# FULWELL INFANT SCHOOL ACADEMY

# OVER-ARCHING MEDICAL PROCEDURES POLICY

**Including sub-policies for:**

- ***First Aid Procedures Policy***
- ***Accident Reporting Policy***
- ***Administration of Medicine*** (inc. practical advice on Asthma, Epilepsy, Diabetes and Anaphylaxis) ***Policy***
- ***Head Lice & Contagion Control Policy***
- ***Pandemic Policy***
- ***Drug Policy***
- ***AIDS & HIV Infection Policy***

Many of the policies regarding the wellbeing of pupils and staff overlap into different areas. It is therefore considered good practice to have all medical related policies together under one umbrella.

Statutory guidance can be bypassed if justified by governors and included in the policy.

*NB : This policy should be read in conjunction with the supporting Risk Assessments for each sub-section.*

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## FIRST AID PROCEDURES POLICY

**Introduction:**

This Policy outlines Fulwell Infant School Academy's responsibility to provide adequate and appropriate first aid to pupils, staff, parents and visitors and the procedures we have in place to meet that responsibility. The policy is reviewed periodically and updates applied as necessary.

The Policy has been compiled with observance and reference to the following advice:

- City of Sunderland First Aid Code of Practice 3.12 - 2005
- DCFS booklet 'Guidance on First Aid for Schools'
- City of Sunderland 'Incident Investigation & Reporting Procedures – Code of Practice 3.11' - 2004

***Aims of the Policy:***

- To identify the first aid needs of the School in line with the Health and Safety (First-Aid) Regulations 1981, the Management of Health & Safety at Work Regulations 1992 and 1999.
- To ensure that first aid provision is available at all times while people are on the school premises, and also off the premises whilst on school visits.

***Objectives:***

- To appoint the appropriate number of suitably trained people as Appointed Persons and First Aiders to meet the needs of the School;
- To identify training needs and ensure monitoring of the procedures takes place;
- To provide sufficient and appropriate resources and facilities for the administration of first aid;
- To inform staff and parents of the School's first aid arrangements;
- To keep appropriate first aid/accident records as advised by the Corporate Health and safety Team, with particular consideration of the HSE regulations of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations – 1995).

***Duties of the Head Teacher & Governing Body:***

The Governing Body with delegated authority to the Headteacher are responsible for ensuring the health and safety of their employees and anyone else on the premises is appropriately managed at all times. This includes all staff within school, the pupils and visitors where appropriate (including contractors on site).

They must ensure that Risk Assessments are undertaken to identify potential risks and implement suitable controls wherever possible, and that appointments, training and resources for first aid are appropriate and in place.

They should also ensure that the School is appropriately covered for claims arising from actions of their staff acting within the scope of their employ.

The Head Teacher is responsible for putting this policy into practice and for developing detailed procedures in consultation with Senior Management personnel. The policy should be made available to all staff as part of ongoing policy implementation and to parents *upon request*.

Teachers and all support staff are expected to do all they can to secure the welfare of the pupils in their care.

*Minimum First Aid Provision:*

As per the DCSF guidance, the minimum first aid provision is considered:

- A suitably locked first aid container
- An appointed person to take charge of first aid arrangements
- Information for employees on first aid arrangements

This minimum provision MUST be supported with a Risk Assessment to determine any additional provision.
First-aid provision must be available at all times while people are on the school premises, and also off the premises whilst on school visits.

In conjunction with the First Aid Policy, the School must also be able to offer Health & Safety guidance stating specific arrangements for first aid, based on a risk assessment of the school, which will cover:

- ✓ The number of First Aiders / Appointed Persons;
- ✓ The number and locations of first-aid containers;
- ✓ Arrangements for off-site activities
- ✓ Out of hours arrangements e.g. after school clubs or parents evenings

*(See Staff Handbook and other Policies/Risk Assessments e.g. School Visits)*

<u>What is the interpretation of a First Aider & what are their main duties?</u>

First Aiders **<u>must</u>** complete a training course *approved by the Health & Safety Executive (HSE).* They must hold a valid certificate of competence verifying their authority to administer first aid. Academy employees who undertake first aid duties in addition to their normal duties are provided with a payment for undertaking this role.

The designated First Aider for Fulwell Infant School Academy is Janet Boucher who holds the HSE approved qualification ' First Aid at Work'. This qualification is renewed every three years.

The main duties include:

- Giving immediate help to casualties with common injuries or illnesses and those arising from specific hazards in school.
- When necessary, ensuring an ambulance or other professional medical help is called.

What is the interpretation of an Appointed Person and what are their duties?

An Appointed Person is someone who is appropriately trained and authorised to *take charge of the situation*, if there is a serious injury or illness, in the *absence* of the designated First Aider. Their training is limited to:

- ✓ Cardiopulmonary resuscitation;
- ✓ Control of bleeding;
- ✓ Treatment of the unconscious casualty;
- ✓ Communication;
- ✓ Contents of first aid containers and, if appropriate, specific workplace hazards.

