant education provider, parents and, where appropriate, the pupil, to identify and meet the pupil's educational needs throughout the period of absence and to remain in touch with the pupil throughout.

5.5 When a pupil is considered well enough to return to full time education at the academy, the Headteacher or someone designated by them will develop a reintegration plan in partnership with the appropriate individuals/organisations.

[1] *Ensuring a good education for pupils who cannot attend school because of health needs (January 2013)*

6 Individual Healthcare Plans (IHP) – see Annex A

6.1 Where it is decided that an IHP should be developed for the pupil, this shall be developed in partnership between the academy, the pupil's parents/carers, the pupil and the relevant healthcare professional(s) who can best advise on the particular needs of the pupil. This may include the school nursing service. The local authority will also be asked to contribute where the pupil accesses home-to-school transport to ensure that the authority's own transport healthcare plans are consistent with the IHP.

6.2 The aim of the IHP is to capture the steps which the academy needs to take to help the pupil manage their condition and overcome any potential barriers to getting the most from their education. It will be developed with the pupil's best interests in mind. In preparing the IHP the academy will need to assess and manage the risk to the pupil's education, health and social well-being and minimise disruption.

6.3 IHP's may include:

- details of the medical condition, its triggers, signs, symptoms and treatments
- the pupil's resulting needs, including medication (dose, side-effects and storage) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage their condition, dietary requirements and environmental issues e.g. crowded corridors or travel time between lessons
- specific support for the pupil's educational, social and emotional needs – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons or counselling sessions
- the level of support needed (some children will be able to take responsibility for their own health needs), including in emergencies; if a pupil is self-managing their medication, this will be clearly stated with appropriate arrangements for monitoring
- who will provide this support, their training needs, expectations of their role and confirmation of proficiency to provide support for the pupil's medical condition from a healthcare professional and cover arrangements for when they are unavailable
- who in the academy needs to be aware of the pupil's condition and the support required
- arrangements for written permission from parents/carers and the Headteacher for medication to be administered by a member of staff, or self-administered by the pupil during school hours
- separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the pupil can participate, e.g. risk assessments
- where confidentiality issues are raised by the parent/pupil, the designated individuals to be entrusted with information about the pupil's condition
- what to do in an emergency, including whom to contact, and contingency arrangements; some children may have an emergency healthcare plan prepared by their lead clinician that could be used to inform development of their IHP

6.4 The IHP will also clearly define what constitutes an emergency and explain what to do, including ensuring that all relevant staff are aware of emergency symptoms and procedures. Other pupils in the academy should know what to do in general terms, such as informing a teacher immediately if they think help is needed. If a pupil (regardless of whether they have an IHP) needs to be taken to hospital, staff will stay with the pupil until the parent/carer arrives, or accompany a pupil taken to hospital by ambulance.

6.5 Except in exceptional circumstances, or where the healthcare provider deems that they are better placed to do so, the academy will take the lead in writing the plan and ensuring that it is finalised and implemented.

6.6 Where a pupil is returning to the academy following a period of hospital education or alternative provision (including home tuition), the academy will work with the local authority and education provider to ensure that the IHP identifies the support the pupil will need to reintegrate effectively.

6.7 Where the pupil has a special educational need identified in an Education Health and Care Plan (EHCP), the IHP will be linked to or become part of that EHCP.

7 Reviewing Individual Healthcare Plans (IHP)

7.1 Every IHP shall be reviewed at least annually. The Headteacher (or someone designated by them) shall, as soon as practicable, contact the pupil's parents/carers and the relevant healthcare provider to ascertain whether the current IHP is still needed or needs to be changed. If the academy receives notification that the pupil's needs have changed, a review of the IHP will be undertaken as soon as practicable.

7.2 Where practicable, staff who provide support to the pupil with the medical condition shall be included in any meetings where the pupil's condition is discussed.

8 Staff training

8.1 The Headteacher is responsible for:

- ensuring that all staff (including new staff) are aware of this policy for supporting pupils with medical conditions and understand their role in its implementation
- working with relevant healthcare professionals and other external agencies to identify staff training requirements and commission training required
- ensuring that there are sufficient numbers of trained staff available to implement the policy and deliver against all IHPs, including in contingency and emergency situations

8.2 In addition, all members of school staff will know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help.

8.3 The academy has in place appropriate levels of insurance regarding staff providing support to pupils with medical conditions, including the administration of medication. Copies of the academy's insurance policies can be made accessible to staff as required.

9 Administering medication

9.1 Any member of school staff may be asked to provide support to pupils with medical conditions, including the administering of medicines, although they cannot be required to do so. Although administering medicines is not part of teachers' professional duties, they should take into account the needs of pupils with medical conditions that they teach. School staff should receive sufficient and suitable training and achieve the necessary level of competency before they take on responsibility to support children with medical conditions. Any member of school staff should know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help.

9.2 Only staff registered to administer medicines should do so. The details of employees who will be administering medicines should be recorded on the table in annex 3. The annex should be displayed in school and reviewed at the beginning of each academic year.

9.3 Medicines are only to be administered at school when we have been instructed to by a

relevant medical professional or a parent or carer **and** it would be detrimental to the pupil's health or school attendance not to do so. Such medicines can be prescription or non-prescription but not herbal. The BMA provides clarification on dispensing prescription medications in schools.

9.4 Medicines will only be administered at the academy when it would be detrimental to a pupil's health or school attendance not to do so. Where clinically possible, medicines should be administered in dose frequencies which enable them to be taken outside of school hours.

9.5 No child under the age of 16 should be given medicine containing aspirin unless prescribed by a doctor. Medication e.g for pain relief, should never be administered without first checking maximum dosages and when the previous dose was taken.

9.6 If a pupil requires medicines or medical devices, such as asthma inhalers, blood glucose testing meters or adrenaline pens, in school it is vital that the parent/carer advises the academy accordingly, so that the process for storing and administering medication can be properly discussed.

9.7 The academy will only accept medicines that are in-date, labelled, provided in the original container and include instructions for administration, dosage and storage. Pre-loaded medicines like salbutamol cannisters and adrenaline or insulin auto-injectors must still be in date but can be accepted in the dispenser rather than the packaging.

9.8 The medication must be accompanied by a complete written instruction form signed by the pupil's parent/carer. The academy will not make changes to dosages labelled on the medicine or device on parental instructions. School Staff should refer to the Separated Parents Policy for guidance on permission from separated parents.

9.9 The pupil and staff supporting the pupil with their medical condition should know where their medicines are at all times and be able to access them when needed. The most appropriate method for storing medicines and medical devices will be discussed with the pupil's parent/carer but the academy will ultimately decide the approach to be taken.

9.10 Wherever possible, pupils will be allowed to carry their own medicines and relevant devices or be able to access their medicines for self-medication quickly and easily. Where it is appropriate to do so, pupils will be encouraged to administer their own medication, under staff supervision if necessary. Staff administering medication should do so in accordance with the labelled instructions. Staff who volunteer to assist in the administration of medication will receive appropriate training and guidance before administering medication.

