



# Normanhurst School

## Sickness and Medication Policy

### Main School and EYFS

## Part 2 – Administration of Specific Medication

Refer to Part 1 for the list of exclusions and general information about sickness and medication.

### PART 2 – Guidelines for the Administration of Specific Medication

#### **Paracetamol**

The administration of non-prescribed paracetamol to pupils should only be necessary in exceptional circumstances, for instance where they suffer regularly from acute pain such as migraine. On such occasions the parent must authorise and supply the paracetamol, with written instructions on when the medication should be administered. If a child has a temperature, he/she should be kept at home. Calpol can only be administered in school as a **mild pain relief** and not as fever control or for underlying conditions. For more details, refer to Part 1.

#### **Tablets**

The number of tablets should be tipped into the lid of the container and handed to the pupil. A glass of water should be available to ease swallowing unless the instruction for the medication indicates otherwise. Record details in the log book. Wherever possible, tablets should not be touched. The member of staff administering the tablets should assure themselves that the tablet(s) have been swallowed. Follow the specific instructions for the type of tablets, i.e. chew, store under tongue.

#### **Liquid**

The medicine should be measured out using a 5ml medicine spoon or the spoon, cup or syringe provided by the parent.

#### **Topical Medication**

Disposable gloves should be worn by the member of staff administering topical medications. The instructions with the medicine should be followed, e.g. spread thinly. The parent should clearly indicate the area of skin to be treated. When selecting disposable gloves for the application of topical medication, non-powdered latex gloves should be selected. If there are either staff or pupils who have known latex allergy, then either vinyl or PVC gloves must be selected.

#### **Eye Drops**

Reference should be made to the instructions accompanying the medication.

The pupil should be seated or lying with their head tilted backwards and chin pointing upwards. The dropper must not touch the pupil's eye or eyelids to prevent cross infection. The pupil should be asked to look upwards immediately before instilling the drop. The drops should be dropped into the lower eyelid which should be held away from the eye, unless the directions indicate otherwise, which can sometimes be the case. The number of drops (dosage) should be indicated by the parent and be on the packaging. The pupil should be

encouraged to close their eye afterwards to distribute the drops over the eye. The parents should clearly indicate which eye is to be treated and if both eyes, which eye is to be treated first.

Ointments should also be applied to the inner part of the lower eye lid from the nasal corner outwards. A 2 cm line should be applied, unless indicated otherwise. The pupil should then close their eye, wait until any blurring of vision has cleared before allowing the pupil to class or play.

### **Ear Drops**

Reference should be made to the instructions accompanying the medication.

If facilities exist, the pupil should lie on their side with the ear to be treated uppermost otherwise the head should be reclined at an angle so the ear to be treated is facing upwards. Warm drops to body temperature if instructions allow this. Hold the ear backwards and upwards whilst administering the drops from the dropper provided into the ear canal. The parents should clearly indicate which ear is to be treated. The pupil should stay in this position for one or two minutes after administration of the drops.

### **Injection**

There are different types of injection, dependent on the medication to be administered. There are also different injection sites. All staff who volunteer to administer injections must have received training and refresher training (consult the School Nurse for advice and frequency of this training) in the specific injection type and site. In order to ensure the safety of the pupil and member of staff, the following principles apply:

- Work in a clean environment and wash hands
- Talk quietly and confidently to the pupil
- Keep all equipment needed in a clean container
- Ensure that all packaging of sterile equipment is intact
- Ensure sharps container is within reach for immediate disposal of used needle and syringe
- Clean injection site
- Keep hands away from injection site
- Never re-sheath a needle
- Dispose of whole needle and syringe together into sharps container
- Never try to catch a falling needle
- Record the medication administered, dosage, date, time and site of the injection.

### **Disposal of Clinical Waste**

#### **Clinical Waste**

Any waste which contains or is contaminated with human blood, body fluids or excreta is defined as clinical waste. Its safe disposal is necessary to protect staff and others who may come into contact with it against the risk of infection, to prevent contamination of the environment and to ensure compliance with the Environmental Protection Act. The Environmental Protection Act places a duty of care on waste producers to ensure that it is disposed of properly. The appropriate means of disposal for clinical waste will depend on the level of risk (e.g., waste contaminated with blood would be at greater risk than incontinence waste) and the amount produced.

