GRANBY PRIMARY SCHOOL HEALTH AND SAFETY POLICY

1. Health and Safety Policy Statement

1.1 The aim of the Governing Board is to provide a safe and healthy working and learning environment for staff, pupils and visitors. The Governing Board believes that the prevention of accidents, injury or loss is essential to the effective operation of the school and is part of the education of its pupils.

1.2 The Governing Board acknowledges the provisions of the Health and Safety at Work etc. Act 1974 and in particular the duty of every 'employer' (see 2) to conduct their business in such a way as to ensure, so far as is reasonably practicable, that persons who are in their employment, and also persons who are not but who may be affected by it, are not exposed to unacceptable risks to their health and/or safety. The Governing Board accepts that it has a responsibility to take all reasonably practicable steps to ensure the health, safety and welfare of staff and others.

1.3 The safety of the children in our care is of paramount importance. At the same time, children learn by taking risks - about their capabilities, about overcoming obstacles, about testing their boundaries and exploring their emotions. We aim to create an environment therefore which allows children to take appropriate risks and to develop a sense of responsibility for their own safety.

1.3 The arrangements outlined in this policy statement, and the various other safety provisions made by the Governing Board, cannot in themselves prevent accidents or ensure safe and healthy working conditions. This can only be achieved through the adoption of safe methods of work and good practice by every individual. The Governing Board will take all reasonable steps to identify and reduce hazards to a minimum but all staff and pupils must appreciate that their own safety and that of others also depends upon their individual conduct and vigilance while on the school premises, or whilst taking part in school sponsored activities.

1.4 The Governing Board will review this policy statement every year. Updates, modifications or amendments to this document will be made as necessary to ensure the health, safety and welfare of staff and pupils.

Signed **Chair of Finance, Premises, Health and Safety**			
Signed **Head Teacher**			
Date		**Date for review**	

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2. The Employer and the Governing Board

2.1 The 'Employer': In Granby Primary School, the employer is the Local Authority, Leicester City Council

2.2 The Health & Safety at Work etc. Act 1974 places duties on employers to safeguard, as far as is reasonably practicable, the health, safety and welfare of their employees and the health and safety of other persons who may be affected by their work activities, such as pupils and visitors. Employers also have additional duties under other legislation such as, for example, The Control of Substances Hazardous to Health Regulations and School Teachers Pay and Conditions (work life balance).

2.3 Governing Boards of maintained schools, although not the employer, are required to base their health and safety policies on those of the Local Authority.

2.4 The Local Authority **requires** that all Governing Boards implement relevant health & safety enactments, policies, codes of practice/guidelines and operate effective safety management systems for all activities on all sites that they manage. (See 9 re: Hirers, Contractors and Others.)

2.5 For the purposes of health & safety management, the Head Teacher is deemed to be the Key Manager.

2.6 This policy, like all policies of Granby Primary School, applies to the before and after school club.

3. Responsibilities and duties of the Governing Board

3.1 Governors are responsible for monitoring compliance with statutory requirements and with Local Authority guidance. As such governors are required to ensure that the management structure detailed in the diagram (see 7) is documented, implemented and effective.

Health and safety will feature as a regular agenda item at Finance, Premises, Health & Safety Committee. This Board will periodically monitor and review the effectiveness

of the school health and safety policy and ensure that any necessary changes are made. (Terms of reference for the committee are available).

Reports on health and safety will be received from the Head Teacher and any of the following as appropriate:

- The Local Authority's Health and Safety Adviser (new initiatives/local advice)
- The school's health and safety committee
- Union safety representatives
- The Site Manager
- The Business Manager
- The SENCO
- The lead DSL
- The school nurse

3.2 The Governing Board will, so far as is reasonably practicable, ensure:

- Adequate allocation of resources, including time, for work and activities with implications for health and safety to take place
- A safe environment for staff, pupils, contractors, hirers and others to go about their various activities
- Adequate and appropriate welfare facilities
- Necessary safety and protective equipment and clothing
- Safe plant, equipment and systems of work
- Safe arrangements for the handling, storage and transport of articles and hazardous substances
- Adequate information, training, instruction and supervision so that all staff, pupils, contractors, hirers and others, can perform their activities in a safe and healthy manner
- The opportunity for all staff to receive health and safety training appropriate to their duties and responsibilities. This should be given before an employee commences any relevant work. Wherever training is required by statute, or considered necessary for the safety of staff, pupils and others, the Governing Board will ensure that such training is provided. Records will be kept of all training. Training will be regularly updated
- The following health and safety reports:
    - Information to parents via the minutes of normal meetings
    - On other occasions, as appropriate, and in response to specific concerns

3.3 The Governing Board, so far as is reasonably practicable and in consultation with the Head Teacher will:

- Make itself familiar with the requirements of the Health and Safety at Work etc. Act 1974 and any other health and safety legislation and codes of practice that are relevant to the work of the school, in particular the Management of Health and Safety at Work Regulations 1999
- Adopt and maintain an effective policy, organisation and arrangements for the provision of health and safety throughout the school
- Identify and evaluate risk control measures in order to select the most appropriate means of minimising risks to staff, pupils and others
- Set standards and ensure responsibility is assigned for:
    - Reporting accidents
    - Recording and investigating accidents
    - Establishing and participating in the school health and safety committee (including Governing Board representation)
    - Undertaking, recording and reviewing risk assessments, especially with regard to:
        - Potential accidents
        - Health hazards
        - School sponsored on and off site activities
        - Pupils and their behaviour
    - Monitoring adherence to health and safety standards
    - Reviewing documentation and distributing information from the Local Authority etc
    - Carrying out inspections
    - Providing health and safety training
    - Providing first aid
    - Dealing with emergencies
    - Supervising storage facilities
    - Dealing with waste disposal
    - Monitoring housekeeping standards
    - Dealing with complaints on health and safety
    - Purchasing and maintaining equipment
    - Testing of plant and equipment to ensure it is safe
    - Carrying out minor repairs to doors, fences, windows etc
    - Organising security and fire protection arrangements
    - Implementing risk control measures

3.4 So far as is reasonably practicable, the Governing Board, through the Head Teacher, will make arrangements for all staff, including temporary and voluntary staff and helpers, to access a copy of this policy and comprehensive information on:

- All other relevant health and safety matters
- The instruction and training that will be given to all employees so that they may carry out their duties in a safe manner without placing themselves or others at risk

3.5 Where the Local Authority or the governors delegate responsibility for carrying out a particular health and safety function to an employee, they will ensure that the person is aware of the duty, knows how he/she is expected to perform it, and is provided with any necessary information, instruction, training and supervision and resources (including time). In addition, suitable measures for monitoring performance standards will be put in place.

3.6 Governors are directly responsible for safety management/compliance during lettings and ensuring that premises, equipment and substances are safe and without risk to health.

3.7 Where Governing Boards award contracts independent of the Local Authority - such as cleaning, catering services and building works, etc. - they will give proper consideration to the health and safety aspects before the tendering of any such contract takes place and they will satisfy themselves that successful contractors comply with all relevant safety legislation. Governors, who act responsibly, taking note of relevant guidance and seeking advice when in doubt, should have no difficulty in meeting these obligations.