9.11 The academy will keep a record of all medicines administered to individual pupils, stating what, how and how much was administered, when and by whom. Any side effects of the medication will be noted. The academy/nursery must inform the parents/carers when medication had been administered on the same day, or as soon as reasonably practicable. A pre-agreed schedule for administering medication may be used for long-term conditions.

9.12 If a pupil refuses to take their medication, staff will not force them to do so, and will inform the parent/carer of the refusal as a matter of urgency. If a refusal to take medicines results in an emergency, the school's emergency procedures will be followed.

9.13 It is the parent/carers' responsibility to renew the medication when supplies are running low and to ensure that the medication supplied is within its expiry date.

9.14 It is the responsibility of parents/carers to notify the academy in writing if the pupil's need for medication has ceased. When no longer required, medicines will be returned to the parent/carer to arrange for safe disposal. Sharps boxes should always be used for the disposal of needles.

9.15 The NHS recommends that all children avoid all herbal medicines due to the dangers that the

unregulated market poses to buyers, so they will not be administered by school staff without the agreement of a medical professional.

10 Managing Anaphylaxis and spare Auto Adrenaline Injectors (AAI's)

10.1 Anaphylaxis is a severe and often sudden allergic reaction. It can occur when a susceptible person is exposed to an allergen (such as food or an insect sting). Reactions usually begin within minutes of exposure and progress rapidly but can occur up to 2-3 hours later. It is potentially life threatening and always requires an immediate emergency response. In severe cases, the allergic reaction can progress within minutes into a life-threatening reaction. Administration of adrenaline can be lifesaving, although severe reactions can require much more than a single dose of adrenaline. It is therefore vital to contact Emergency Services as early as possible. Delays in giving adrenaline are a common finding in fatal reactions. Adrenaline should therefore be administered immediately, at the first signs of anaphylaxis.

10.2 The Department of Health with key stakeholders has developed non-statutory guidance to capture good practice within schools for the management of anaphylaxis. The Trust believes that adopting this guidance and best practice provides pupils within the MAT the best possible protection from the effects of anaphylaxis. All Schools and locations are expected to implement and manage this guidance. See Annex 4.

Guidance will include:

- Basic information relating to Anaphylaxis
- Arrangements for the supply, storage, care and disposals of spare AAI's
- Children to whom an AAI can be administered
- Responding to the symptoms of an allergic reaction
- Roles and responsibilities of staff

11 Managing Asthma and spare Salbutamol inhalers

11.1 Asthma is the most common chronic condition, affecting one in eleven children. On average, there are two children with asthma in every classroom in the UK. There are over 25,000 emergency hospital admissions for asthma amongst children a year in the UK. Children should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them. However, an Asthma UK survey found that 86% of children with asthma have at some time been without an inhaler at school having forgotten, lost or broken it, or the inhaler having run out.

11.2 The Department of Health with key stakeholders has developed non-statutory guidance to capture good practice within schools for using emergency inhalers. The Trust believes that adopting this guidance and developing an asthma management plan will provide pupils within the MAT the best possible protection from the effects of asthma. All Schools and locations are expected to implement and manage this guidance. See Annex 5.

Guidance will include:

- Procedure for inhaler administration
- Managing school supplies of salbutamol
- Staff training on and use of inhalers
- Record keeping
- Exercise and activity - PE and games
- Out of Hours
- Off-site and Residential Visits

12 Unacceptable practice

Although the Headteacher and other school staff should use their discretion and judge each

case on its merits with reference to the pupil's IHP, it is not generally acceptable practice to:

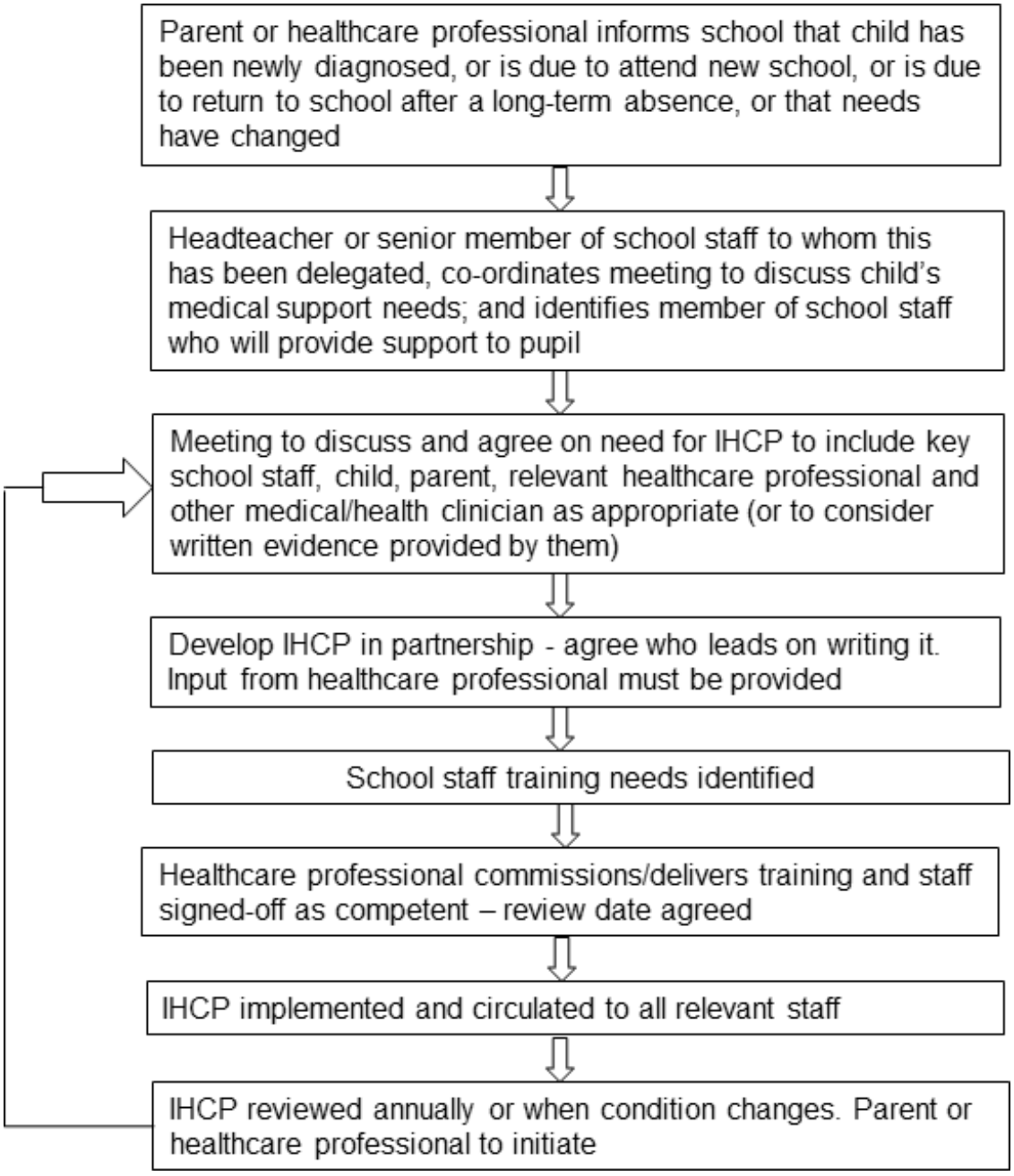
- prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary
- assume that every pupil with the same condition requires the same treatment
- ignore the views of the pupil or their parents/carers or ignore medical evidence or opinion (although this may be challenged)
- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their IHP
- if the pupil becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable
- penalise children for their attendance record if their absences are related to their medical condition e.g. hospital appointments
- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- require parents/carers, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues; no parent/carer should have to give up working because the academy is failing to support their child's medical needs; or
- prevent children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g. by requiring parents/carers to accompany the child

13 Complaints

Complaints regarding this policy or the support provided to pupils with medical conditions should be raised under the academy's usual complaints procedure.