#### **Incontinence Pads/Nappies**

The risk of infection from incontinence pads and nappies will be low, although they can be offensive in nature. In such cases they should be disposed of via a licensed contractor (either by incineration or smaller amounts can be disposed of via landfill).

## **Medical Dressings/First Aid**

If regular large quantities of medical dressings and first aid waste are produced, it should be disposed of by incineration via a licensed contractor. Very small amounts of first aid which are produced irregularly may be double wrapped and disposed through normal waste unless it is known to be from an individual with a higher risk of infection.

## **Syringes**

Syringes and needles may harbour infections which can be passed to the handler via puncture wounds. Generally, syringes will only be used by health care professionals who would be responsible for disposal. If needles are used or found on a regular basis it is necessary to place them in a Sharp's container (complying with BS 7320) which should be sealed when three quarters full and disposed of by incinerator via a licensed contractor. Sharp's containers must not be placed in the normal refuse.

## **Dealing with Certain Medical Conditions**

### **Anaphylaxis**

Anaphylaxis is an acute allergic reaction to foreign substances (allergies) in various forms. They can occur following exposure by ingestion, inhalation or injection and require urgent medical attention. The most common allergens are food, especially nuts (e.g., peanuts), eggs, cow's milk and shellfish. Other triggers may include certain medicines (e.g., Penicillin) or insect stings (e.g., from bees, wasps or hornets). In its most severe form it is life threatening, although incidents of this kind are **very** rare and prompt treatment is effective.

Typical symptoms of anaphylactic shock are:

- Restlessness, itching or a 'metallic' taste in the mouth
- Swollen lips, throat and tongue, difficulty in swallowing
- A change in the voice
- Struggling for breath
- A change in face colour
- Generalised flushing of the skin
- Itchy red or white patches on the skin
- Sudden feeling of weakness or floppiness
- Collapse and unconsciousness.

(NB a child with a known history of the condition may have his/her own description of the symptoms).

If a child is known to have had a severe (anaphylactic) reaction to any substance(s) this should be documented in the school medical records. All staff should be aware of 'at risk' children in school. Anaphylaxis may occur in a child not thought to be 'at risk'.

A child 'at risk' may be wearing a medical alert bracelet, disc or necklace stating the allergy from which the child suffers and possibly any relevant medication the child may require.

All members of staff should be aware of the location of such medication and those agreeing to administer must receive prior training so that they feel confident to do so (the School Nurse will be able to assist with or provide training).

## **Treatment**

- 1.** NEVER leave the child alone.
- 2.** Try to stay calm and reassure the child all the time.

Treatment may include oral antihistamines or adrenaline injection. Injection in the event of an emergency can normally be administered by use of an EpiPen, which gives a pre-measured dose of adrenaline. Administration of adrenaline if the child is not suffering from anaphylactic shock will not cause any adverse reaction in the child. It is far better to administer the adrenaline than to leave administration of adrenaline to a stage where anaphylaxis had progressed too far.

**RAPIDLY WORSENING SYMPTOMS SHOULD BE TREATED WITH INJECTED ADRENALINE** (see pupil's Health Care Plan in Part 1 and individual protocol)

1. Give the injectable dose of adrenaline as described in the child's individual protocol.
2. Dial 999, ask for Ambulance Service and state that the patient is in anaphylactic shock.
3. On large sites, it may be advisable to send someone to the school entrance to direct the ambulance to the patient.
4. Check to see if the child is breathing (look for the rise and fall of the chest. Listen for breathing sounds).
5. If the child stops breathing, their heart stops beating and they become unconscious, you need to start immediate resuscitation.
  - ❑ Start cardiac massage (CPR) on breath to five chest compressions.
  - ❑ If there is no improvement in the child's condition, if available a further dose of adrenaline can be given, by which time professional help should have arrived.

An individual protocol document should be drawn up (preferably in liaison with the pupil's parent or guardian) so that there are clear written procedures for managing the condition. If further advice on this is required, please contact Learning Services Directorate, Health and Safety Services Manager at County Hall (Tel No 01245 436896).

The Anaphylaxis Campaign will provide further information on the condition, including a free pack for schools.