The DCFS guidance document for schools states:

***'…….Appointed persons are not first aiders. They should not give first aid treatment for which they have not been trained. However, it is good practice to ensure that appointed persons have emergency first aid training/refresher training, as appropriate. These courses do not require HSE approval…….'***

***On occasions where the first aider is unavailable in nursery, minor injuries can initially be treated by nursery staff and checked by a first aider if deemed necessary.***

At Fulwell Infant School Academy, we realise that effective first aid is best administered if several staff have had the appropriate training, and the following personnel are fully trained in *Basic First Aid for Appointed Persons.* ***See Appendix A for the current status*:**

Appropriate certification is held for all personnel verifying their authority to administer first aid under the appropriate guidance.

When selecting First Aid personnel, the School always gives consideration to the individuals:

- ✓ Reliability and communication skills
- ✓ Aptitude and ability to absorb new knowledge and learn new skills
- ✓ Ability to cope with stressful and physically demanding emergency procedures
- ✓ Normal duties. A first aider must be able to leave what they are doing and go immediately to an emergency.

The minimum requirement is that an appointed person must take charge of the first aid arrangements. In the case of Fulwell Infant School Academy, the main duty of first aid, including ordering suitable equipment and updating medical records, lies with Ms Boucher as the designated First Aider. However, other staff trained in Basic First Aid can, as an Appointed Person, undertake these duties in her absence.

It should be noted that standard first aid at work training courses do ***not*** include resuscitation procedures for children.

**Recent Ofsted guidance (October 2009) advises that where schools serve children up to the age of 8 years old, there should be at least one member of staff trained in *Paediatric First Aid*. As children at FISA commence from age 3, it is considered good practice to have staff trained in this first aid qualification.**

**Procedures:**

*Risk Assessments*:
Reviews of risk assessments held in respect of first aid are reviewed at least annually, and when circumstances alter, for instance if new procedures are advised by the Corporate Health and Safety team.

*Re-assessment of First Aid Provision:*
As part of the School's annual monitoring and evaluation cycle:

- The Head Teacher reviews the first aid needs of the school following any changes to staff or if circumstances would dictate a change in procedure; for instance amendments to the building/site which could have health and safety implications, off site activities etc.
- The School Business Manager monitors the number of trained first aid personnel, and alerts them to the need for refresher training, booking the courses where appropriate.

- The designated First Aider (Ms Boucher) is responsible for stock control of first aid supplies and liaises with the School Business Manager for the replenishment of equipment as and when necessary.

*First Aid Facilities:*

Whilst guidance suggests that there should be a designated room for first aid, it is accepted that it is often difficult to provide exclusive facilities for this sole purpose. In the case of FIS, there is a Medical Room which is located at the end of the Year 1 corridor.

*Minor accidents - first aid treatment:*

- If an accident occurs at break time, basic first aid treatment will be administered in the medical room (e.g. scraped knee etc.)
- Children also come to the medical room when feeling unwell or having had a minor scrape and in such circumstances, first aid can be administered by an Appointed Person.
- First aid over the lunch period is administered by the two Midday Supervisory staff, who are also Appointed Persons, and is carried out in the Medical Room.
- Parents/carers informed by text or telephone call (if serious) of any incident involving the child receiving medical assistance for any bumps to the head or torso (even if there is no sign of injury) or large grazes.

*Accidents in the classroom:*

- Minor accidents should be referred to an appropriate member of staff for treatment (First Aider or Appointed Persons) and children know that there are designated places in school where they can come for assistance (Medical Room).

*More serious incidents including collapse:*

- If a child sustained a serious injury either as a result of an accident at school or due to sudden serious illness, the child should ONLY be moved from the site of accident once assessed by the First Aider or Appointed Person; if there is **ANY** element of doubt, children should **NOT** be moved but made comfortable as far as practical, particularly if they have sustained a knock to the head.

- If a room is required in which to treat a child, either by the nature of the accident/illness or to make them more comfortable, the designated area in the first instance would be the **Medical Room** situated at the end of the Year 1 corridor. This area meets the suggested requirements of a first aid room in so far as:

✓ It is close to a lavatory
✓ there is hot and cold running water
✓ there is soap and paper towels
✓ drinking water and disposable cups are available
✓ it can be vacated quickly in the event of an emergency
✓ it allows easy access to first aid equipment
✓ there is appropriate seating
✓ telephone assistance is close by
✓ there is suitable disposal facilities available for used dressings etc.

The Medical Room is the best available space that we have and is appropriately identified as such.

*Hygiene/Infection Control:*
All staff should take precautions to avoid infection and must follow basic hygiene procedures. First aid staff should have access to:

✓ single use disposable gloves
✓ hand washing facilities

Extra care should be taken when dealing with blood and bodily fluids **(see specific Risk Assessments – (i) People Risk Assessment) (ii) School Activities Risk Assessment)**

Dressings and equipment are disposed of via the refuse containers specifically for the disposal of clinical waste. There are also yellow clinical waste bags available if wound dressings etc. need to be disposed of from elsewhere in school, and they are stored in the first aid cabinet in the Medical Room and Nursery.