4. Responsibilities and duties of the Head Teacher

4.1 As well as having the general responsibilities/duties of all members of staff (see 5 and 6), the Head Teacher also has responsibility for ensuring that the requirements of all relevant legislation, codes of practice and guidelines are met in full at all times.

4.2 The Head Teacher will be responsible for the day to day maintenance and development of safe working practices and conditions for teaching staff, support staff, pupils, visitors and any other person using the premises or engaged in activities sponsored by, or on behalf of the school. He/she will take reasonable, practicable steps to achieve this and will assign clear safety functions to other members of staff as appropriate.

4.3 In particular, the Head Teacher will, so far as is reasonably practicable:

- Be aware of and ensure compliance with the requirements of the Health and Safety at Work etc. Act 1974 and any other health and safety legislation and codes of practice relevant to the work of the school
- Ensure that statutory health and safety notices are displayed in appropriate locations within the establishment
- Implement this policy with regard to themselves and others, including the carrying out and documentation of hazard identification, risk assessments and suitable and sufficient control measures – identified in an appropriate health and safety action plan

- Ensure that all staff, including those with delegated health and safety responsibilities, understand and fulfil their obligations for the day-to-day implementation of the safety policy, including the carrying out and documentation of hazard identification, risk assessments and suitable control measures
- Ensure that adequate provision is made for employee consultation on matters regarding health, safety and welfare
- Discuss health and safety matters with the Local Authority, the Governing Board, the school health and safety committee and with other staff as appropriate, and seek advice on such matters as necessary from the most appropriate source
- Ensure that their decisions reflect the health and safety intentions articulated in the health and safety policy
- Ensure, at all times, the health, safety and welfare of staff, pupils and others via the provision of safe working conditions, systems of work, practices and procedures
- Ensure that all tools, machinery, plant and equipment are fit for purpose, adequately installed, guarded and appropriately used
- Ensure that all tools, machinery, plant and equipment receive planned maintenance when required and that maintenance records are kept in accordance with statutory legislation
- Ensure that defective equipment which constitutes a safety hazard is removed from service immediately and clearly labelled as defective
- Ensure that all substances provided within the school are handled, stored and used in the manner prescribed by the supplier and in accordance with their own or an appropriate hazard identification and risk assessment
- Ensure that appropriate protective clothing and equipment is provided and used whenever necessary
- Identify the training needs of staff and pupils and make recommendations to the Governing Board on resource implications of meeting such needs
- Ensure that all employees are trained and competent to undertake their work safely, are aware of their own limitations and know they must not undertake any task unless they have been trained, are competent and are confident they can carry out the task safely in the conditions that prevail
- Ensure that adequate instruction and supervision are provided for pupils as required
- Ensure that sufficient first aid cover and facilities are provided
- Collate accident information and, when necessary, carry out accident and incident investigations
- Ensure that emergency procedures including those for fire are in place, known, tested regularly and that any necessary revisions are made and disseminated

- Encourage staff, pupils and others to promote and achieve high standards of health and safety and suggest improvements and ways and means of reducing risks
- Monitor the standard of health and safety throughout the school, including all school based activities by:
  - Ensuring that frequent inspections of the premises are carried out and any deficiencies identified are rectified promptly
  - Carrying out periodic audit and review of the safety management systems that are in place
- Monitor the effectiveness of the implementation of this policy and submit a termly report to the Governing Board on health and safety matters.

5. Responsibilities and duties of other managers

(e.g. middle managers, phase leaders, site manager, etc.)

5.1 As well as having the general responsibilities/duties of all members of staff (see 6), managers will be directly accountable to the Head Teacher for the implementation and operation of the health and safety policy in their relevant departments and areas of responsibility.

5.2 All managers of staff will, so far as is reasonably practicable:

- Make themselves familiar and ensure compliance with the requirements of the Health and Safety at Work etc. Act 1974 and any other health and safety legislation and codes of practice relevant to the work of the School in general and also that specific to their area(s) of responsibility
- In particular be familiar with and take a direct interest in this health and safety policy and in helping other members of staff, pupils and others to comply with its requirements.

5.3 As part of their day to day work all managers will ensure that:

- Safe methods of work exist and are implemented throughout their area of responsibility
- Health and safety regulations, rules, procedures and codes of practice are being applied effectively
- All health and safety information is communicated to the relevant persons
- They themselves and others for whom they have direct responsibility take part in health and safety training as appropriate, (including ensuring that new employees receive health and safety induction training)
- Staff, pupils and others under their management are instructed in safe working practices and adequate supervision is provided at all times

- Regular safety inspections are made of their area of responsibility and recorded and corrective action is taken where necessary to ensure the health and safety of staff, pupils and others
- They carry out/are aware of hazard identification and risk assessments as appropriate for their area of work
- All tools, machinery, plant and equipment in the area in which they work are adequately guarded and are in good and safe working order
- All reasonably practicable steps are taken to prevent the unauthorised and improper use of all tools, machinery, plant and equipment in the area in which they work
- Appropriate protective clothing and equipment, first-aid and fire appliances are provided and are readily available
- Toxic, hazardous and highly flammable substances in the area in which they work are the subject of a written risk assessment, and are correctly used, stored and labelled
- All health and safety signs meet the statutory requirements (e.g. safety signs and signal regulations) and are clearly displayed in appropriate locations.
- They monitor the standard of health and safety throughout the area in which they work, encourage staff, pupils and others to promote and achieve high standards of health and safety and suggest improvements and ways and means of reducing risks.
- They report, as appropriate, any health and safety concerns to their Head Teacher, manager and safety representative.