Annex 1 - Process for developing individual healthcare plans

(*Supporting pupils at school with medical conditions*)



Annex 2 - DfE templates

(Supporting pupils at school with medical conditions)

Templates

Supporting pupils with medical conditions

May 2014

Introduction

In response to requests from stakeholders during discussions about the development of the statutory guidance for supporting pupils with medical conditions, we have prepared the following templates. They are provided as an aid to schools and their use is entirely voluntary. Schools are free to adapt them as they wish to meet local needs, to design their own templates or to use templates from another source.

Template A: individual healthcare plan

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

Family Contact Information

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

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

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

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

Daily care requirements

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

Arrangements for school visits/trips etc

Other information

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

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

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Template B: parental agreement for setting to administer medicine

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

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

Medicine

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

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

Contact Details

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

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) _____ Date _____

Template C: record of medicine administered to an individual child

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

Staff signature _____

Signature of parent_____

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

C: Record of medicine administered to an individual child (Continued)

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Template D: record of medicine administered to all children

Name of school/setting

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

Template E: staff training record – administration of medicines

Name of school/setting	
Name	
Type of training received	
Date of training completed	
Training provided by	
Profession and title	

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Template F: contacting emergency services

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

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

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

Template G: model letter inviting parents to contribute to individual healthcare plan development

Dear Parent

DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child's case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make judgements about how your child's medical condition impacts on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

A meeting to start the process of developing your child's individual health care plan has been scheduled for xx/xx/xx. I hope that this is convenient for you and would be grateful if you could confirm whether you are able to attend. The meeting will involve [the following people]. Please let us know if you would like us to invite another medical practitioner, healthcare professional or specialist and provide any other evidence you would like us to consider at the meeting as soon as possible.

If you are unable to attend, it would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence, for consideration at the meeting. I [or another member of staff involved in plan development or pupil support] would be happy for you contact me [them] by email or to speak by phone if this would be helpful.

Yours sincerely

Annex 3 – Record of employees registered to administer medicines

Record of employees registered for administering medication

Any member of school staff may be asked to provide support to pupils with medical conditions, including the administering of medicines, although they cannot be required to do so. Although administering medicines is not part of teachers' professional duties, they should take into account the needs of pupils with medical conditions that they teach. School staff should receive sufficient and suitable training and achieve the necessary level of competency before they take on responsibility to support children with medical conditions. Any member of school staff should know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help

SCHOOL:	

NAME	SUMMARY OF TRAINING RECEIVED (IF REQUIRED)	DATE

Annex 4 – Guidance on the use of adrenaline auto injectors (AAI's)

Guidance on the use of adrenaline auto-injectors in schools (publishing.service.gov.uk)

1. Basic information relating to Anaphylaxis

Anaphylaxis is a severe and often sudden allergic reaction. It can occur when a susceptible person is exposed to an allergen (such as food or an insect sting). Reactions usually begin within minutes of exposure and progress rapidly, but can occur up to 2-3 hours later. It is potentially life threatening and always requires an immediate emergency response.

What can cause anaphylaxis?
Common allergens that can trigger anaphylaxis are:

- foods (e.g. peanuts, tree nuts, milk/dairy foods, egg, wheat, fish/seafood, sesame and soya)
- insect stings (e.g. bee, wasp)
- medications (e.g. antibiotics, pain relief such as ibuprofen)
- latex (e.g. rubber gloves, balloons, swimming caps).

The severity of an allergic reaction can be influenced by a number of factors including minor illness (like a cold), asthma, and, in the case of food, the amount eaten. It is very unusual
for someone with food allergies to experience anaphylaxis without actually eating the food: contact skin reactions to an allergen are very unlikely to trigger anaphylaxis.

The time from allergen exposure to severe life-threatening anaphylaxis and cardio-respiratory arrest varies, depending on the allergen:

- Food: While symptoms can begin immediately, severe symptoms often take 30+ minutes to occur. However, some severe reactions can occur within minutes, while others can occur over 1-2 hours after eating.4 Severe reactions to dairy foods are often delayed, and may mimic a severe asthma attack without any other symptoms (e.g. skin rash) being present.
- Severe reactions to insect stings are often faster, occurring within 10-15 minutes.

Why does anaphylaxis occur?
An allergic reaction occurs because the body's immune system reacts inappropriately to a substance that it wrongly perceives as a threat. The reaction is due to an interaction between the substance ("allergen") and an antibody called Immunoglobulin E (IgE). This results in the release of chemicals such as histamine which cause the allergic reaction. In the skin, this causes an itchy rash, swelling and flushing. Many children (not just those with asthma) can develop breathing problems, similar to an asthma attack. The throat can tighten, causing swallowing difficulties and a high pitched sound (stridor) when breathing in.

In severe cases, the allergic reaction can progress within minutes into a life-threatening reaction. Administration of adrenaline can be lifesaving, although severe reactions can require much more than a single dose of adrenaline. It is therefore vital to contact Emergency Services as early as possible. Delays in giving adrenaline are a common finding in fatal reactions. Adrenaline should therefore be administered immediately, at the first signs of anaphylaxis.

How common is anaphylaxis in schools?
Up to 8% of children in the UK have a food allergy.5 However, the majority of allergic reactions to food are not anaphylaxis, even in children with previous anaphylaxis. Most reactions present with mild-moderate symptoms, and do not progress to anaphylaxis. Fatal allergic reactions are rare, but they are also very unpredictable. In the UK, 17% of fatal allergic reactions in school-aged children happen while at school.6 Schools therefore need to consider how to reduce the risk of an allergic reaction, in line with *Supporting Pupils*. Box 1 provides a list of actions that schools and parents can take to reduce the risk of exposure to allergens.

Box 1: Reducing the risk of allergen exposure in children with food allergy

- Bottles, other drinks and lunch boxes provided by parents for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- If food is provided by or purchased from the school canteen, parents should check the appropriateness of foods by speaking directly to the catering manager. The child should be taught to also check with catering staff, before purchasing.
- Where food is provided by the school, staff should be educated about how to read labels for food allergens and instructed about measures to prevent cross- contamination during the handling, preparation and serving of food. Examples include: preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Food should not be given to food-allergic children in primary schools without parental engagement and permission (e.g. birthday parties, food treats).
- Implement policies to avoid trading and sharing of food, food utensils or food containers.
- Unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary allergen labelling suggesting a risk of contamination with allergen.
- Use of food in crafts, cooking classes, science experiments and special events (e.g. fetes, assemblies, cultural events) needs to be considered and may need to be restricted depending on the allergies of particular children and their age.
- In arts/craft, an appropriate alternative ingredient can be substituted (e.g. wheat-free flour for play dough or cooking). Consider substituting non-food containers for egg cartons.
- When planning out-of-school activities such as sporting events, excursions (e.g. restaurants and food processing plants), school outings or camps, think early about the catering requirements of the food-allergic child and emergency planning (including access to emergency medication and medical care).