*First Aid materials, equipment and containers:*
There are emergency first aid containers on site:

✓ in the Nursery Kitchen
✓ in the Medical Room
✓ a fully stocked first aid container is held in the Medical Room

The containers are easily accessible and available at all times, and are clearly identifiable; all are dark green boxes marked with white first aid crosses.

The contents of each box are strictly controlled to ensure adherence to Health & Safety guidance, and the following list identifies what each box holds as *standard*:

| **Item** | **Number** |
|---|---|
| Guidance card | 1 |
| Individually wrapped sterile adhesive dressings (assorted sizes) | 20 |
| Sterile eye pads with attachment | 2 |
| Individually wrapped triangular bandages | 4 |
| Safety pins | 6 |
| Medium sized individually wrapped sterile un-medicated wound dressings (approx 12cmx12cm) | 6 |
| Large sterile individually wrapped un-medicated wound dressings (approx 18cmx18cm) | 2 |
| Pair of disposable gloves | 1 |
| Individually wrapped moist cleaning wipes (in the event that running water is unavailable) | 10 |

In addition to the recommended equipment contained in this list, each box also contains a pack of disposable plastic aprons and additional disposable gloves and moist wipes.

Stock use is monitored in the first instance by Ms Boucher as designated First Aider and items used replenished from additional stock held in school.

*Sports/PE specific first aid kits:*

Designated staff are responsible for taking the kits with them when participating in PE events either on site or off and suitably trained in First Aiders as Appointed Persons.

*First aid support on school visits:*

*At least one member of staff who is a designated First Aider will accompany every school outing. They are responsible for ensuring that inhalers etc are taken for any child who may require them and for ensuring the medical First Aid kit is suitably stocked for the trip and any used items are replenished on their return to School. (See Risk Assessment – School Visits).*

*Providing First Aid Information:*

The Head Teacher in the first instance, with support from the School Business Manager, will ensure that first aid procedures are communicated to staff in an appropriate manner by way of:

- ✓ Staff Handbook
- ✓ As part of the induction process of newly appointed staff
- ✓ First Aid notices naming First Aiders are positioned around school

Instructions will also include the location of equipment and the members of staff appropriately trained in first aid. All children are advised where to go in the event they require treatment during breaktime and lunchtimes. If an accident occurred during lesson time a TA (if qualified) would deal with the incident or take the child to the nearest First Aider

*First Aid & Visitors to the School:*

The H&S regulations do not oblige schools to provide first aid for anyone other than their own staff, but employers do have health and safety responsibilities towards non-employees. The HSC guidance recommends that organisations, such as schools, which provide a service for others should include them in their Risk Assessments and provide for them. In light of their legal responsibilities for those in their care, schools should consider carefully the likely risk to pupils and visitors, and make allowance for them when drawing up policies and deciding on the numbers of first aid personnel. The recommended number of certified first-aiders is one per 100 pupils/staff: at FIS, there are enough appropriately trained personnel, which would provide sufficient cover in the event of accident involving visitors to the school.

Schools are generally classed as low risk environments, but the management team should consider the requirements at specific times of

the day, places and activities taking place when deciding the level of first aid provision (supporting Risk Assessments held where appropriate).

## ACCIDENT REPORTING POLICY:

*Pupil Accident Reporting Procedure:*

The City of Sunderland Code of Practice (October 2006) clearly defines the separate practices to adopt for pupil accidents and employee accidents.

There is a legal responsibility to record all accidents to employees, pupils and visitors in school. The information can:

- Help the school identify accident trends and possible areas for improvement in the control of health and safety risks;
- Be used for reference in future first aid needs assessments;
- Be helpful for insurance and investigative purposes.

The accident reporting procedure for **pupils** within schools has been revised, to enable the recording and monitoring of accidents to be as simple as possible and less time consuming for those involved.

Schools can record minor accidents/incidents at a local level, without the necessity to use the IR1 form; the only exceptions to this would be:

- Accidents attributable to school organisation, such as a lack of supervision
- Accidents arising from the use of damaged or faulty equipment
- Incidents involving hazardous substances
- Accidents involving the condition of the premises

However, it is important to stress that this local level of reporting must not be used to report accidents of a significant nature in which case the Council's Incident Reporting Procedure ***must*** be followed.

*Internal Accident Recording Procedure:*

Accidents resulting in injuries considered to be of a minor nature and which are dealt with on site, such as pupil to pupil collision, or scraped knee, should be recorded on the ***School's Pupil Accident Record Sheet***.

There is one generic record in operation at FIS:

- ✓ The generic *Pupil Accident Record* to be completed for incidents which occur during the day. The record must be completed by a designated First Aider.

The forms are filed in date order and once the file is complete it is kept in the School Office.