### **Diabetes**

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high or too low because the body is unable to use it properly. People with diabetes have lost the ability to produce insulin (the hormone which controls blood glucose levels) as the cells in the pancreas, which produce it, have been destroyed. Without insulin the body cannot store glucose and so the blood glucose level rises and excess glucose leaks into the urine. Fat is also broken down to replace glucose as the body's energy source. Symptoms of undiagnosed diabetes include weight loss, thirst, tiredness and an increased need to pass urine.

Diabetes cannot be cured, but can be treated effectively with regular insulin and/or an appropriate diet. The aim is to keep blood glucose levels close to normal and so prevent hyperglycaemia (too high levels) or hypoglycaemia (too low levels). A child with diabetes is taught from an early age how to administer their own insulin injection. Usually a child will need two insulin injections a day and so will not need an injection at school; however, some children may need to administer an additional injection at lunch times. The diabetic diet is based on starchy foods. Generally, it will be low in sugar and fat and high in fibre. Diabetic children need to eat at regular times of the day and to have snacks between meals. Children with diabetes may also need to carry out occasional blood tests to monitor their blood glucose level. On very rare occasions a child

may have an insulin pump fitted which will require detailed instructions on use from the Parent or Guardian. An insulin pump does not require the use of needles or syringes.

The greatest risk to a child with diabetes is hypoglycaemia (low blood glucose). This may be caused by a missed or delayed meal or snack, extra exercise or too much insulin. Hypoglycaemia may also occur more frequently in very hot or very cold weather. Each child's symptoms will differ, but may include:

- Hunger;
- Sweating;
- Drowsiness;
- Pallor;
- Glazed eyes;
- Shaking;
- Mood changes;
- Lack of concentration.

Treatment is by immediately giving the child fast acting sugars such as chocolate, sugary drinks, fruit juices, honey or jam, or glucose tablets or gels (known as Hypo-stop). When the child has recovered (which usually takes 10 to 15 minutes) he/she should be given slower acting starchy food (e.g., sandwiches, milk, biscuits). On rare occasions, unconsciousness may result if the child is not given fast acting sugars promptly. If this occurs, the child should be put into the recovery position and an ambulance called. Sugary materials such as jam or honey can also be rubbed into the inside of the cheek. The child will fully recover with medical assistance.

### **Cystic Fibrosis**

Cystic Fibrosis is an inherited condition that affects the glands which secrete body fluids, damaging organs, including the lungs, pancreas, digestive tract and reproductive system. It causes thick, stick mucus to be produced, which clogs the respiratory tract and also prevents the body's natural enzymes from digesting food. People with Cystic Fibrosis are therefore prone to chest infections and malnutrition.

In the past, babies born with the condition were only likely to survive a few months. However improved diagnosis and treatment has led to an increasing number of people with Cystic Fibrosis surviving to adolescence and adulthood.

Treatment includes a combination of:

- Physiotherapy to prevent the build up of mucus in the lungs. Children with the condition are encouraged to take responsibility for their own physiotherapy and breathing exercises from an early age.
- Regular exercise to maintain fitness.
- Inhaled medication and antibiotics to control chest infections.
- High energy foods and enzyme supplements to combat digestive problems.

Further information, including a guidance booklet for schools and educational videos, can be obtained from the Cystic Fibrosis Trust, whose address is given in Appendix II.

### **Attention Deficit Disorder**

Attention Deficit Disorder (A.D.D.) (with or without hyperactivity) is a neurological condition (possibly genetic in origin). The sufferer has a very reduced ability to maintain attention without distraction; control of doing or saying something due to impulsiveness and lack of appropriate forethought. The sufferer also has the reduced ability to control the amount of physical activity appropriate to the situation (where hyperactivity is also present).