Treatment

While “allergy” medicines such as antihistamines can be used for mild allergic reactions, they are ineffective in severe reactions – only adrenaline is recommended for severe reactions (anaphylaxis). The adrenaline treats both the symptoms of the reaction, and also stops the reaction and the further release of chemicals causing anaphylaxis. However, severe reactions may require more than one dose of adrenaline, and children can initially improve but then deteriorate later. It is therefore essential to always call for an ambulance to provide further medical attention, whenever anaphylaxis occurs. The use of adrenaline as an injection into the muscle is safe and can be life-saving.

Children and young people diagnosed with allergy to foods or insect stings are frequently prescribed AAI devices, to use in case of anaphylaxis. AAIs (current brands available in the UK are EpiPen®, Emerade®, Jext®) contain a single fixed dose of adrenaline, which can be administered by non-healthcare professionals such as family members, teachers and first-aid responders.

Children at risk of anaphylaxis should have their prescribed AAI(s) at school for use in an emergency. The MHRA recommends that those prescribed AAIs should carry TWO devices at all times, as some people can require more than one dose of adrenaline and the AAI device can be used wrongly or occasionally misfire.

Depending on their level of understanding and competence, children and particularly teenagers should carry their AAI(s) on their person at all times or they should be quickly and easily accessible at all times. If the AAI(s) are not carried by the pupil, then they should be kept in a central place in a box marked clearly with the pupil’s name but NOT locked in a cupboard or an office where access is restricted.

It is not uncommon for schools (often primary schools) to request a pupil's AAI(s) are left in school to avoid the situation where a pupil or their family forgets to bring the AAI(s) to school each day. Where this occurs, the pupil must still have access to an AAI when travelling to and from school.

2. Arrangements for the supply, storage, care and disposal of AAIs

Supply

Schools can purchase AAIs from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed: i.e. small quantities on an occasional basis and the school does not intend to profit from it. A supplier will need a request signed by the principal or head teacher (ideally on appropriate headed paper) stating:

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

A template letter which can be used for this purpose is provided in Annex 4A. Please note that pharmacies are not required to provide AAIs free of charge to schools: the school must pay for them as a retail item.

A number of different brands of AAI are available in different doses depending on the manufacturer. It is up to the school to decide which brand(s) to purchase. Schools are advised to hold an appropriate quantity of a single brand of AAI device to avoid confusion in administration and training. Where all pupils are prescribed the same device, the school should obtain the same brand for the spare AAI. If two or more brands are currently held by the school, the school may wish to purchase the brand most commonly prescribed to its pupils. However, the decision as to how many devices and brands to purchase will depend on local circumstances and is left to the discretion of the school.

AAIs are available in different doses, depending on the manufacturer. The Resuscitation Council (UK) recommends that healthcare professionals treat anaphylaxis using the age- based criteria, as follows:

- For children age under 6 years: a dose of 150 microgram (0.15 milligram) of adrenaline is used (e.g. using an Epipen Junior (0.15mg), Emerade 150 or Jext 150 microgram device).

- For children age 6-12 years: a dose of 300 microgram (0.3 milligram) of adrenaline is used (e.g. using an Epipen (0.3mg), Emerade 300 or Jext 300 microgram device).

- For teenagers age 12+ years: a dose of 300 or 500 microgram (Emerade 500) can be used.

In the context of supplying schools rather than individual pupils with AAIs for use in an emergency setting, using these same age-based criteria avoids the need for multiple devices/ doses, thus reducing the potential for confusion in an emergency. Schools should consider the ages of their pupils at risk of anaphylaxis, when deciding which doses to obtain as the spare AAI. Schools may wish to seek appropriate medical advice when deciding which AAI device(s) are most appropriate.

The emergency anaphylaxis kit

It is good practice for schools holding spare AAIs to store these as part of an emergency anaphylaxis kit which should include:

- 1 or more AAI(s).
- Instructions on how to use the device(s).
- Instructions on storage of the AAI device(s).
- Manufacturer's information.
- A checklist of injectors, identified by their batch number and expiry date with monthly checks recorded.
- A note of the arrangements for replacing the injectors.
- A list of pupils to whom the AAI can be administered.
- An administration record.

Schools might like to keep the emergency kit together with an "emergency asthma inhaler kit" (containing a salbutamol inhaler device and spacer). Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis.

Severe anaphylaxis is an extremely time-critical situation: delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices – including those belonging to a younger child, and any spare AAI in the Emergency kit – are kept in a safe and suitably central location: for example, the school office or staffroom to which all staff have access at all times, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. Schools should ensure that AAIs are accessible and available for use at all times, and not located more than 5 minutes away from where they may be needed. In larger schools, it may be prudent to locate a kit near the central dining area and another near the playground; more than one kit may be needed.

Any spare AAI devices held in the Emergency Kit should be kept separate from any pupil's own prescribed AAI which might be stored nearby; the spare AAI should be clearly labelled to avoid confusion with that prescribed to a named pupil.

Storage and care of the AAI
The Headteacher must ensure that responsibilities for maintaining the spare anaphylaxis kit is developed and implemented. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

- on a monthly basis the AAIs are present and in date.
- that replacement AAIs are obtained when expiry dates approach (this can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer).

The AAI devices should be stored at room temperature (in line with manufacturer's guidelines), protected from direct sunlight and extremes of temperature.

Schools may wish to require parents to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Disposal
Once an AAI has been used it cannot be reused and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the ambulance paramedics on arrival or can be disposed of in a pre-ordered sharps bin for collection by the local council.

School trips including sporting activities
Schools should conduct a risk-assessment for any pupil at risk of anaphylaxis taking part in a school trip off school premises, in much the same way as they already do so with regards to safe-guarding etc. Pupils at risk of anaphylaxis should have their AAI with them, and there should be staff trained to administer AAI in an emergency. Schools may wish to consider whether it may be appropriate, under some circumstances, to take spare AAI(s) obtained for emergency use on some trips.

3. Children to whom a spare AAI can be administered

The spare AAI in the Emergency Kit should only be used in a pupil where both medical authorisation and written parental consent have been provided for the spare AAI to be used on them. This includes children at risk of anaphylaxis who have been provided with a medical plan confirming this, but who have not been prescribed AAI. In such cases, specific consent for use of the spare AAI from both a healthcare professional and parent/guardian must be obtained. Such a plan is available from the British Society for Allergy and Clinical Immunology (BSACI). Paediatric Allergy Action Plans - BSACI

The school's spare AAI can be used instead of a pupil's own prescribed AAI(s), if these cannot be administered correctly, without delay

This information should be recorded in a pupil's individual healthcare plan. Where a pupil has no other healthcare needs other than a risk of anaphylaxis, schools may wish to consider using the BSACI Allergy Action Plan. All children with a diagnosis of an allergy and at risk of anaphylaxis should have a written

Allergy Management Plan. Paediatric Allergy Action Plans - BSACI

Procedures should already be in place to ensure that schools are notified of pupils that have additional health needs, and this information will enable them to compile an allergy register. Some schools will already have such a register as part of their medical conditions policy.