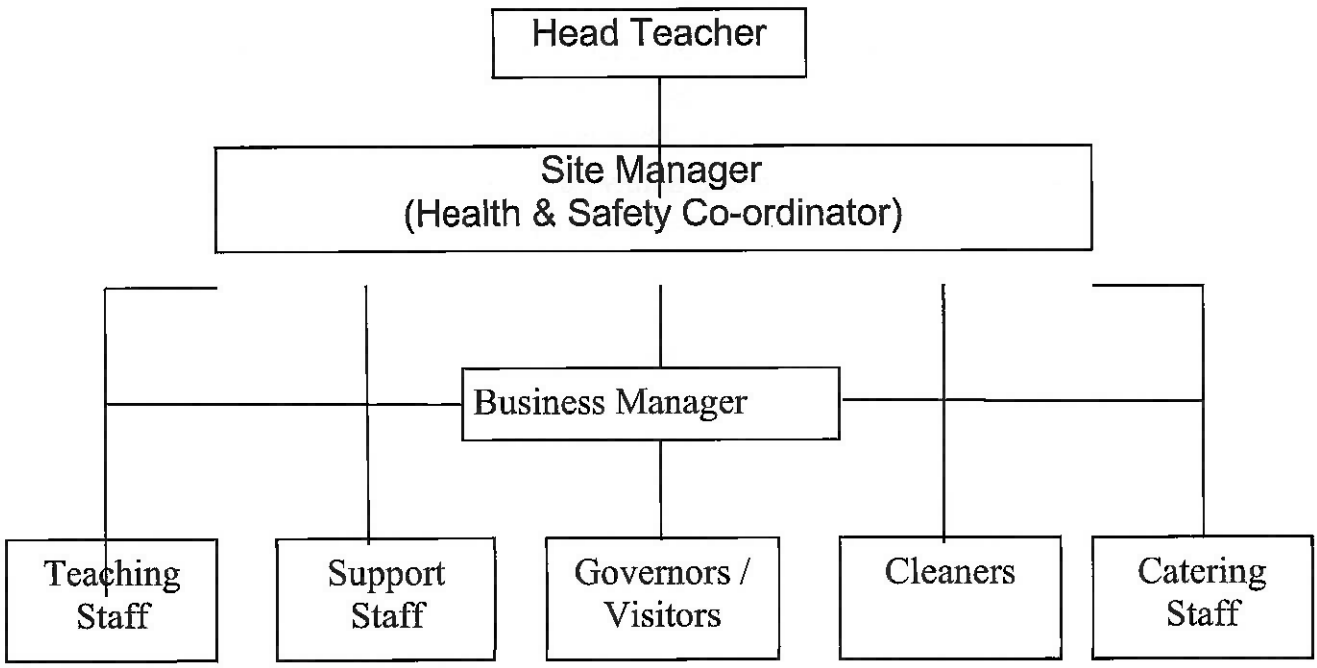
6. Responsibilities and duties of all staff

6.1 All staff will make themselves familiar and ensure compliance with the requirements of the Health and Safety at Work etc. Act 1974 and any other health and safety legislation and codes of practice relevant to the work of the School and also the particular area in which they work. They will, so far as is reasonably practicable:

- Be familiar with this health and safety policy and all safety arrangements including those for fire, first aid and other emergencies as laid down by the Governing Board
- Ensure that health and safety regulations, rules, routines and procedures are being applied effectively.
- Carry out/be aware of hazard identification and risk assessments as appropriate for their area of work
- Take part in health and safety training as required
- Inform their manager if there is any reason they are unable to perform any task without undue risk (e.g. illness, incapacity, etc.).
- Only undertake any task for which they have been trained and are competent or confident of undertaking safely. **If they are in any doubt they must seek further advice**

- Take reasonable care of their own health and safety and that of any other persons (staff, pupils, visitors, etc.) who may be affected by their acts or omissions at work
- Co-operate fully, as a legal duty, with their employer on health and safety matters, including following safe systems of work and not interfering with or misusing anything provided for their health, safety or welfare. This includes being prepared to 'whistle blow'
- Ensure that all tools, plant, machinery and equipment are adequately guarded, are in good and safe working order and are not used by unauthorised persons or in an improper manner
- Ensure that toxic, hazardous and highly flammable substances are correctly used, stored and labelled in accordance with their written risk assessment
- Use the correct equipment and tools for the job and any protective equipment, protective clothing or safety devices that may be supplied.
- Report any defects that they observe in the premises, plant, equipment and facilities and take action to ensure no one is put at risk
- Report all accidents and near misses immediately, whether injury is sustained or not, using the appropriate procedure, and recording these events on the appropriate online or hard copy form
- Report any medical or physical condition which adversely affects their ability to conduct their work in a safe and healthy manner to their line manager
- Where an imminent and significant risk to a person's health or safety exists, the activity being undertaken should be stopped and the line manager must be contacted immediately (as soon as safe to do so)
- Promote and achieve high standards of health and safety and suggest improvements and ways and means of reducing risks.

7. Health and safety reporting & communication arrangements



School systems must be clearly documented and understood. Therefore establishments are required to adopt consistent terminology in all their safety documentation.

8. Staff consultative arrangements

8.1 Employers must consult employees on matters that may affect their health and safety. This can be achieved by establishing a school health and safety committee.

8.2 The main function of a Safety Committee is to consult with employees on health and safety matters that may affect them, formulate and encourage implementation of health and safety arrangements; bring to light deficiencies in health and safety which arise, with a view to resolving them; and to review measures taken to ensure the health & safety of employees. This is often done by analysing accident figures, monitoring safety arrangements and making appropriate safety recommendations to the employer.

8.3 Employees have a statutory right to be consulted about health & safety matters and can make significant contributions towards achieving safe conditions at work. The Safety Representatives and Safety Committee Regulations, 1977 state that a recognised trade union may appoint safety representatives at a workplace where it has one or more members. Under the Health and Safety at Work etc. Act, an employer has a legal obligation to set up a safety committee if requested to do so by two or more safety representatives.

8.4 Representation on this committee will cover all appropriate areas of work or special hazards. As a group, the nominated safety representatives of each accredited trade union or staff association will be entitled to a place on the committee and shall decide amongst themselves which individuals should sit on the committee.

8.5 The Safety Committee will report to the Head Teacher, the Governing Board and/or the Local Authority as appropriate.

8.6 The functions of the Safety Committee are:

- To assist in the development of safety rules and safe systems of work
- To assist in the identification of hazards
- To receive, monitor and analyse accident statistics and trends and make recommendations for corrective action as appropriate
- To receive and examine safety audit reports
- To consider the introduction of new or revised safe systems of work
- To consider the implications with regard to health and safety of the introduction of new technologies into the workplace
- To instigate and promote health and safety awareness campaigns

- To assist in checking that the declared health and safety policy is fulfilled
- To receive and act upon reports from the Health & Safety Executive
- To consider reports from safety representatives
- To assist in the identification of safety training requirements
- To monitor the effectiveness of safety training

8.7 The functions of the safety representative are

- To attend safety committee meetings
- To investigate health and safety complaints by employees
- To investigate accidents, potential hazards and dangerous occurrences at the workplace
- To make representation to the employer on matters arising from the above
- To carry out regular formal inspections of the workplace and inspections following accidents
- To represent employees
- To receive health & safety information from the Head Teacher/employer/ Governing Board or Local Authority

8.8 Safety representatives are entitled to the following safety information:

- Records of accidents, notifiable diseases and dangerous occurrences
- Results of any health & safety tests or measurements in the workplace
- Information on articles/ substances used at work
- Technical information about health & safety hazards
- Information about proposed changes which may affect health & safety of employees/ pupils/visitors

Except where:

- The information is specific to an individual and without their consent
- Any disclosure which would, for reasons other than its effect on health, safety or welfare at work, cause substantial injury to the employers undertaking
- The information is obtained by the employer for the purpose of bringing, prosecuting or defending any legal proceedings

8.9 Safety representatives are entitled to reasonable time off work with pay to carry out their duties and for training. Training is not, however the responsibility of the employer but of relevant Unions or Professional Associations. They are also entitled to reasonable facilities to allow them to carry out their function, including facilities to meet and discuss issues.

Safety representatives are allowed to carry out an inspection of the workplace(s) that they represent subject to giving the employer reasonable notice, and providing the last inspection (of that part of the workplace) was not carried out in the previous three months; and may carry out more frequent inspections by agreement with the employer.