The following information is recorded as a minimum:

Date and time of the incident
Name of the injured person
Description of the injury (e.g. cut)
Where the accident happened (e.g. Reception Yard)
Cause of the injury (e.g. tripped over)
Name of the person completing the form and the treatment given
Whether any follow up was required (for instance contacting parents)
Reference to the appropriate Risk Assessment if an accident occurred as a direct result of a specific activity

**All Accidents/Incidents which need to be recorded and forwarded to the Health and Safety Team must be reported using the following link:**

**http://www.sunderland.gov.uk/index.aspx?articleid=11933**

**Password = Safety**

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, some accidents **MUST** be reported to the Health and Safety Executive (HSE).

Accidents occurring to pupils in school will be reportable to the HSE if the accident is attributable to any of the following criteria and the injured person taken directly to hospital from site by a parent or staff:

The school organisation for example a lack of supervision during lessons or any other activities arranged by the school such as off-site visits;

- Damaged/faulty equipment for example electrical equipment, PE equipment, chairs, access equipment;
- Hazardous substances
- The condition of the premises such as damaged or uneven interior or exterior surfaces.

- Injuries sustained during PE lessons

*Incident Reporting : Non-Pupil*

The online forms are also an essential part of recording accidents/incidents in school that **do not** involve pupils. The incident investigation process covers:

- All work related accidents and injuries
- Near misses
- Ill health conditions as a result of work
- Violence at work incidents

The Code of Practice is ***NOT*** intended to include the reporting and investigation of racial incidents as there is a separate procedure for managers to follow in this event.

In the event of a work related incident occurring, the following procedures must be followed:

1. Work related incidents cover the criteria listed above
2. All fatalities, major injuries and reportable dangerous occurrences arising out of or in connection with work, must be immediately notified to the Corporate Health and Safety Team (0191 561 2375).
3. Injuries to members of the public arising out of or in connection with work activities that result in the person being immediately taken from the scene to hospital must also be immediately notified to the Corporate Health and Safety Team.
4. Immediate support and advice will be provided by a health and safety advisor, who will notify the Health and Safety Executive.
5. In the case of a fatality occurring outside normal working hours, the Civic Centre control room will assist in contacting the Duty Health and Safety Officer. The emergency services will contact the Health and Safety Executive Duty Officer.

Attached at **Appendix B** is the City Councils interpretation of the criteria that would instigate the completion of the IR1 form, and the associated flowchart of responsibility indicates each part of the process in conjunction with the Corporate Health and Safety Team's Code of Practice (3.11 – Incident Investigation and Reporting Procedures).

Where an incident/accident occurs as the result of an approved activity, the associated Risk Assessment should be referred to and attached to any IR1 form completed.

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ADMINISTRATION OF MEDICINE POLICY:

*This policy has been compiled in conjunction with LEA guidance and the DCSF document 'Managing Medicines in Schools and Early Years Settings'*

*Rationale:*

To ensure we address the medical needs of pupils with a regard for the restrictions of school life and issues of safety.

*Aims:*

To meet the framework as advised in the LEA guidance first supplied to schools in 2005.
To meet the medical needs of pupils.

*Objectives:*

To ensure we have suitably trained people capable of administering medication to children when required, and that those persons can be readily identifiable by pupils and staff.
To organise effective training in the administration of medicine.
To inform parents of the school policy.
To inform all staff of the school policy regarding the administration of medicine by means of:

- Staff Handbook
- First Aid Poster
- Induction
- Safeguarding training & updates

We will adopt any advice and guidance as provided by the LEA, and ensure our practices follow their suggested guidance.

This policy should be read in conjunction with the supporting Risk Assessments, within the sections of *(i) 'Pupil Safety and Wellbeing' and (ii) Safe Working Practices.*

The Schools policy needs to be clear to all staff, parents and children. It is included in the annual Brochure to parents. The policy covers:

- procedures for managing prescription medicines which need to be taken during the school day
- procedures for managing prescription medicines on trips and outings
- a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
- a clear statement on parental responsibilities in respect of their child's medical needs
- the need for prior written agreement from parents for any medicines to be given to a child
- the circumstances in which children may take any non-prescription medicines
- the school policy on assisting children with long- term or complex medical needs
- staff training in managing medicines safely and supporting an identified individual child
- record keeping and safe storage of medicines
- access to the school's emergency procedures
- Risk Assessment and management procedures

At Fulwell Infant School Academy, we are committed to meeting the needs of ALL pupils and understand that there may be occasions when prescribed medicine has to be administered or special arrangements made, including:

- Serious medical conditions such as Diabetes or Epilepsy
- Food intolerances, including special diets
- Asthma

We will adopt the guidance of the LEA, including the right for each request to be considered on its own merits.

**What type of medicine can be administered in school?**

From 1st September 2014 a new duty of care came into force for Governing Bodies to make arrangements to support pupils at school with medical conditions.
However, there is no legal duty that requires School staff to administer medicine. However, we appreciate that children should be supported as far as possible, and will review each request individually.