The register could include:

- Known allergens and risk factors for anaphylaxis.
- Whether a pupil has been prescribed AAI(s) (and if so what type and dose).
- Where a pupil has been prescribed an AAI whether parental consent has been given for use of the spare AAI which may be different to the personal AAI prescribed for the pupil.
- A photograph of each pupil to allow a visual check to be made (this will require parental consent).

The register is crucial as in larger schools (and secondary schools in particular), it may not be feasible for individual members of staff to be aware of which pupils have been prescribed AAIs. Consequently, schools should ensure that the register is easy to access and easy to read. Schools will also need to ensure they have a proportionate and flexible approach to checking the register. DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN ASSOCIATED WITH FATAL OUTCOMES. Allowing pupils to keep their AAIs with them will reduce delays, and allows for confirmation of consent without the need to check the register.

Schools will want to consider when consent for use of the AAI is best obtained but the most appropriate time would be as part of the introduction or development of the individual care plan. Consent should be updated regularly – ideally annually – to take account of changes to a pupil's condition.

4. Responding to the symptoms of an allergic reaction

AAIs are intended for use in emergency situations when an allergic individual is having a reaction consistent with anaphylaxis, as a measure that is taken until an ambulance arrives. Therefore, unless directed otherwise by a healthcare professional, the spare AAI should only be used on pupils known to be at risk of anaphylaxis, where both medical authorisation and written parental consent for use of the spare AAI ha been provided.

This information should be recorded in a pupil's individual healthcare plan which should be signed by a healthcare professional and kept in the schools allergy register.

In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare emergency AAI is appropriate.

Staff should be aware of the difficulties younger children may have in explaining how they feel. Further information and film clips showing adrenaline being administered can be found at: http://www.sparepensinschools.uk

The signs of an allergic reaction are:

Mild-moderate allergic

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

ACTION:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine according to the child's allergy treatment plan
- Phone parent/emergency contact

Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction):

Airway:	Persistent cough Hoarse voice Difficulty swallowing, swollen tongue
Breathing:	Difficult or noisy breathing Wheeze or persistent cough
Consciousness:	Persistent dizziness Becoming pale or floppy Suddenly sleepy, collapse, unconscious

IF ANY ONE (or more) of these signs are present:

1. Lie child flat with legs raised: (if breathing is difficult, allow child to sit)

2. Use Adrenaline autoinjector* without delay
3. Dial 999 to request ambulance and say ANAPHYLAXIS

*** IF IN DOUBT, GIVE ADRENALINE ***

After giving Adrenaline:

1. Stay with child until ambulance arrives, DO NOT stand child up
2. Commence CPR if there are no signs of life
3. Phone parent/emergency contact
4. If no improvement after 5 minutes, give a further dose of adrenaline using another autoinjector device, if available.

Anaphylaxis may occur without initial mild signs: ALWAYS use adrenaline autoinjector FIRST in someone with known food allergy who has SUDDEN BREATHING DIFFICULTY (persistent cough, hoarse voice, wheeze) – even if no skin symptoms are present.

Mild-moderate symptoms are usually responsive to an antihistamine. The pupil does not normally need to be sent home from school, or require urgent medical attention. However, mild reactions can develop into anaphylaxis: children having a mild-moderate (non- anaphylactic) reaction should therefore be monitored for any progression in symptoms.

What to do if any symptoms of anaphylaxis are present
Anaphylaxis commonly occurs together with mild symptoms or signs of allergy, such as an itchy mouth or skin rash. Anaphylaxis can also occur on its own without any mild-moderate signs. In the presence of any of the severe symptoms, it is vital that an adrenaline auto-injector is administered without delay, regardless of what other symptoms or signs may be present.

Always give an adrenaline auto-injector if there are ANY signs of anaphylaxis present.

You should administer the pupil's own AAI if available, if not use the spare AAI. The AAI can be administered through clothes and should be injected into the upper outer thigh in line with the instructions issued for each brand of injector.

IF IN DOUBT, GIVE ADRENALINE

After giving adrenaline do NOT move the pupil. Standing someone up with anaphylaxis can trigger cardiac arrest. Provide reassurance. The pupil should lie down with their legs raised. If breathing is difficult, allow the pupil to sit.

If someone appears to be having a severe allergic reaction, it is vital to call the emergency services without delay – even if they have already self-administered their own adrenaline injection and this has made them better. A person receiving an adrenaline injection should always be taken to hospital for monitoring afterwards.

ALWAYS DIAL 999 AND REQUEST AN AMBULANCE IF AN AAI IS USED.

Practical points:

- Try to ensure that a person suffering an allergic reaction remains as still as possible, and does not get up or rush around. Bring the AAI to the pupil, not the other way round.
- When dialling 999, say that the person is suffering from anaphylaxis ("ANA-FIL-AX-IS").
- Give clear and precise directions to the emergency operator, including the postcode of your location.
- If the pupil's condition does not improve 5 to 10 minutes after the initial injection you should administer a second dose. If this is done, make a second call to the emergency services to confirm that an ambulance has been dispatched.
- Send someone outside to direct the ambulance paramedics when they arrive.
- Arrange to phone parents/carer.
- Tell the paramedics:
    - if the child is known to have an allergy;
    - what might have caused this reaction e.g. recent food;
    - the time the AAI was given.

Recording use of the AAI and informing parents/carers
In line with *Supporting Pupils*, use of any AAI device should be recorded. This should include:

- Where and when the REACTION took place (e.g. PE lesson, playground, classroom).
- How much medication was given, and by whom.
- Any person who has been given an AAI must be transferred to hospital for further monitoring. The pupil's parents should be contacted at the earliest opportunity. The hospital discharge documentation will be sent to the pupil's GP informing them of the reaction.

5. Roles and responsibilities of staff

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

SEVERE ANAPHYLAXIS IS AN EXTREMELY TIME-CRITICAL SITUATION: DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN ASSOCIATED WITH FATAL OUTCOMES. It is therefore appropriate for as many staff as possible to be trained in how to administer AAI.

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

Schools will want to ensure there are a reasonable number of designated members of staff to provide sufficient coverage, including when staff are on leave. In many schools, it would be appropriate for there to be multiple designated members of staff who can administer an AAI to avoid any delay in treatment.

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

It would be reasonable for ALL staff to:

- be trained to recognise the range of signs and symptoms of an allergic reaction;
- understand the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;
- appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);
- be aware of the anaphylaxis guidance and protocols;
- be aware of how to check if a pupil is on the register;
- be aware of how to access the AAI;
- be aware of who the designated members of staff are, and the policy on how to access their help.

Schools must arrange specialist anaphylaxis training for staff where a pupil in the school has been diagnosed as being at risk of anaphylaxis. The specialist training should include practical instruction in how to use the different AAI devices available. Online resources and introductory e-learning modules can be found at http://www.sparepensinschools.uk, although this is NOT a substitute for face-to-face training.