Some symptoms of A.D.D. include:

- **Inattention:** Many sights, sounds, memories and other stimulation's compete for a child's attention at the same time. This makes the child easily distracted, flit from one thing to another and forget instructions. Some are distant and dreamy at times, making them look spaced out. One to one supervision of the child works well, but it must be remembered that the child has a poor short-term memory.
- **Impulsiveness:** The child may speak or act without thinking, at times inappropriately and may have a short fuse, leading to temper tantrums.
- **Over-activity:** The child can be restless and fidgety, constantly tapping their foot or fiddling with their fingers.
- **Insatiability:** Never satisfied. The child appears to go on and on about a certain subject. Can seem as if they are interrogating and generally tries to intrude or take over conversation. This can cause enormous tension.
- **Social Clumsiness:** The child never seems to 'fit in' with their peer group and can act silly in a group. They can be overpowering and bossy wanting to be the centre of attention whatever the cost.
- **Poor Co-ordination:** The child may be clumsy and appear awkward in their movements. They have difficulty doing two actions at the same time and will probably produce untidy written work.
- **Disorganisation:** Blind to mess and oblivious to organisation. The child can have problems structuring school work and find homework/projects difficult to start.
- **Volatility:** The child can have severe mood swings and be very volatile. They can have good and bad days with no real explanation.
- **Specific Learning Difficulties:** Although most children appear to have a high IQ, most will have learning difficulties due to their poor attention span. Many, however, do appear to have a combination of A.D.D. and a more specific learning difficulty, for example, Dyslexia or a language problem.

The A.D.D. child may also suffer from asthma, eczema or ear, nose and throat (ENT) problems, all of which may be exacerbated by stress.

#### **Side effects of Ritalin and other medication prescribed for A.D.D.**

When these medications are first administered side effects, such as nervousness, restlessness and insomnia are common. The performance of skilled tasks may be affected. It is suggested that staff restrict pupils' use of machinery within Design and Technology during the first week of treatment. During this period, side effects should become apparent. Any effects which increase the risk of injury when using machinery should be noted and regular assessments undertaken to determine when it is safe for the pupil to use the machinery.

#### **'Blood Borne' Diseases**

Blood borne diseases need to enter directly into the bloodstream and are normally prevented from doing so by an intact skin barrier. They enter through cuts or other skin wounds and through mucous membranes (the covering of eyes, mouth and genitalia). These infections include Hepatitis B & C and HIV (Human Immunodeficiency Virus).

The route of transmission of the infection is an important consideration in the risk assessment; if it is not present via broken skin etc., there will only be a negligible risk.

If the risk from exposure to blood and body fluids at work cannot be satisfactorily controlled by safe work practices and protective clothing, employees should be encouraged to receive hepatitis B immunisation. NB. The cost incurred should be met from delegated budgets.

The staff most likely to require immunisation are those who:

- a) regularly work with blood and body fluids where there is a risk of contamination of eyes, skin or significant risk of sharps injury;
- b) regularly work with pupils/clients who bite or who cause other injuries where infected blood could contaminate wounds.

The following body fluids are not considered to present a risk of infection unless contaminated with blood:

- Urine
- Faeces
- Saliva
- Sweat
- Vomit

There is a risk of exposure to blood borne viruses at work if:

- a) a sharps injury or other injury takes place with a contaminated needle or other sharp object;
- b) blood or high risk body fluids contaminate an open wound, the eyes, nose or the mouth;
- c) human bites occur and blood is drawn.

The greatest risk is from a sharps injury, but only if the source person is carrying a blood borne infection. There will be a risk in every day contact such as touching, sharing utensils or from coughs and sneezes.

### **Control Measures**

- Use good basic hygiene practices including hand washing and avoiding hand to mouth/eye etc. contact.
- Wear vinyl or latex gloves (but not thin polythene) and a disposable apron. Where staff or pupils are known or suspected of having a latex allergy, vinyl gloves must be worn. In any case latex gloves purchased must be un-powdered and low protein.
- Prevent puncture wounds, cuts, abrasions in the presence of blood and body fluids.
- Protect all breaks in exposed skin by means of waterproof dressings and impervious gloves.
- Control surface contamination by blood and bodily fluids by containment and appropriate decontamination procedures.
- Dispose of all contaminated waste safely.

Immunisation should be considered if the above control measures do not control the risks identified. It is recommended that staff who regularly (at least once a month) are exposed to biting incidents where the skin is broken received Hepatitis B immunisation from their own GP. The School is responsible for reimbursing the cost of this from the school budget.