The Children's Services guidance advises that **ONLY** prescription medicines can be stored and administered in School; this must be, in all cases, clearly labelled with the dispensing practitioner's name, the child's name and the dosage required. Teaching staff ***do not*** have any obligation to administer medicine, and at FISA we have appropriately trained staff who can undertake this duty (***refer to Appendix A***):
***NB : Only prescribed medicine can be dispensed by a member of staff.***

*Non-Prescription Treatments:*

Over the counter remedies such as Calpol, Disprin etc. **cannot** be dispensed in School by a member of staff. Parents who wish their child to receive such a treatment can make arrangements to come into school to dispense the remedy themselves to their own child.

Prior to **ANY** medicine being administered, parents must fill in a **Medical Statement**, detailing:

- ✓ The nature of the ailment
- ✓ The medicine prescribed
- ✓ The dosage required to be taken in school and at what time
- ✓ The contact arrangements in the event of an emergency

They must sign the declaration at the bottom of the statement authorising staff to dispense medicine in school on their behalf, and to administer first aid should it become necessary.

**No** medicine will be issued without a Statement being completed.

**How will medicine be stored and dispensed?**

Once the Medical Statement has been completed by the Parent, arrangements will be made with the Designated Person for Medicine (Mrs Gibson or Ms Boucher) to have the medicine securely stored in either the Medical Cabinet (Medical Room) or Medical Fridge (Rainbow Room), whichever is appropriate. Medicine should be brought to School by the

parent or the parent's representative, not the child and handed in to the Office and collected from there either each evening (in the case of medicine).

Parents have the prime responsibility for their child's health and should provide the School with appropriate information about their child's medical condition. The more information we hold, the better we can support the child within School and disseminate the required information to all staff that may come into contact with that child (Class Teacher, outside agencies).

The Designated Person for Medicine reserves the right to refuse to administer any medicine if it is considered to be a contravention of the LEA/School policy, such as medicines that have been taken out of the container as originally dispensed or where an alteration has been made to dosages or parental instructions without prior agreement.

Medicine will be administered to children at the required time as specified on the Medical Statement by the Designated Person in the first instance, but any other member of trained personnel can administer in her absence.

Each dosage given is recorded on the official log *'Record of medicines administered to all children'* and signed by the member of staff dispensing the treatment. This log is held in the Medical File retained in the School Office.

Expiry dates of medicines retained in school will be regularly checked and parents contacted where out of date treatments are held. It is the responsibility of the parent to come into school and collect the medicine – it will NOT be given to the child to bring home. The only exception to this would be if we have your written authorisation for it to be given to your child, but the school reserves the right to refuse this if it is deemed inappropriate.

**Ad-hoc treatment:**

Daily short term or ad hoc requirements that have been prescribed can normally be taken over the course of the day *without* the necessity to take at school, e.g. breakfast time, teatime, bedtime. In such circumstances, we would advise that parents administer the treatment themselves. However, if required, we can administer on your behalf and the same protocol will apply as stated above.

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

- Prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours

- Prescribers consider providing two prescriptions, where appropriate and practicable, for a child's medicines: one for home and one for use in the school or setting, avoiding the need for repackaging or relabelling of medicines by parents

**Children with longer term medical needs:**

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

The School will support children who may need to attend regular medical appointments and liaise closely with parents regarding their individual needs. Where appropriate, specific Care Plans will be drawn up for those children identified. This could include:

- details of a child's condition
- special requirement e.g. dietary needs, pre-activity precautions
- and any side effects of the medicines
- what constitutes an emergency
- what action to take in an emergency
- what <u>not</u> to do in the event of an emergency
- who to contact in an emergency
- the role the staff can play

**Self Administration of Medicine:**

It is good practice to support and encourage children, who are able, to take responsibility to manage their own medicines from a relatively early

age and the school will encourage this *where appropriate, as this will largely be dependent on the condition from which the child suffers and the type of medication required*. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility, but only after thorough discussion and approval from the Parent and at the agreement of the school.

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their Parent. Children develop at different rates and so the ability to take responsibility for their own medicines varies. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made.

It is also worth noting that there may be circumstances where it is ***not*** appropriate for a child of any age to self-manage. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

If children can take their medicines themselves, staff may only need to supervise, but this is likely to be in isolated instances such as Diabetes control, and should always be considered bearing in mind the safety of other children and medical advice from the GP in respect of the individual child.

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

**Refusing Medicines**

If a child refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures, which may be set out in the child's Medical Statement or Care Plan where appropriate. Parents should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the School's Emergency First Aid procedures should be followed.

**Medicine & Educational Visits:**

It is good practice for schools to encourage children with medical needs to participate in safely managed visits. We will always consider what

reasonable adjustments can be made to enable children with medical needs to participate fully and safely on visits. This might include reviewing and revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medical needs. In all such cases, an appropriate Risk Assessment will be compiled.

Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any Medical Statements/Care Plans should be taken on visits in the event of the information being needed in an emergency.

On such visits the Headteacher has deemed it possible for named / trained first aid members of staff to dispense medication to children as set out in the child's individual care plan.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the School Health Service or the child's GP.