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

DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN ASSOCIATED WITH FATAL OUTCOMES. Thought should be given to where delays could occur (for example, a phone call is made to summon help but there is no answer).

The school's plan should include a procedure for allowing a quick check of the register as part of initiating the emergency response. This does not necessarily need to be undertaken by a designated member of staff, but there may be value in a copy of the register being held by at least each designated member. If the register is relatively succinct, it could be held in every classroom. Alternatively, allowing pupils to keep their AAI(s) with them will reduce delays, and allows for confirmation of consent without the need to check the register.

Designated members of staff should be trained in:

- recognising the range of signs and symptoms of severe allergic reactions;
- responding appropriately to a request for help from another member of staff;
- recognising when emergency action is necessary;
- administering AAIs according to the manufacturer's instructions;
- making appropriate records of allergic reactions.

Liability and indemnity

Supporting pupils requires that governing bodies ensure that when schools are supporting pupils with medical conditions, they have appropriate levels of insurance in place to cover staff, including liability cover relating to the administration of medication. The only exception will be where the actions of the employee amount to serious and wilful misconduct. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

Annex 4A - Letter template to Pharmacy to obtain AAI

Schools must provide a written letter when ordering "spare" back-up adrenaline auto-injector devices. A sample letter is provided below, which can be printed on the school's headed paper and signed by the head teacher at the school. Ideally appropriate headed paper should be used, although this is not a legislative requirement.

In line with legislation, the order must state:

- the name of the school for which the adrenaline auto-injector devices are required;
- the purpose for which that devices are required; and
- the total quantity required for each device.

[To be completed on headed school paper]

[Date]

We wish to purchase emergency Adrenaline Auto-injector devices for use in our school/ college.

The adrenaline auto-injectors will be used in line with the manufacturer's instructions, for the emergency treatment of anaphylaxis in accordance with the Human Medicines (Amendment) Regulations 2017. This allows schools to purchase "spare" back-up adrenaline auto-injectors for the emergency treatment of anaphylaxis. (Further information can be found at https://www.gov.uk/government/consultations/allowing-schools-to-hold-spare-adrenaline-auto-injectors).

Please supply the following devices:

Brand name*		Dose* (state milligrams or micrograms)	Quantity required
	Adrenaline auto-injector device		
	Adrenaline auto-injector device		

Signed: _____ Date: _____

Print name:
Head Teacher/Principal

*AAIs are available in different doses and devices. Schools may wish to purchase the brand most commonly prescribed to its pupils (to reduce confusion and assist with training).
Guidance from the Department of Health to schools recommends:

For children age under 6 years:	For children age 6-12 years:	For teenagers age 12+ years:
Epipen Junior (0.15mg) or Emerade 150 microgram or Jext 150 microgram	Epipen (0.3 milligrams) or Emerade 300 microgram or Jext 300 microgram	Epipen (0.3 milligrams) or Emerade 300 microgram or Emerade 500 microgram or Jext 300 microgram

Further information can be found at http://www.sparepensinschools.uk

Annex 4B – Emergency Administration of Adrenalin Record

Date	Name of Child	Time	Where & When	Dose(s) Given	Staff Signature	Print Name

Useful Links for further information relating to Anaphylaxis

- Spare Pens in Schools http://www.sparepensinschools.uk

- Official guidance relating to supporting pupils with medical needs in schools:
    - Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England (Department for Education, 2014). https://www.gov.uk/government/publications/supporting-pupils-at-school-with- medical-conditions--3
    - Supporting Learners with Healthcare Needs. (Welsh Government, 2017). http://learning.gov.wales/resources/browse-all/supporting-learners-with-healthcare- needs/?lang=en
    - The Administration of Medicines in Schools (Scottish Executive, 2001). http://www.scotland.gov.uk/Publications/2001/09/10006/File-1
    - Supporting Pupils with Medication Needs, (Department of Education, Department of Health, Social Services and Public Safety Northern Ireland, 2008) https://www.education-ni.gov.uk/articles/support-pupils-medication-needs

- Allergy UK https://www.allergyuk.org/
    - Whole school allergy and awareness management (Allergy UK) https://www.allergyuk.org/schools/whole-school-allergy-awareness-and- management

- Anaphylaxis Campaign https://www.anaphylaxis.org.uk
    - AllergyWise training for schools https://www.anaphylaxis.org.uk/information-training/allergywise-training/for- schools/
    - AllergyWise training for school nurses (Anaphylaxis Campaign) http://www.anaphylaxis.org.uk/information-resources/allergywise-training/for- healthcare-professionals/

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

- Food allergy quality standards (The National Institute for Health and Care Excellence, March 2016) https://www.nice.org.uk/guidance/qs118

- Anaphylaxis: assessment and referral after emergency treatment (The National Institute for Health and Care Excellence, 2011) https://www.nice.org.uk/guidance/cg134?unlid=22904150420167115834

Annex 5 – Managing Asthma and spare (emergency) Salbutamol inhalers

HOW TO RECOGNISE AN ASTHMA ATTACK

The signs of an asthma attack are

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

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

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

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

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

1. Managing pupils' asthma medicines

Pupils with asthma need immediate access to their reliever medicine and are encouraged to carry their reliever inhaler as soon as their parent or carer, GP or asthma nurse, and class teacher agree they are mature enough. The reliever inhalers of children who are not capable of carrying it safely themselves are kept. [give examples of their locations e.g., in their classroom]

It is explained to all staff as part of their induction that any child who appears to need or has asked for their reliever inhaler should be given it immediately and what procedure they must follow.

We ask all parents and carers to ensure that they provide school with a spare reliever inhaler (and spacer device if required) which they have clearly labelled with their child's name. An appropriate member of staff will hold this device separately in case the pupil's own inhaler runs out, or is damaged, lost, or forgotten.

It is the responsibility of parents and carers to ensure that medicines provided by them for their child to use at school have a reasonable length of time left before their expiry date considering how long we will need to keep it. For example, a preventer inhaler to be used once a day after breakfast and due to expire in 2 weeks will be acceptable when school only needs to hold it for a 2-night residential starting that day. A reliever inhaler which may be required infrequently but could be needed at any time should have no less than 2 months left before it expires on the day it is received so that the expiry will be flagged in good time to request a replacement by the regular medicines check we carry out.

If it comes to the attention of staff through their normal duties or regular checks that a medicine has expired or will expire soon, we will inform a parent or carer and ask for a replacement.

If a pupil appears to be using their reliever inhaler more often than expected according to the needs outlined in their care plan, we will inform their parents/carers. We might need to review the child's plan with them, or the child might need to see their GP or a community asthma nurse for an asthma review after which we might also need to review their child's plan with them.

It will be agreed between school and home and recorded on the care plan how parents or carers would like to be informed about their child's use of their asthma medicines. Notifications can be in person face-to-face at the end of the school day or by paper slip, telephone call, SMS, email, app [reflect only the notification options you use here].

School staff are not required to administer asthma medicines to pupils (except in an emergency), however many staff at this school are trained and willing to either do this, or to supervise or provide other support to a pupil whilst they self-administer.

School staff who agree to administer medicines are insured by the local authority/governing body to do so when they are acting in accordance with our policies and their training given the circumstances they faced at the time.