9. Hirers, contractors and others

9.1 When the premises are used for purposes not under the direction of the Head Teacher then, subject to the explicit agreement of the Governing Board, the principal person in charge of the activities for which the premises are in use will have responsibility for safe practices as indicated in the 'responsibilities and duties of the Head Teacher' (See 4).

The Governing Board notes its residual responsibility for the control of premises and will take all reasonable steps to ensure that such persons detailed above comply with the terms of this Policy.

9.2 The Head Teacher/Governing Board or their designated representative will seek to ensure that hirers, contractors and others who use the school premises conduct themselves and carry out their operation in such a manner that all statutory and advisory safety requirements are met at all times.

9.3 Where Governing Boards award contracts independent of the Local Authority - such as cleaning, catering services and building works etc. - they must give proper consideration to the health and safety aspects before the tendering of any such contract takes place and they must satisfy themselves that successful contractors comply with all relevant safety legislation. Governors, who act responsibly, taking note of relevant guidance and seeking advice when in doubt, should have no difficulty in meeting these obligations.

9.4 When the premises or facilities are being used out of normal school/college hours for an activity then, for the purposes of this policy, the organiser of that activity, even if an employee, will be treated as a hirer and comply with the requirements of this section.

9.5 When the premises are hired to persons outside the 'employ' of the Governing Board, it will be a condition for all hirers and others using the premises or facilities, that they are familiar with this policy, that they comply with all safety directives of the Governing Board and that they **do not**, without the prior consent of the Governing Board:

- Introduce equipment for use on the school premises
- Alter fixed installations
- Remove fire and safety notices or equipment
- Take any action that may create hazards for any persons using the premises

Hirers must:

- Comply with all school policies as described in the letting agreement (e.g. in relation to smoking, substance abuse, alcohol, etc.)

- **Not exceed** the capacity figures detailed on any lettings documentation.

9.6 All contractors who work on the premises are required to ensure safe working practices by their own employees under the provisions of the Health and Safety at Work etc. Act 1974 and must pay due regard to the safety of all persons using the premises in the accordance with this Act.

9.7 In instances where the contractor creates hazardous conditions and refuses to eliminate them or to take action to make them safe, the Head Teacher or their representative will take such actions as are necessary to prevent persons in his or her care from a risk or injury.

9.8 The Governing Board will draw the attention of all users of the premises (including hirers and contractors) to Section 8 of the Health and Safety at Work etc. Act 1974, which states that no person shall intentionally or recklessly interfere with, or misuse, anything which is provided in the interest of health, safety or welfare in pursuance of any of the relevant statutory provisions.

10. Risk Assessment

10.1 The Head Teacher will ensure that regular written risk assessments are undertaken of premises, methods of work and all school sponsored activities. These must be reviewed following changes in circumstances or personnel or in accordance with agreed timetables. The Local Authority requires a regular programme of planned assessments to be completed. In high-risk areas such as laboratories, workshops, gymnasiums, etc., risk assessments should be reviewed termly. In other activity areas, establishments should review risk assessments on an annual basis.

Written risk assessments will identify all defects and deficiencies together with the necessary remedial action or risk control measures.

10.2 The results of all risk assessments will be reported to the Governing Board who will prioritise issues and assign resources to undertake remedial/control measures where required.

11. Emergency Plans

11.1 The Head Teacher will ensure that emergency plans are prepared to cover all foreseeable major incidents that could put the occupants or users of a school at risk. In undertaking this work Head Teacher will have regard to the **Crisis Line** and **Snow Line** procedures published by the Local Authority.

11.2 The school plan will indicate the actions to be taken in the event of a major incident so that everything possible is done to save lives, prevent injury and minimise loss.

11.3 The school emergency plan will include arrangements for:

- Contacting emergency services
- Informing parents/guardians and the Local Authority
- Dealing with the media
- Business Continuity

11.4 The plans will be agreed by the Governing Board and any necessary actions will be rehearsed regularly by staff and pupils. The result of all such rehearsals will form part of the regular risk assessment review and the outcome will be reported to the Governing Board.

12. Emergency procedures

12.1 Granby Primary School has set out emergency procedures to be followed when necessary. These are detailed below.

12.2 Each class will have two red cards labelled with the classrooms number. In cases where the class teacher is unable to leave the room to summon help, a child takes one of the cards to the neighbouring classroom and the second card is sent directly to the school office. The arrival of a red card should initiate an immediate response to that classroom. Planned occasional testing of this system is undertaken. The cards should be suspended from a hook by each white board or blackboard in the classroom.

12.3 In case of fire or any other emergencies, an electrical bell will be sounded. When this is heard the school must be cleared. All children and personnel should exit on to the playground via the accepted routes for their class. Any child not in their classroom at the time of the bell will leave the building by the shortest route. All classes line up in register order on the playground, on the appropriate playground symbol. Everyone should remain on the playground until registers are taken and the all clear is given by the Head Teacher.

12.4 Where there is no electrical power or there is a fire alarm malfunction, handbells are to be found, one in the school office and one in the Key Stage 2 Hall. The children evacuate the building in exactly the same way as for the normal fire drill procedure.

12.5 Regular fire drills will take place in which the following points should be emphasised:

- Children and all adults will make their way to the nearest exit, closing any doors behind them
- Where staircases are blocked, the fire escapes should be used
- Children walk quickly and quietly to their assembly point on the playground

- If children are somewhere other than their classroom, they should go directly to the assembly point and NOT return to their classroom
- Children working with another adult will be escorted to the playground
- Children must not take their personal belongings with them or return to classrooms to collect personal items
- Children barefoot in PE should not stop to put on shoes and socks
- Class teachers will take a head count and a roll call using the registers which will be brought from the office
- Missing children, visitors or staff must be reported immediately
- Appointed staff will check the cloakrooms and toilets on their way to the playground
- No-one is to return to the building until the all-clear is given
- If the entire site needs to be evacuated, children will then proceed, with their teachers, to Aylestone Hall Gardens

13. Fire safety

13.1 Granby Primary School adopts the Leicester City Council's Fire Safety in LCC Workplaces Safety Management Standard and the setting's evacuation procedure which is below:

13.2 If an adult discovers a fire they should:

- Sound the fire alarm by breaking the glass of the nearest fire alarm call point. There is one positioned in each stairwell and one positioned in each of the halls. Adults and children should ensure that they know the position of these buttons.
- Call the Fire Brigade.
- Evacuate the building according to plan evacuation procedure
- Attack fire (only if safe to do so without endangering anyone).

13.3 Fire emergency procedures are posted on each classroom wall. The same procedure would be used for a gas leak or other evacuation. Staff should familiarise themselves with evacuation procedures; fire drills are undertaken at least once a term. Fire drills are undertaken out of school hours at least annually. In the event of a fire, an electrical bell will be sounded. If the electrics are down, a hand bell and/or megaphone will be used. The procedure for evacuation of the building is given in Section 12.