*Residential Visits:*

Where children participate on visits to venues such as Derwent Hill, the School will expect parents to complete an appropriate Medical Statement detailing any treatment they may need to receive whilst away form home. FIS policy suggests that a member of staff trained in Basic First Aid should always accompany a trip of this nature, and there is therefore the provision for staff to administer medicine under such circumstances. Non-prescription medicine will **ONLY** be administered by school staff if children are on a residential visit and there must be clear, written instruction and approval from the parent detailing exactly when such medicine should be given.

**Safety Management and Storage of Medicines:**

All medicines may be harmful to anyone for whom they are not appropriate, and when dispensing medicine on a parent's behalf we **must** ensure that the risks to the health of others are properly controlled.

This duty is set out in the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

***Storing Medicines:***

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

Staff are responsible for making sure that medicines are stored safely. All emergency medicines, such as asthma inhalers are readily available to children in their own classroom and should not be locked away. Epi-pens and secondary treatments are held in a **labelled unlocked container in the Medical Room**, in case of emergency. Other non-emergency medicines are held in either a lockable fridge in the Rainbow Room or lockable first aid cabinet in the Medical Room – this is not accessible to children.

Certain medicines need to be refrigerated. They can be kept in the lockable medical fridge Rainbow Room) and should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines. No children will be allowed to access the refrigerator under ANY circumstance and medicines, when required, will be taken from the fridge by the member of staff administering the medicine.

**Disposal of Medicines:**

Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are removed from School. They should also collect medicines held at the end of each term. If parents do not collect all medicines, the school is within its right to take the medicine to a local pharmacy for safe disposal.

Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP. Collection and disposal of the boxes should be arranged with the Local Authority's Environmental services.

**Hygiene and Infection Control:**

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

**COMMON CONDITIONS :**

**PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS**

**INTRODUCTION**

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

**ASTHMA**

**What is Asthma?**

1. Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have asthma in the UK.

2. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

3. However in some settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is

therefore imperative that staff know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by appropriate Medical Statements, and regular training and support for staff. Children with significant asthma should have an individual Care Plan as their need may be more serious.

Where possible most staff attend annual instruction from a medical practitioner on the use of administering inhalers and in an event of an emergency an epipen, for those children prescribed such medications.

**Medicine and Control**

4. There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

5. Children with asthma **need to have immediate access** to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

6. Class based staff should make sure that all inhalers are stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

7. The school guidance specifies that all children who need to take an inhaler ***during the school day*** MUST complete a Medical Statement and have an inhaler in school for use as and when required.

8. The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

9. When a child has an attack they should be treated according to their individual Medical Statement as agreed with parents. An ambulance should be called if:

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

10. It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken.

11. Children with asthma should participate in all aspects of the School day including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided.

12. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

13. Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

## EPILEPSY

### What is Epilepsy?

14. Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

15. Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual Care Plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

    - any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
    - any unusual "feelings" reported by the child prior to the seizure
    - parts of the body demonstrating seizure activity e.g. limbs or facial muscles
    - the timing of the seizure – when it happened and how long it lasted
    - whether the child lost consciousness
    - whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

16. What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

17. In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

18. After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for

several hours.

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

**Medicine and Control**

20. Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours but clear instruction must be available in the event of seizure/treatment.

21. Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

22. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming. Concerns about safety should be discussed with the child and parents as part of the Care Plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

23. An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's Care Plan
- a seizure lasts for five minutes if you do not know how long they

usually last for that child

- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

24. Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The Epilepsy Nurse or a Paediatrician should provide guidance as to when to administer it and why.

25. Specialist training in the administration of rectal diazepam would be required if ever we received a child that needed such treatment. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor.

26. Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

## DIABETES

### What is Diabetes?

27. Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

28. About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

29. Each child may experience different symptoms and this should be discussed when drawing up the Care Plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

**Medicine and Control**

30. The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

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

32. Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

33. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

34. Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

35. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

36. Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

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

38. An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes
- the child becomes unconscious

39. Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and

staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

40. Such information should be an integral part of the school emergency procedures.

**ANAPHYLAXIS**

**What is anaphylaxis?**

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

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

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

44. Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction. More information is attached at **Appendix C**.

**Medicine and Control**

45. The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and Infant.

46. Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

47. Staff who volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

48. The decision on how many adrenaline devices the school hold, and where to store them, has to be decided on an individual basis between the Head, the child's parents and medical staff involved.

49. Studies have shown that the risks for allergic children are reduced where an individual Care Plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

50. Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

51. Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will be offered annually by a trained medical practitioner. Staff should have the opportunity to practice with trainer injection devices.

52. Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. Academy kitchen staff are advised of any child with specific medical dietry requirements and will liaise with our catering partner to ensure the child has a specifically tailored and balanced meal plan.

53. Parents often ask for the Head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be

taken. For example, we request parents do not provide peanuts in their child's packed lunches due to the children in School who could have a reaction if they came into contact with them accidentally.

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

55. Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

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**HEAD LICE AND CONTAGION CONTROL POLICY:**

This policy has been compiled in conjunction with the guidance to schools from the City of Sunderland Primary Health Trust following consultation with the organisations involved.