2. Procedure for inhaler administration

The school-owned emergency salbutamol inhaler can only be used by children, for whom written parental consent to use it has been given **and** who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

A pupil who has been prescribed an inhaler for their asthma which contains an alternative reliever medicine to salbutamol (such as terbutaline), should still use the salbutamol inhaler if their own inhaler is not accessible and consent is held – it will still help to relieve their asthma symptoms and could save their life.

All children with a diagnosis of asthma should have a written Asthma Care Plan or School Asthma Card and can complete the Childrens_Asthma_Plan_A4_trifold_DIGITAL.pdf (shopify.com), although a generic Individual Health Care Plan (IHCP) is not unsuitable.

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

could lead to a delay in the child getting the treatment they need.

In an emergency which resembles symptoms of asthma in a pupil who has not been prescribed a reliever inhaler and who does not have a medical plan that indicates school should administer the school emergency salbutamol either, the rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations the member of staff administering it, in an emergency and acting under medical instruction, does not need to have had any specialist training.

Staff will supervise or otherwise support a pupil who is able to self-administer their own or the school emergency inhaler, or they will administer it for pupils who are unable to self-administer it in accordance with their training.

Staff will be aware of and prepared to manage the well-known, normally mild, and temporary side effects of inhaling salbutamol which are not likely to cause serious harm e.g., the child feeling a bit shaky or trembling and their heart beating faster.

Summary of action staff should take in response to a suspected asthma attack

1. Establish that the pupil in difficulty is experiencing an asthma attack as far as possible and try to keep them calm.
2. Establish the pupil's identity and the correct action to take according to their plan.
3. Obtain the child's inhaler, the child's spare inhaler, and/or the school emergency inhaler and spacer if required.
4. Check the medicine to be administered is correct, not expired, and will be given at the right dose in the right way i.e., whether a spacer is used.
5. Administer or support self-administration of the reliever inhaler in accordance with the pupil's Plan and call for an ambulance if necessary.
6. Record the administration.
7. Inform parents or carers as agreed or as soon as possible if an ambulance has been called.

3. Managing school supplies of salbutamol

The Human Medicines (Amendment) (No.2) Regulations 2014 allows (but does not require) schools to keep a salbutamol asthma reliever inhaler for use in an emergency.

Schools should purchase and manage at least 2 reliever inhalers and spacers in case of an asthma emergency occurring both on and off site at the same time where a child's own inhaler or spare is not available or safe to use. It could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life. This decision does not in any way release parents or carers from their absolute duty to ensure that their child attends school with a fully functional inhaler containing sufficient medicine for their needs.

Obtaining salbutamol
School will buy salbutamol, inhalers, and suitable spacer equipment (as advised by a person no less qualified than a pharmacist) from a pharmaceutical supplier in writing confirming the following:

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

The model letter in Annex 4A can be adapted for this purpose

The emergency asthma kit
Each emergency asthma kit will contain:

- 2 salbutamol metered dose inhalers (MDI).
- At least two single-use plastic or disposable spacers compatible with the inhaler.
- Manufacturer's information and instructions on using the inhaler and spacer/ plastic chamber.
- Instructions on how to administer the inhaler using a spacer/plastic chamber e.g., How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk) or the inhaler manufacturer's videos.
- Advice that disposable salbutamol inhalers and spacers are for use by one person only because of the risk of Covid. Instructions on storing and disposing of single use inhalers/spacers and/or

instructions on cleaning and storing inhalers and spacers that are not disposable and are allocated and limited to the use of one person.
- The issuing pharmacist's contact information.
- A checklist of inhalers, identified by batch number and expiry date, with monthly checks recorded.
- A note of the arrangements for replacing the inhaler and spacers.
- A list of children permitted to use the emergency inhaler as detailed in their IHCP or other written parental consent (asthma register).
- A record of administration (i.e., when the inhaler has been used).

Storage and care of inhalers
It is the responsibility of (insert the names of at least 2 individuals) to maintain the school emergency asthma kit ensuring that:
- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available.
- replacement inhalers are obtained when expiry dates approach.
- replacement spacers are available following use.
- the plastic inhaler housing (which holds the canister) has been cleaned, dried, and returned to storage following use, or that replacements are available if necessary.

Emergency/spare Inhalers and spacers are kept (state where e.g., the office or staffroom etc.) which is a safe and suitably central location in school, known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. They will not be locked away. School inhalers and spacers will be kept separate from any child's own prescribed inhaler which is stored in a nearby location and the emergency inhaler will be clearly labelled to avoid confusion with a child's own device.

Storage will always be in line with manufacturer's guidelines, usually below 30°C and protected from direct sunlight and extremes of temperature. Spacers will not be stored in plastic bags to avoid them developing a static charge that causes the asthma medicine stick to the spacer rather than being delivered into the lungs.

An inhaler should be tested before use e.g., held away from the face while spraying one or more puffs as necessary. As it can become blocked again when not used over a period of time, testing will be carried out before each use and monthly as part of the working order checks.

To avoid possible risk of cross-infection and because it goes directly in the mouth and can only be cleaned with gentle detergents, the plastic spacer cannot be reused by a different person and could be given to the child who used it to take home/keep labelled with their name in school for future personal use. The inhaler itself however can usually be reused, provided it is cleaned after use. The canister of salbutamol should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, the cap replaced, and the inhaler returned to the designated storage place. If there is any risk of contamination with blood i.e., if the inhaler has been used without a spacer, it should not be re-used but disposed of.

Disposal
Used or expired Salbutamol inhalers should not be placed in the general waste and should be returned to your local pharmacy so that they can be recycled or incinerated with medical waste rather than go into landfill. All pharmacies should offer this service..

4. Staff training on and use of inhalers

The individual responsible for overseeing the protocol for use of the school emergency inhaler, monitoring its implementation, and for maintaining the asthma register is [name of person/role].

All staff are trained to recognise symptoms of an asthma attack, how to distinguish symptoms from choking or other conditions with similar symptoms, and how to respond to an attack appropriately. Designated staff have a specific responsibility for helping to administer the school emergency inhaler, i.e., they have volunteered to help a child use the school emergency inhaler, are trained to do so, and are identified in these procedures as people to whom all staff can turn to for support in an asthma emergency.

All staff are also made aware of:

- the school policy for supporting pupils at school with medical conditions, and their role.
- our asthma procedures, and their role in them.
- how to check if a child is on the asthma register.
- how to access and use the school's emergency inhaler.
- who the designated members of staff are and how to summon their help.

Pupils are involved in age and developmentally appropriate ways in our emergency asthma procedures e.g., fetching help or equipment, to increase community asthma awareness, build peer-to-peer resilience, promote leadership skills, and reduce stigma or bullying.

Designated staff are trained in everything that all staff are trained in listed above and:

- responding appropriately to a request for help from another member of staff.
- recognising when emergency action is necessary.
- administering salbutamol inhalers through a spacer.
- making appropriate records of asthma attacks; and
- ensuring parents are informed.

We ask children with inhalers to demonstrate to their teachers how they use it, with parental support, if necessary, to understand their technique, to compare it with their asthma care plan and training staff have received.