13.4 The Fire Officers are:

- Dale Cross - Headteacher
- Rob Penny - Site Manager
- Linda Broadhead - KS2 & playground stairwell
- Lisa Jarvis - KS2 & car park stairwell
- Tim Allured - KS1

- Sue Foreman – Business Manager

13.5 In the event of an "Invacuation", the megaphone horn will be sounded and all FS & KS1 children must go to the KS1 Hall and KS2 children must go to the KS2 Hall. The megaphones are located in the office. Invacuation drills take place regularly. The teachers' first priority is the safety of the children.

13.6 In the event of a fire alarm the following office responsibilities should be completed:

- Take grab bag
- Lock Camelot entrance
- SIMs – copies of today's registers should be handed to class teachers
- InVentry – copies of Evac lists should be handed to class teachers
- Medical records taken out of office
- Notice placed on front door – Drill in progress

13.7 In the event of a real fire it might be necessary, because of smoke etc, for children to be taken out of the school to Aylestone Hall Gardens. This possibility may be discussed with the children, the important thing being that they must do precisely what their teacher tells them to do in a calm and sensible way. Teachers must see for themselves what route and position is best for their class, depending on the location of the fire and smoke.

Children's safety must be our first priority. Class teachers must remain with them, rather than attempt to operate fire appliances. These may be operated by other staff. The person discovering the fire or the office staff will call the emergency services.

14. Personal Emergency Evacuation Plans (PEEPs)

14.1 Granby Primary School adopts the Leicester City Council's Evacuation arrangements for People with Disabilities – Personal Emergency Evacuation Plan Safety Management Standard

14.2 It is our responsibility to regularly review emergency provision for any pupils or staff with disabilities who require Personal Emergency Evacuation Plans

14.3 Any new pupils or staff who need PEEPs will have one drawn up immediately.

14.4 Visitors' needs and temporary needs of any pupils or staff will also be considered to ensure that prompt and safe evacuation can take place in an emergency.

15. First aid

15.1 Granby Primary School adopts the Leicester City Council's First Aid at Work Management Standard.

15.2 The arrangements for first-aid provision will be adequate to cope with all foreseeable incidents. First aid risk assessments will be carried out annually (and whenever significant changes occur) and appropriate actions will be taken to resolve any issues identified.

15.3 Pupils, parents, volunteers and visitors, as well as our employees, have been considered when assessing first aid provision.

15.4 The number of designated first-aiders will not, at any time, be less than the number required by law. This is determined by risk assessment. There are enough first aiders to cover for leave and other absences. This will include paediatric first aiders. Designated staff will be given such training in first-aid techniques as is required to give them an appropriate level of competence.

15.5 Each first-aider will have 'their own' first aid kit and be responsible for ensuring this is fully stocked and up to date. They must take care to ensure that when items are discarded, they are discarded safely. Other first aid kits are checked monthly to ensure that stock is adequate and in date. This function is undertaken by office staff. A first aid room is not required.

15.6 The Business Manager is responsible for ensuring that a sufficient back-up stock is held on site. Back-up stock is used to replenish first aid kits on an 'as-used' basis, and as part of the monthly check. Back-up stock levels are monitored by office staff and replenished monthly as required.

15.7 Notices will be displayed in prominent locations throughout the establishment identifying how to summon first aid in an emergency, who the first aiders are and their contact and location details. All first-aid signs and containers must be identified by a white cross on a green background.

15.8 First-aid kits must also be held at various locations throughout the school as determined by risk assessment (e.g. laboratories, gymnasiums, workshops, playgrounds, sports fields, etc.). A first-aider should be located within the immediate vicinity of one of these 'first aid points'. These locations will be prominently marked. Notices will also be displayed prominently in these areas See12.7).

Reception (Outside in foyer)	**KS1 Hall**	**Nursery**	**FS Cloakroom**

Fowler Cabin	**Kitchen**	**KS2 Hall x 2**	**Camelot Room**
Staff Room	**Office**	**KS2 cloakroom – playground side**	**Minibus**

15.9 A written record will be kept of all first aid administered either on the school premises or as part of a school related activity. Accident and incident forms (online and/or hard copy) will be completed as appropriate. Any accident requiring medical attention by anyone other than an in-house first aider, should be reported to the Local Authority using this link: https://lcc.info-exchange.com/schoolincidents

15.10 Adequate and appropriate first-aid provision will form part of the arrangements for out of hours activities at the school for which it is responsible, and also all out of school activities.

15.11 Off-site first aid kits are provided when groups are working off site; and a first aid kit is kept in the school minibus. First aid provision is co-ordinated by the Business Manager.

15.12 Any accident which is caused by unsafe situations, suspect equipment or other cause for concern will lead to an in-depth investigation and will be reported to Leicester City Council.

15.13 First Aid Box contents:

There is no mandatory list of items that should be included in a first aid container. The Business Manager should decide what to include in the first-aid containers from information gathered during their assessment of first-aid needs. As a guide, where no special risk arises in the workplace, the HSE recommend a **minimum** stock of first-aid items would normally be:

- A leaflet giving general guidance on first aid (for example HSE leaflet 'Basic Advice on First Aid at Work)
- 20 individually wrapped sterile adhesive dressings (assorted sizes) appropriate to the type of work (dressings may need to be of a detectable type for food handlers)
- Two sterile eye pads
- Four individually wrapped triangular bandages (preferably sterile)
- Six safety pins
- Six medium sized individually wrapped sterile unmedicated wound dressings - approximately 12 cm x 12 cm
- Two large sterile individually wrapped unmedicated wound dressings - approximately 18 cm x 18 cm
- At least 3 pairs of disposable gloves

- One pair blunt ended scissors
- Where mains tap water is not readily available for eye irrigation, at least a litre of sterile water or sterile normal saline (0.9%) in sealed, disposable containers should be provided. Once the seal has been broken, the containers should not be kept for reuse.

This is only a suggested contents list. It is likely that greater quantities of the above will be required in a school environment to reduce the risk of not re-stocking quickly enough. The assessment may conclude that there is a need for additional materials and equipment, for example a blanket, adhesive tape, disposable aprons, individually wrapped moist wipes. These should be kept in the first aid container if there is room, but may be stored separately as long as they are available for use if required.

15.14 First aid guidelines are as follows:

- Staff and midday supervisors are encouraged to be aware of the current advice about treatment of simple wounds and grazes, including the use of gloves
- Always use gloves when treating children where the skin has been broken
- Do not use cotton wool to clean wounds, use the sterile gauze which is provided
- Do not apply any creams, only water to the wound
- Where there is damage to the eye, only sterile eye washing solution should be used and after use the remaining fluid should be disposed of
- Record the injury using the online/hard copy accident and incident report form
- In the case of a more serious injury, please leave the children and seek the advice of a trained First Aider.

15.15 Epi-pens and inhalers

School keeps spare inhalers and epi-pens which may be used for children who have been prescribed these medicines. These are kept by school in case a child's own medication has been left at home or is out of date.