Aim:
To decrease the prevalence of head lice infection across the population of Sunderland.

*Objectives:*

1. To support the provision of consistent advice from all professionals dealing with headlice infections.
2. To educate health-care staff and teaching professionals on the detection and treatment of headlice infection.
3. To promote self or parental inspection of hair at weekly intervals, leading to early detection of infection.
4. To provide an accessible and professional source of support and advice for families concerned about headlice infection within their home communities.
5. To treat headlice as an infection and minimise social stigma.
6. To educate families on the correct use of the current recommended treatments.

The true prevalence of headlice infection is unknown but is probably much lower than public and professional perception.

## 1.1 Health implications

Headlice are not a serious health problem in this country. They rarely, if ever, cause physical health problems other than itching of the scalp. Adverse health effects mainly derive not from the lice themselves, but from the human perception of them:

- excessive public and professional reactions lead to an inflated perception of prevalence, to unnecessary, inappropriate or ineffective action, and to a great deal of unwarranted anxiety and distress.
- these actions and reactions in themselves cause problems, especially from the misuse and overuse of treatments.

## 2.0 Headlice – the key facts

2.1

- ✓ Headlice are wingless insects that are about the same size as a sesame seed found on burger buns.
- ✓ Headlice require a temperature of 31° or above and therefore live close to the scalp where they feed by biting and sucking blood from the scalp.
- ✓ Female lice lay 6–10 eggs per day. Each egg is glued to the base of an individual hair shaft and is grey/brown in colour. The eggs hatch after 7–10 days.
- ✓ 'Nits' are the empty egg shells; they are stuck to the hair shafts and are pearly white in colour. The presence of nits does not indicate a current infection from headlice. However, it does indicate that an infection has previously occurred.
- ✓ A headlice infection is only present if living, moving lice are found in the hair. Both adults and children can be infected.
- ✓ Headlice transfer from head to head only through sustained and direct contact. They literally walk from one head to another.
- ✓ Headlice can infect people with different levels of personal hygiene.
- ✓ Headlice infection is a problem affecting the whole community, not just children in schools. Infections are just as prevalent during school holidays as they are during term time.

2.2 Head Lice do not:

- ✓ Jump, hop or fly.
- ✓ Live on domestic pets or other animals

2.3 An objective of this policy is to promote and encourage families to take greater responsibility for their health and well-being. This policy aims to promote inspection of hair at weekly intervals together with daily grooming.

Education and prevention advice will be provided primarily by:

1. Accredited Community Pharmacists
2. Health Visitors
3. School Nurses
4. Practice Nurses.

This advice will include:

- Nature and cause of infection
- Transmission
- The value of weekly family head inspections using a headlice detection comb. ***It is not the role of any health professional or member of teaching staff to carry out routine head inspections. This is parental or carers responsibility.***
- The value of daily brushing and combing; the need for weekly combing with an approved fine-toothed plastic detection comb.
- The availability of the current recommended treatments, the appropriate application technique and follow up.
- The importance of contact tracing.
- Advice about non-chemical treatment and prevention.
- Offer advice leaflets where available

*2.4 Treatment:*

The treatment of headlice is a self or parental responsibility

Treatment can be obtained from an accredited pharmacist when proof of infection has been seen.

*2.5 The role of the School:*

Fulwell Infant School Academy staff will support the policy and any changes to it as advised by the Primary Health Trust.

Routine head inspections will NOT be carried out by the School Nurse.

Alert letters may be issued from school if headlice infection is suspected or confirmed. It is a community problem and as such cannot be controlled by the school.

We will direct parents/carers to accredited pharmacists for advice if headlice infection is suspected.

We will work collaboratively with the School Nurse to facilitate health promotion/education sessions and provide approved information on the management of headlice/health issues.

***Guidance on Infection Control in Schools:***

We would always act on the advise issued by the LEA; there is a document held in schools from 1997 **'Guidance for the Control of Communicable Diseases in Schools'** which can be referred to when identifying ailments considered infectious/contagious. It is contained at **Appendix D for communicable diseases guidance and Appendix E for Meningitis advice.** This is the most recent Sunderland specific information available at this time, but can be read in connection with the 2009 Health Protection Agency guidance, which lists those conditions where time away from school would be recommended.

We will liaise with parents as much as possible regarding new guidance and act appropriate to our other medical/health related policies.

We would always ensure staff display good practice in encouraging good standards of hygiene, and this will be communicated in curricular lessons such as PSHE.

**PANDEMIC POLICY:**

Aims and Objectives:

- ✓ To act in accordance with the LEA guidance regarding how to respond to a Pandemic situation;

- ✓ To keep parents informed of any potential threat of school closure;

- ✓ To ensure we work with the appropriate Health Agencies in monitoring the number of cases of contagion and responding appropriately to advice issued by the Health Protection Agency.

We have responded to the guidance issued to schools in September 2009 regarding the compilation of a Pandemic Plan, particularly in response to the Swine Flu virus and this is attached at **Appendix F**

This model would be adopted and amended for any similar Pandemic outbreak, with additional guidance added where appropriate.