### **Emergency Procedures**

In the event of a sharps injury involving blood or body fluids or other significant contamination, the following action should be taken without delay:

- wash with soap and running water;

- encourage bleeding if the skin has been broken;
- wash out splashes in the eye preferably using eye wash from a fresh eye wash bottle (alternatively use tap water) or nose or mouth with copious amounts of tap water;
- cover with a waterproof dressing;
- record source of contamination (name/type of injury);
- report the incident to your Supervisor or Line Manager or other person responsible for health and safety at work;
- contact your GP immediately for advice or go straight to local A & E Department, noting the time of the sharps injury or bite.

### **Asthma**

Asthma is a common cause of ill health among school children, particularly of primary school age. It is a disorder of the lungs in which the air passages become sensitive to a variety of common stimuli and become narrowed making it difficult to breathe. This may occur as a sudden acute attack, or lesser, more persistent narrowing may lead to chronic, less dramatic symptoms.

A variety of stimuli may induce an asthma attack including:

- Virus infections;
- Allergy (e.g., to dust, feathers, fur or, in rare cases, certain foods);
- Exercise;
- Cold weather or strong winds;
- Excitement or prolonged laughing.

Asthmatic children vary in the extent to which they are affected and most cases are mild and easily controlled. The majority of children will be able to participate fully in the School curriculum including sports activities. It may be necessary to take specific precautions for children whose asthma is triggered by particular allergens (e.g., keeping them away from school pets or flowering grasses).

### **Medication**

Children with asthma may need to take medication during school hours. If it is not taken regularly or properly, severe asthma may develop. Two types of asthma treatment may be prescribed:

- a) Treatments which give immediate relief. These are called bronchodilators. These should be readily available for the child to use whenever he/she needs to relieve asthma symptoms of coughing, wheezing or breathlessness. Examples of bronchodilators are Bricanyl and Ventolin.
- b) Preventative treatments. These are taken regularly to damp down the sensitivity for the air passages. They must be taken regularly every day to get the best results and should not be used to relieve sudden attacks of wheezing and breathlessness as they do not have an immediate effect. It is unlikely that schools would need to keep preventative inhalers in school as administration of this medication can usually take place at home.

Treatment is usually given in the form of an inhaler. If the inhaler is used incorrectly it may spray into the surrounding air rather than into the lungs. However, asthmatic children would normally have spent many hours learning to use their inhaler properly. It is important that they should have access to their medication, particularly bronchodilators. They should be kept in the classroom or, pupils considered capable by their GP or the School Nurse, should carry their own inhaler. An emergency, unused, bronchodilator and Ventolin is available and is stored in the medical room.



## **Spacers**

A spacer is a large plastic container, which usually comes in two halves that click together. At one end is a mouthpiece containing a valve and at the other end a hole that fits the aerosol inhaler. Spacers help pupils take their asthma medication more effectively. They trap the medication and keep it in suspension until the pupil is ready to breathe in the treatment.

Spacers reduce the problems of co-ordination because pupils do not have to activate the inhaler and breathe in at the same time. They also help to get more medication into the lungs and consequently reduce the chance of side effects.

Spacers are especially useful when asthma is bad and it is more difficult to breathe in fully. Children under five are more likely to need to use a spacer with an aerosol inhaler. There are several types of spacers which are compatible with different makes of inhalers.

## **Treatment of Asthmatic Pupils**

The following guidelines give a basis for the appropriate treatment of asthmatic pupils.

1. Talk to the parents to find out about the child's asthma. In particular ascertain whether it is triggered by specific allergens, what treatment the child is taking and the extent to which the child may require help when taking medication. Ask them to provide these details in writing. If the child has severe asthma it may be helpful to consult the School Nurse or doctor or the child's GP.
2. Staff who come into contact with an asthmatic child should be made aware of the problem and any restrictions which may need to be applied to the child's activity. An entry should be made in the School's asthma register.
3. Allow the child to take medication when needed. It should be kept available, either by the child or in the classroom, NOT locked away. It is particularly important that bronchodilators are readily available.
4. Before an attack the child may show the following symptoms:
  - Pallor;
  - Lethargy;
  - Cough
  - Running nose.

At this stage a child should not be left unattended and should remain in full view of a teacher or another adult.

5. Unless there is medical advice against exercise, pupils should be encouraged to participate in sport, unless the child shows signs which may indicate an imminent attack (see 4 above), or becomes too wheezy during the Games to continue.
6. Where necessary, PE teachers should allow pupils to take a dose of bronchodilator 10 to 15 minutes before taking part in any exercise. The child should also have the bronchodilator available on the sports field.