15.16 Our qualified First Aider at Work is Sue Foreman. 30 other staff members have completed Emergency First Aid, including most teaching assistants; 11 staff members have paediatric first aid training and 2 members are trained as Forest School first aiders. Additional information regarding staff who have attended epi-pen training and who are trained to support children with diabetes is located in he main office.

When an accident occurs, the child is reassured, treated and then, if considered fit, returned to class. Teachers are told what has happened and the accident/ incident is recorded.

15.17 In the event of a more severe injury, the child should remain where they fell. They are kept warm while an ambulance is called. No attempt should be made to move them until instructed to by a qualified First Aider. There should be only two adults with the child; the other adults in the area should be used to keep children away. Parents or relatives are then informed of the incident. In an urgent emergency the school will contact the Ambulance and then call parents to advise them about the incident and about which hospital their child is being transferred to. A member of staff would always accompany a child to hospital and remain with them until a relative arrives.

In some cases of serious injury it is necessary to complete forms and make appropriate phone calls. Members of staff should check with the Business Manager or Head Teacher to see if this applies.

15.18 If a child is unwell or if he/she is observed for a short period and it is felt appropriate, parents are invited to take him/her home. We do not have a medical room nor do we have the staff to cope with sick children at school. Before any contact is made please check with the Business Manager. Parents will never be sent a text to say that their child is ill or injured, although text might be used to ask parents to contact school.

Every effort will be made to contact the parents, although our main concerns are with the health and safety of the child. It is the responsibility of the parent to keep school informed of any changes to contact details.

16. Administration of Medicine

16.1 Granby Primary School adopts the Leicester City Council's Guidance No. 36A, Administration of Medicines which is shown at Appendix A

16.2 The appropriate form must be completed before any medications can be administered. This is available on our website.

17. Asthma

17.1 Asthma is sometimes described as wheezy bronchitis. It causes the airways in the lung to narrow, making breathing difficult. Children with asthma have inflamed airways which react to certain triggers (irritants) e.g. viral infections, allergies, exercise, cold weather, temperature changes, excitement, laughter, glue, paint and tobacco smoke.

17.2 Chemicals, cleaning materials and paint sprays are not to be used whilst pupils are present. Pets should be housed away from the classroom. Avoiding these in the school environment can lessen the incidence of asthma attacks.

17.3 It is essential that staff understand how to deal with medication and inhalers effectively. There are two types of treatment, both of which come in an inhaler. **RELIEVERS** – which help the child's breathing difficulties, these are generally in blue containers. **PREVENTERS** – which make airways less sensitive, these generally come in brown/white containers.

17.4 Children with asthma should have easy access to their inhalers in case they need them for any reason and be responsible for their use. Do not cause delay by locking up inhalers. Make sure all inhalers are always taken on school trips. Liaise with health professionals if a child needs the use of a nebuliser at school.

17.5 Children with asthma should have the opportunity participate fully in all areas of the school curriculum, including physical education. Children with exercise-induced asthma may be advised to take a puff of their inhaler before they start exercise. They should bring inhalers to the hall, swimming pool and sports fields. Children who say they are too wheezy to continue, should take their reliever inhaler and rest until they feel better.

17.6 An asthma attack can cause severe distress to the child and be a frightening experience when first observed. Action needed to deal with an asthma attack does not require specific medical training, and the following guidelines may be helpful:

- ensure that the reliever medicine is taken
- stay calm and reassure the child
- encourage the child to breathe slowly and deeply
- send for assistance if necessary
- contact the parents immediately
- call an ambulance urgently if the reliever has no effect after 5-10 minutes, the child is either distressed or unable to talk, the child becomes exhausted, there are any doubts about the child's condition

17.7 Spare inhalers are kept in school for emergency use by children for whom these have been prescribed.

18. Sun safety

18.1 Granby Primary School will take action to protect and educate children about staying safe in the sun. Education will take place through the curriculum including PSHE and through our pastoral care.

18.2 Children are encouraged to bring a bottle of water to school every day. This is kept with the child in their classroom and they are encouraged to help themselves to a drink at appropriate times during the day. In hot weather, children are particularly

encouraged to drink plenty - bottles can be re-filled at school. There are also drinking fountains available for the children to use.

18.3 In hot, sunny weather children are encouraged to cover up, wear a hat and use any shade available on the playground. If necessary, children will be brought in earlier than usual to have some indoor play, out of the heat of the midday sun.

18.4 Parents are encouraged to send sun cream in for their children. These must be clearly named. We will support children with the application of sun cream, aiming for them to be independent in its application.

18.5 In accordance with our uniform policy, we do not allow children to wear flip flops or sandals without a heel strap. This is to protect their feet from scrapes, cuts and bruises; and to help children to stay safe on our stairs.

19. Control of Substances Hazardous to Health (COSHH)

19.1 Granby Primary School adopts the Leicester City Council's COSHH – Hazardous Substances Safety Management Standard which is shown at Appendix B

19.2 There are times in school when people need to work with potentially hazardous substances. Before these substances are used, a responsible person for that area must have carried out a risk assessment to ensure that the substances are appropriate for the job in hand, and that they are used according to the instructions given by the manufacturer.

19.3 All persons who use the substances must strictly follow instructions, understanding the Health and Safety data given by manufacturers, taking care in the use of the substance, wearing appropriate personal protective equipment, and being aware of other people who may come into contact with what they are doing.

19.4 Bleach is not to be stored on the school site.

20. Safeguarding and child protection policy

20.1 Granby Primary School has a robust Safeguarding and Child Protection Policy which can be found on the school website

21. Intimate care

21.1 Granby Primary School accepts that some children in our care may accidentally wet or soil themselves; or be wearing nappies. It is our policy to ensure that any child will be promptly cleaned and dried. The following precautions are to be followed:

- staff to wear disposable gloves and aprons while dealing with the incident

- soiled nappies to be double wrapped or placed in hygienic disposal facilities if available
- changing area to be cleaned after use
- hot water and liquid soap is available for immediate hand washing
- a hot air dryer or paper towels are available for drying hands
- children will be cleaned and changed as soon as possible
- two members of staff will always look after a child needing intimate care

21.2 There are facilities for showering children and for laundry if required.

22. Lone Working

22.1 Granby Primary School adopts the Leicester City Council's Lone Working Safety Management Standard

22.2 All lone working activities have been identified and risk assessed. Lone workers must not engage in manual handing or work at height. There is no permitted activity which is not safe. There are control measures which have been identified and implemented.

22.3 Employees who may be lone workers are offered strategies for preventing and managing violence and keeping safe. There are procedures in place for dealing with incidents, accidents and emergencies.

22.4 Lone working procedures have been developed and communicated. These are regularly reviewed, along with the control measures identified.