We will always strive to work with parents and the community in advising and responding to crises as and when they arise.

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## DRUGS POLICY:

Those sections marked with an asterisk need individual school input.
Please refer to additional guidelines.

***Aims:***
We believe and support the following educational aims in respect of substance use and misuse:-

- To enable pupils to make healthy, informed choices by increasing knowledge, challenging attitudes and developing and practising skills;
- To provide accurate information about substances;
- To increase understanding about the implications and possible consequences of use and misuse;
- To improve self-knowledge, particularly in terms of risk-taking;
- To promote positive attitudes towards healthy lifestyles

***Range of Substances Covered:***

The policy covers all drugs in the context of drug education and management of drug related incidents.

Volatile (sniffable) substances;
Over-the-counter medicines;
Prescription medicines;

Alcohol;
Tobacco;
Other legal drugs (e.g. caffeine and khat);
Illegal drugs.

***School Boundaries:***

The physical boundaries of the school define the extent of the school premises during the school day and school term.
The drugs policy remains in force in the following situations as well as situations within the school day and school site. Children are constantly reminded that off site supervision situations have the same rules as inside school.

Visits – extra curricular
School trips
Residential trips

***Drugs on School Property:***

Various situations exist where drugs are found on school property, specifically:

Possession on premises
Drugs found on premises
Staff under the influence of drugs
Disclosure of involvement
Sale of drugs
Syringes/needles on premises

There is further LEA guidance available for these incidents and this will be updated as new advice becomes available.
Such incidences will involve the Head Teacher and SMT in discussions to agree action when options are given. The Chair of Governors would be informed of any incidences.
Any incidences would be recorded, using the suggested LEA proforma.

***Medical Emergency:***

In the unlikely event of a child/adult being at immediate risk of drugs related harm, advice can be found in Appendix 3.

***Provision for drug education within the curriculum:***

Aims:

- ✓ To make children aware of and differentiate between 'good' drugs and 'bad' drugs and occasions where these labels can change;
- ✓ To broaden the children's knowledge about drugs, including alcohol and tobacco, and the effects it can have on them both physically and mentally;
- ✓ To enable the children to make the correct choices in the future based on the knowledge and skills they have acquired in lessons;
- ✓ To increase the children's knowledge about drugs – their use and abuse;
- ✓ To enable children to create a safer environment for themselves through an increased awareness and knowledge of drug use and abuse.

***Delivery:***

Drug education is taught specifically by the class teacher within the Personal Development curriculum.

Year 4 Chemicals including medicines
Year 6 Healthy body and harmful substances – drugs, alcohol and tobacco.
Understanding drugs and medicines, safe/not safe, peer pressure, passive smoking.

The whole Personal Development curriculum will impact on drugs education as it promotes the development of self reliant, responsible adults able to make good choices based on sound understanding.

***Responsibilities:***

In addition to the overall responsibility for the drugs policy, the Head Teacher has legal responsibilities. The Head Teacher is "In loco parentis", which is not very clearly defined in law, but confers responsibility upon the Head Teacher (and the staff) to be seen to act as a responsible, caring parent would.

Specifically:

- Overall charge of the process which forms and reviews the drugs policy (yearly return to Governors);
- Responsibility for implementing monitoring systems;
- Ensuring co-ordination and coherence of drug education and the management of drug related

incidents;
- Co-ordinating planned action to manage medicines in school;
- Initiating or co-ordinating responses to any unplanned situations involving drugs;
- Co-ordinating links with external agencies;
- Cross-phase liaison with other primary or secondary schools.

The Chair of Governors would act as a Lead Governor on drug issues.
The PSHE Co-ordinator will support the Head Teacher in a shared role as School Drugs Co-ordinators.
Parents and carers would be informed and involved as appropriate.

***Police:***

The Impact Team will work closely and sensitively with schools in the investigation of drug related incidents, where appropriate. (Tel : 0191 565 6326)

***Use of Outside Agencies – for curriculum support and guidance:***

The school recognises its responsibility for what is taught in the drug education programme. Visitors and outside agencies can augment the school's drug education provision but they should not be used in such a way as to diminish the responsibility of teaching staff. Outside support should be fully integrated into the drug education programme with the class teacher also taking a major role. It is the school's responsibility to lay down guidelines within which visitors should work.

**"When an outside speaker is invited to work with a class, it is necessary to make sure that they can offer something definite to the drug education programme. The school's drug education aims and approaches to working with children should be explained before working in the classroom situation". "Healthwise : The Primary School's Drug Pack"**

We will only use identified designated visitors with whom, prior to the lesson, the actual contents can be discussed and agreed

**AIDs & HIV INFECTION POLICY:**

We have consulted the City of Sunderland advice regarding the formulation of an appropriate policy for AIDs and HIV Infection education.
policy has been adopted by the school as it is considered the best advice available for this very specific health and safety control.

Signed (Headteacher) Wendy Angus Date: January 2020

Signed (Chair of Governors ) Date January 2020