5. Record keeping

At the beginning of each school year or when a child joins our school, parents/carers are asked if their child has any medical conditions, including asthma, on their enrolment form.

All parent/carers of pupils with asthma are asked to complete an Asthma UK School Asthma Card sometimes known as an Asthma Care Plan or an Individual Health Care Plan [delete as appropriate] with advice from their GP or asthma nurse where needed to help us manage their child's asthma symptoms during school activities.

The information will be used to update the school asthma register, which is made available to all school staff and other adults working in the school to ensure reliever medicines are administered appropriately.

We review all asthma plans at least annually, asking parents and carers to update their existing plan or exchange it for a new one and we remind them to tell us as soon as possible if their child's condition or medical needs changes.

Use of a pupil's own reliever inhaler is recorded and notified if necessary and as agreed with parents/carers.

The use of the school emergency inhaler is recorded every time [state where] and reported to parents/carers [state how].

6. Exercise and activity - PE and games

Taking part in sports, games and physical activities is an essential part of school life for all pupils but can be a trigger for pupils with asthma.

To maximise participation by and minimise the risks to pupils with asthma we:

- Take reasonable steps to make the activities we offer accessible so that they can participate alongside their peers e.g., moving an outdoor activity indoors at times of very high pollen counts, if necessary, kit checks that include inhalers.
- Ensure all staff and other activity leaders are aware which of the pupils they work with have asthma, how to recognise an asthma attack, and what to do, and have access to the emergency asthma kit and asthma register e.g., in the school emergency asthma kit they might need to use.
- Require all activity leaders to remember to include emotions and pollen in their dynamic risk assessments and take steps to control asthma triggers where possible including regularly

reminding pupils at risk how to reduce their exercise-related triggers or reduce their response to triggers e.g., using their reliever inhaler just before warming up for exercise.

- Require all activity leaders to encourage pupils experiencing worsening asthma symptoms to stop, take their reliever inhaler and to sit out quietly until their symptoms have gone before starting the activity again. Anyone experiencing asthma symptoms must not be left alone until they feel better and are continuing with normal activities.
- Have a simple procedure for ensuring pupils' own inhalers are easily available to them during activities when they are not competent to or cannot physically carry them which is clearly communicated with signage if necessary. Procedures vary slightly depending on the pupils and locations, but they all involve the principle of staff gathering clearly labelled personal inhalers, storing them in a hygienic manner which is immediately accessible to pupils throughout activities, carrying or having access to a pupil's own spare inhaler if they have one, and returning them.
- Have clear learning objectives for and plans for the inclusion of pupils with asthma who are too unwell to participate in physical activities e.g., referee, coaching, or other lower risk role.
- Take steps to reassure parents, carers, and pupils that we understand their asthma and can help them manage it and be active.

7. Out of Hours

Extra-curricular activities and out-of-school clubs operated by this school are open to all pupils equally and those with asthma are encouraged to participate in everything we offer alongside their peers.

To enable pupils with asthma to participate as safely as possible, we ensure that all teaching, teaching support staff, sports coaches, and other activity leaders who run school activities outside of normal school hours are aware of our asthma procedures and the pupils they need to be applied for.

Adults leading physical activities are provided with information about minimising asthma triggers and how to encourage pupils to use the advice.

8. School Environment

This school does all that we reasonably can to ensure the school environment is as favourable to pupils with asthma as it is to their peers who do not have the condition.

We also have a duty of care for the health, safety, and wellbeing of pupils and must identify the seriousness of the risks to their health from exposure to their known triggers of asthma and take action to eliminate or manage the risks.

Areas of the curriculum we pay particular attention to which may expose pupils to humidity, extremes of temperature, fumes, smoke, dust, and other aerosol pollutants include science, design technology, food technology, art, religious studies, drama, and PE.

We do not own or keep animals that are known asthma triggers and where it is unavoidable that contact with an animal trigger can become e.g., in the presence of disability service animals or on educational visits off-site, we carefully manage situations that may cause an asthma attack. [Consider animals in school and include what actions are taken]

This school has a strict 'no smoking' policy in force throughout the site, both indoors and outdoors, and steps are taken to ensure that staff and other adults leading or supervising off-site visits also adhere to this policy.

This school is kept well ventilated to control humidity and temperature, and to prevent dust accumulation, damp, and mould through open doors and windows and through forced ventilation/air conditioning. [delete as applicable]

We actively look for damp and mould problems through normal premises condition monitoring and take action to prevent and deal with incidents as a high priority.

Local Exhaust Ventilation (LEV) systems are regularly maintained, and checks carried out to ensure that equipment is effectively situated and working well. The Design and Technology areas are regularly wet mopped or vacuumed. [delete as applicable]

When we have pupils or staff with severe asthma triggered by dust, we will ensure classrooms and any other areas necessary are regularly wet dusted to reduce dust and dust mites.
When contractors are on site, regular discussions take place with them to ensure that their work will not increase risks to pupils or staff with asthma in an unmanageable way e.g., create fumes, smoke, dust etc.

Where possible, grassed areas are not mowed during school hours, and we avoid keeping pollinating plants inside school buildings.

Rooms where pupils change their clothing are well ventilated and pupils are encouraged to use unscented and non-aerosols deodorants or other permitted products.

9. Off-site and Residential Visits

All procedures to be followed on-site to manage asthma, including pupils carrying their own reliever inhaler if they can and staff support for the administration of other asthma medicines or treatments like preventer inhalers, oral steroids, or nebulisers not usually administered during normal school hours, have been adapted to be carried out off-site.

Visit leaders are expected to check the medical needs of pupils in good time to ensure equality of access to the curriculum and to be adequately prepared for their educational visit e.g.

- to understand which pupils, have asthma.
- the severity of their symptoms.
- relevant triggers to be avoided or reduced.
- their treatment or care plan and the role of staff in it.
- and the pupil's competence in carrying and administering their own medicines.

Parental consent to attend a residential visit may need to include additions to the asthma plan because a preventer medicine or other treatment school does not normally manage is required.

All medicines provided for educational visits must be provided to school clearly labelled with the pupil's name by parents or carers.

10. When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their asthma is disturbing their sleep at night, [insert role of person i.e., class teacher] will initially talk to the parents/carers to develop a plan to support better management of their asthma and/or to prevent their child from falling behind. If appropriate, the teacher will then talk to the school nurse and special education needs coordinator about the pupil's needs. We recognise that it is possible for pupils with asthma to have special education needs due to their asthma.

11. Bullying

Whilst bullying can happen to any pupil, this school recognises that those who feel or seem different to others can be particularly vulnerable. Our Anti-bullying procedures which are part of the Whole School Behaviour Policy will be used and enforced in any situation where a pupil is being bullied or intimidated due to their medical condition.

12. Disclaimer

While every effort will be made to ensure that the appropriate medical attention is sought at the earliest opportunity in the event of a pupil experiencing an asthma emergency, this school cannot accept responsibility for adverse events when parents/carers have failed to provide the working reliever inhaler their child needs to manage their asthma symptoms.

Annex 6 – Emergency Administration of Salbutamol Inhaler

Date	Name of Child	Time	Where & When	Dose(s) Given	Staff Signature	Print Name