## **Severe Asthma Attacks**

Severe asthma attacks are rare, however, they can be life threatening so it is important that staff know what to do if a child experiences an attack. Asthmatic children often know what to do during an asthmatic attack as they have learned from past attacks. Staff should therefore listen to what they say or want.

1. Make sure that a bronchodilator is used promptly and properly. Younger children may find the use of a spacer useful to ensure that all medication reaches the lungs. See section on Spacers.
2. Stay calm and reassure the child. Try to encourage him/her to breathe slowly and deeply and to relax.
3. Encourage the child to adopt a position which they find comfortable and will help them breathe. Most find it easiest to sit upright or slightly forward, resting their hands on their knees to support their chest. It is not recommended to lay the child on his/her back. If a pillow is used it should be of a synthetic material, not feather.
4. If the room is warm, open the window to let in some fresh air (unless it is very cold outside). It is also helpful to loosen tight clothing around the neck and to offer the child a drink of warm water.
5. After a mild attack the child should be able to continue with normal school activities including sports.
6. An ambulance should be called in the following situations:
  - If all the recommendations for treatment have been carried out correctly and things are no better 10 minutes later;
  - If the child is distressed and unable to talk;
  - If the child is getting exhausted;
  - If the child's lips turn blue;
  - If the child's pulse rate is faster than 120 beats per minute;
  - If the child loses consciousness, however brief, at any time;
  - If there are repeated attacks

The parents should be informed immediately if it is necessary to call an ambulance.

### **Further Information**

The National Asthma Campaign produces information packs for schools. An asthma nurse from a local branch of the organisation may also be willing to visit the School and talk to staff on coping with asthma attacks. The address of the National Asthma Campaign can be found in Appendix II.

### **Epilepsy**

Epilepsy is a condition which results from a tendency towards brief disruptions in the normal electrical activity of the brain. This may vary from momentary inattention without loss of consciousness (Minor Epilepsy) to muscular spasm and convulsions (Major Epilepsy).

In the majority of cases, the parents of an epileptic child will advise the School of the child's condition and appropriate emergency treatment. The parent should be asked to provide this information in writing. Staff who will come in contact with the child should be made aware of the condition. In the absence of specific advice, the following guidelines should be followed:

### **Minor Epilepsy**

A child suffering from minor epilepsy may appear to be day dreaming or staring ahead blankly, or they may start behaving strangely (e.g., chewing, smacking their lips, saying odd things or fiddling with their clothing). They may also suffer transient memory loss. The child should be kept calm and should be closely supervised until he/she has recovered. It is not unusual for a major fit to follow a minor one.

## **Major Epilepsy**

Most major epileptic attacks occur unexpectedly, although sometimes a person experiences an aura beforehand, during which their normal mood may be altered. During an epileptic attack a child will suddenly lose consciousness, falling to the ground. He/she will then become rigid for a few seconds and breathing may cease, before the muscles relax and begin convulsive movements. During this stage, his/her breathing may become difficult or noisy through clenched jaws and froth may appear around the mouth. Finally, his/her muscles will relax and he/she will remain unconscious for a few more minutes. The fit would normally last less than 5 minutes, but the child may feel dazed and confused for several minutes to an hour afterwards.

The following action should be taken if a child has a major epileptic fit;

1. Clear a space around the child;
2. If possible, loosen the child's clothing around the neck and place something soft, (e.g., a rolled up coat) under the head.
3. **DO NOT** move the child unless he/she is in danger. **DO NOT** restrict the child's movements. **DO NOT** give anything to drink. **DO NOT** put anything between the teeth.
4. After convulsions have ceased, turn the child onto his/her side in the recovery position to aid breathing and general recovery. Do not try to wake the child.
5. Stay with the child until you are certain recovery is complete.
6. **IF THE CHILD DOES NOT RECOVER CONSCIOUSNESS WITHIN 5 MINUTES SUMMON MEDICAL AID WITHOUT DELAY.**
7. Medical aid should also be summoned if the child has a repeat attack.
8. Inform the parents on the same day that the child has had an attack.