22.5 At Granby Primary School lone working is an occasional activity rather than a routine activity and occurs when people work outside of normal working hours. Only 6 people are currently authorised to be lone workers. Any future authorisations will consider any unstable health conditions that may make lone working unadvisable, such as epilepsy or diabetes. Currently authorised lone workers are:

- The site manager
- The IT technician
- The Head Teacher
- The deputy Head Teachers
- The Business Manager
- A relief key holder

22.6 Lone working tasks include, but are not limited to:

- Locking or unlocking the site
- Desk based work outside of normal hours

- IT technician's work outside of normal hours
- Site management work outside of normal hours

22.7 The place of work may represent an increased risk because of:

- Long stone stairways
- Working in more remote parts of the building

Lone workers should always secure themselves in the building, in the knowledge that the fire doors provide quick and easy means of escape if needed.

22.8 Women who are lone working may be more vulnerable than others.

22.9 Lone workers are instructed to have a mobile phone with them at all times whilst in the building. This includes taking the phone with them from one part of the building to another. If their phone is not available, or the battery is dead, lone working is not permitted.

22.10 Authorised lone workers will have one another's mobile phone numbers and a list of emergency family contacts for all authorised lone workers for use in extreme circumstances.

22.10 Lone workers are instructed to arrange in advance to send a text message to another authorised lone worker immediately prior to entering the building. This message should explain that they are about to enter the building and the estimated time at which they expect to leave the building. The recipient should acknowledge receipt. If receipt is not acknowledged, the lone worker should try another authorised lone worker.

22.11 Lone workers are instructed to send a text message to the same authorised lone worker immediately on leaving the site. The message should explain that they have left the building and the site is secure. The recipient should acknowledge receipt.

22.12 If a lone worker does not make contact on leaving the building, the other authorised user should leave no more than 20 minutes after the estimated time given before making contact with the lone worker. If contact cannot be established, the lone worker's emergency family member should be contacted.

22.13 If there is still a question mark over the lone worker's well-being, two others should arrange to attend the premises and if a visual check suggests violence, the police should be called before entering the building.

22.14 These arrangements will be regularly monitored and reviewed to ensure that they remain effective.

23. Mobile Phones

23.1 Granby Primary School sets out its policy in relation to mobile phones in the school's Communication Policy.

24. Manual Handling

24.1 Granby Primary School adopts the Leicester City Council's Manual Handling Safety Management Standard

24.2 All manual handling operations have been identified, risk assessed and control measures put in place as appropriate. Only people who have been identified and trained in manual handling are permitted to engage in manual handling operations.

24.3 The risk assessments, and control measures, are regularly monitored and reviewed. These set out risks and control measures and provide the basis for our actions in this respect.

25. Display Screen Equipment

25.1 Granby Primary School is guided by Leicester City Council's Display Screen Equipment (DSE) guidance and information for employees on display screen equipment.

25.2 DSE users are defined according to the DSE regulations; teachers are not considered DSE users. All users are risk assessed on an annual basis and appropriate control measures are put into place. Staff are actively encouraged to rotate tasks to spend a few minutes in every hour away from the DSE.

25.3 Employees are expected to complete their DSE risk assessment in a timely manner; to set up and operate their workstation correctly and to abide by the procedures laid down.

25.4 Any employee who is designated as a DSE user has the right to request an eye test. The employer reserves the right to designate an optician for this purpose. The frequency of follow up eye tests will be determined by the optician.

25.5 Where the optician confirms in writing that glasses are needed exclusively for DSE use, the school will contribute £70 towards the cost. This figure is reviewed periodically and is set to reflect the cost of a basic pair of glasses. If employees wish to purchase a more expensive pair, this amount will be made available towards the cost. The balance will be funded by the employee.

26. Work at height

26.1 Granby Primary School adopts Leicester City Council's Work at Height Management Standard Issue 3 (April 2011) Appendix C

26.2 All work at height activities have been identified, risk assessed and control measures put in place as appropriate. Appropriate equipment has been selected and provided to minimise the risk to our employees. The equipment is periodically tested and repaired as required. Inspection and maintenance records are kept.

26.3 Work at height may include, but is not limited to:

- Working on a flat roof
- Working from a ladder or stepladder
- Work on stairwells

27. Smoking

27.1 Granby Primary School is a no smoking site. This applies to inside the building, playground, Camelot Room and elsewhere. It also applies on all trips and visits. Any persons wishing to smoke should sign out and leave the vicinity of the building.

28. Asbestos Awareness

28.1 In order to avoid being exposed to asbestos, staff must be aware of the locations of asbestos within the school.

28.2 If staff are unsure about any material, and it fits the suspect material category (see site manager for advice), assume that it is until it is, verified otherwise.

28.3 Asbestos in ceiling tiles, floor tiles, undamaged laboratory cabinet tops, fire doors etc will not release asbestos fibres unless they are disturbed/damaged in some way.

Asbestos Cement Pipework Sleeve	Court Yard infill to window	Court Yard pipework	Court Yard pipe sleeve in wall
Court Yard Debris to wall	Boiler Room Debris to wall	CP stairwell – insulation board to door	PL stairwell – insulation board door surround
CP stairwell – insulation board door surround	PL stairwell – insulation board door surround	Hall – Insultation Board door surrounds	

29. Trips and Visits

29.1 Granby Primary School adopts the Leicester City Council's procedures under EVOLVE software for planning, processing, monitoring and reporting on educational visits. All visits must be approved by the Head Teacher via Evolve before occurring.

29.2 Booking a visit is the responsibility of the member of staff concerned, in liaison with the Head Teacher. This includes the completion of risk assessments, calculation of costs and an outline of staffing arrangements. Letters requesting parental permission will be produced by the office team and arrangements must be in hand at least a month before the anticipated travel date.

29.3 There is an expectation that trips will represent good value for money and enhance the classroom experience, with clear learning objectives identified.

29.4 Staff must cater for the inclusion of children with special needs and medical conditions. A mobile phone, first aid kit and a first aider must be taken on the trip. Information about the trip, and the names of children and adults on the trip, must be recorded at school on departure.

30. Staff well being

30.1 Granby Primary School adopts Leicester City Council's Stress at Work H&S Employee Information Sheet Issue 2 (June 2009); and the Stress Management Health and Safety Management Standard, parts A, B, C and D. All of these can be found at Appendix D

30.2 The Health and Safety Executive defines stress as *"the adverse reaction people have to excessive pressure or other types of demand placed on them."* This makes an important distinction between pressure and stress. Pressure can be motivating and improve performance. Stress is a negative reaction that people have to excessive pressures which may make them feel unable to cope.

Stress is not an illness, but, if experienced for a prolonged period, can result in psychological illness such as anxiety, depression or physical symptoms such as headaches. If particularly severe, it is thought to be able to contribute to physical illnesses such as high blood pressure or heart disease and susceptibility to frequent minor illness. Developing coping strategies such as taking exercise and finding ways of relaxing can help combat the effects of stress.

At an organisational level, stress can result in deterioration of morale, performance and staff turnover. Sickness absence due to stress can cause a domino effect where increased workload due to sickness absence of a colleague can in turn lead to increased workload pressures and stress in other members of the team.

30.3 Granby Primary School is committed to promoting a healthy and supportive working environment and we aim to preserve the physical and psychological health and well-being of all staff. We recognise that our staff are our most important asset and that their well-being is essential to effective work performance. We recognise that we have a responsibility to support staff experiencing workplace induced stress, and also that sources outside of work can be a significant factor in causing stress. Although we have no control over external and personal factors, we are committed, where possible, to manage the risks which are within our control.