## **Rectal Diazepam**

Some children and young people with learning disabilities have a type of epilepsy which is difficult to control. In some cases, it is necessary to treat breakthrough fits with rectal diazepam. Such cases are rare however. If staff are willing to administer rectal diazepam, they must be given appropriate training (the School Nurse will usually be able to arrange this). If the School can arrange for two adults, of the same gender as the pupil, to be present for the administration of intimate or invasive treatment, this minimises the potential for accusations of abuse. Two adults often ease practical administration of treatment too. Staff should protect the dignity of the pupil as far as possible, even in emergencies.

The treatment needs to be administered in an emergency and as quickly as possible. The issue for shared carers are that often there is only one person present, not two. This is not a health and safety issue, but one of good practice.

The Joint Epilepsy Council care plan for the administration of rectal diazepam should be used to record arrangements for deciding when to administer rectal diazepam and to record details of when it is administered. An outline care plan for the administration to individual pupils of rectal diazepam for non-medical/non-nursing staff can be found at the back of this policy.

**JOINT EPILEPSY COUNCIL GUIDELINES FOR ADMINISTRATION OF RECTAL DIAZEPAM IN EPILEPSY AND FEBRILE CONVULSIONS FOR NON-MEDICAL/NON-NURSING STAFF**

Individual Care Plan to be completed by or in consultation with the medical practitioner

Name of pupil \_\_\_\_\_ Age \_\_\_\_\_

**Seizure classification and/or description of seizures, which may require rectal diazepam.**

(Record all details of seizures, e.g., goes stiff, falls, convulses down both sides of body, convulsions last 3 minutes, etc. Include information re: triggers, recovery time, etc. If status epilepticus, note whether it is convulsive, partial or absence)

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Usual duration of seizure? \_\_\_\_\_

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Other useful information \_\_\_\_\_

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**DIAZEPAM TREATMENT PLAN**

**1. When should rectal diazepam be administered?** (Note here should include whether it is after a certain length of time or number of seizures)

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**2. Initial dosage: How much rectal diazepam is given initially?** (Note recommended number of milligrams for this person)

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**3. What is the usual reaction(s) to rectal diazepam?**

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**4. If there are difficulties in the administration of rectal diazepam** (e.g., constipation/diarrhoea, what action should be taken?)

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5. Can a second dose of rectal diazepam be given?

YES/NO

After how long can a second dose of rectal diazepam be given? (State the number of milligrams to be given and how many times this can be done, and after how long?)

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6. When should a person's usual doctor be consulted?

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7. When should 999 be dialled for emergency help?

If the full prescribed dose of rectal diazepam fails to contrail the seizure

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or

Other (Please give details)

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8. Who should administer the rectal diazepam and who should witness the administration? (e.g., another member of staff of the same sex)

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9. Who/where needs to be informed:

Parent/Guardian \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Prescribing Doctor \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Other \_\_\_\_\_ Telephone Number: \_\_\_\_\_

10. Insurance cover in place?

YES/NO

11. Precautions: Under what circumstance should rectal diazepam not be used?

e.g., Oral Diazepam already administered within the last \_\_\_\_\_ minutes.

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**This plan has been agreed by the following:**

Prescribing Doctor \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Pupil \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Head \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorised person(s) trained to administer rectal diazepam:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**RECORD OF USE OF RECTAL DIAZEPAM**

|   |  |  |  |
|---|--|--|--|
| <b>Date</b>                               |  |  |  |
| <b>Recorded by</b>                        |  |  |  |
| <b>Type of Seizure</b>                    |  |  |  |
| <b>Length and number of seizures</b>      |  |  |  |
| <b>Initial dose</b>                       |  |  |  |
| <b>Outcome</b>                            |  |  |  |
| <b>Second dose (if any)</b>               |  |  |  |
| <b>Outcome</b>                            |  |  |  |
| <b>Observations</b>                       |  |  |  |
| <b>Parent/Guardian informed</b>           |  |  |  |
| <b>Prescribing Doctor informed</b>        |  |  |  |
| <b>Other information</b>                  |  |  |  |
| <b>Witness</b>                            |  |  |  |
| <b>Name of Parent re-supplying dosage</b> |  |  |  |
| <b>Date delivered to school</b>           |  |  |  |