Furthermore we aim to:

- minimise the harmful effects of stress
- provide effective support for all staff
- help each individual to achieve an appropriate work-life balance
- take a positive and understanding approach to the management of stress in line with current good practice
- respect confidentiality.

30.4 We understand that the following actions undertaken by Granby Primary School can help to avoid and/or manage stress:

- Ensure good communication between management and staff, particularly where there are organisational or procedural changes
- Ensure staff are fully trained to discharge their duties
- Ensure staff are provided with meaningful opportunities to develop
- Monitor workloads to ensure that people are not overloaded
- Attend training as required in good management practice and health and safety
- Be vigilant and offer additional support to a member of staff who is experiencing stress outside work e.g. bereavement or separation.

30.5 Whilst Granby Primary School will make every effort to help employees, often the first step must come from the individual. It is the responsibility of each employee to seek assistance as early as possible if he or she is manifesting symptoms of stress.

If any individual believes that they are suffering from stress or are struggling with their work-based duties then the issues should be discussed with the line manager. Where this is not appropriate, concerns should be raised with the Head Teacher, Deputy Head Teacher or the Business Manager.

If any individual believes that a fellow work colleague is showing signs of stress then this should be reported to a member of the school's Senior Management Team in order that the appropriate action can be taken.

30.6 As a school, we promote work life balance. We seek advice from outside support agencies such as occupational health. We have policies and procedures to deal with bullying, harassment and issues of personal safety. We seek opportunities to

care for the staff through initiatives and through discussions within performance and development reviews.

30.7 We undertake a regular staff wellbeing survey which informs an action plan within the school development plan. Any issues are incorporated and addressed over the coming year.

30.8 Staff can benefit from a counselling service provided by Vivup, part of Leicester City Council's traded Health and Safety Service. It is open 24 hours a day, 365 days a year. The number is 0800 023 9324

30.9 Bullying of any kind is unacceptable at our school. If bullying does occur, staff should be able to tell and know that incidents will be dealt with promptly and effectively. We are a TELLING school. This means that anyone who knows that bullying is happening, is expected to tell.

30.10 If someone feels that they are being bullied at work, they should:

- Tell the bully and ask them to STOP!
- Report bullying to their line manager or any member of the Senior Management Team
- Report the matter using the anti-bullying email address:
- bullying@granby.leicester.sch.uk
- Be a survivor – not a victim. The difference between a child being bullied and an adult being bullied is that adults can take personal responsibility for how they deal with the situation. Address it; resolve it. Staff will be supported through the process.
- Take advice from the confidential staff counselling service, Vivup
- If the bullying doesn't stop, the grievance procedure is to be used as a last resort
- In addition, trade union representatives are available to provide support
- Speaking with a close colleague could provide a starting point if nothing else seems possible

30.11 If someone hears any member of staff being bullied, it should be challenged. If staff know that a colleague is suffering as a result of bullying at work, that person should be encouraged to take action.

30.12 Staff may be concerned about what would happen if they told a manager. This process would be followed:

- First, the bullied member of staff would be listed to. It is important that someone being bullied feels that they are believed, supported and empathised with
- When the member of staff is ready, over a period of time if need be, they would be asked to write down all the examples they can think of when the bullying has happened. Dates, times and names of any witnesses would help with this but if staff can't remember, that's okay. Moving forwards, staff would be asked to record this

information routinely

- We would work with the bullied member of staff to reach a stage where they felt that they could tell the bully about the impact of their behaviour. This wouldn't be rushed and the bullied member of staff would completely set the pace. There would be discussion about how this might be - whether it's done face to face or via an intermediary or using the written statements or in a completely different way. This can feel very uncomfortable so we will work with staff to find the most acceptable way forward and someone of their choosing can be with them, if they wish.
- The possible outcomes are that the situation could be resolved informally; the person doing the bullying may be subject to disciplinary action under the terms of our policy; and if members of staff feel that their situation is not being addressed adequately by management, they may decide to use the grievance procedure to formalise their complaint.

30.13 Staff who think they need help to address their own bullying behaviour and want support to stop bullying or change their behaviour, should speak to a member of SMT.

31. Abuse against staff

31.1 Granby Primary School adopts the Leicester City Council's Violence and Aggression Management Standard

31.2 All work activities which could give rise to violence and aggression have been identified and risk assessed. No unsafe activities have been identified; some control measures are in place, reviewed regularly.

31.3 Where appropriate, staff receive training in strategies for preventing and managing violence and keeping safe. A violence and aggression procedure has been developed and communicated to all employees.

31.4 Procedures are in place for dealing with incidents, accidents and emergencies; these are monitored and reviewed regularly.

31.5 Violence and aggression is defined as "Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work".

31.6 The principles on which this policy is based are:

- All violence is unacceptable, whatever form it takes and whatever reasons are cited for it
- We recognise the risks to staff from violence at work and the obligations of the organisation to minimise the risks
- Dealing with, or being subject to, violent behaviour is not considered to be a failure on the part of the employee

- Violence is not considered to be an acceptable part of any job, nor is it part of the duties of an employee to accept violent behaviour
- We recognise the potentially damaging effects of violence on individuals, work performance and the organisation as a whole, and are committed to combating it
- Staff who have been assaulted or suffered verbal abuse are fully supported by the managers and Governing Board
- All reported incidents of violence will be appropriately investigated and reported to the police, subject to the agreement of the employee
- The Governing Board will send formal letters to any people making threats against, or verbally abusing staff

31.7 The working environment can play an important part in the prevention of violence or aggression. Examples of factors that can increase violence or aggression at Granby Primary School include:

- Poor staffing arrangements
- Excessive waiting times
- Lack of, or poor seating
- Poor quality of services
- Mistakes, especially in cash payments
- Time of day
- Security work
- Reception work
- Poor quality environment
- Delivering challenge to parents
- Feelings running high about the children's experience

31.8 It is recognised that hazards presented by a particular task may vary. The following list gives examples of activities which may present a risk of violence or aggression:

- Working alone
- Contact with members of the public who have a known history of violence
- Collecting cash
- Building management - locking up and call outs
- Transporting people who have challenging behaviour
- Physical intervention strategies
- Visiting families in their own home

31.9 Practical measures which help us to prevent these risks include (but are not limited to):

- Using two people to carry out the work
- Providing means of communication -mobile phones, radios, etc
- Having a cash collection service or a cashless office
- Having a home visits and/or lone working procedure

- Having shared calendars and leaving an itinerary at the Office if need be
- Periodic reporting to a colleague or buddy

31.10 Preventative measures include but are not limited to:

- Security doors; reinforced barrier at reception
- Reception layout prevents a person from easily climbing over the desk
- CCTV cameras in use
- Emergency red card system in operation in all classrooms
- Clear information, instructions and training provided to staff
- Personal Safety Awareness training is accessible through e-learning via Leicester Learning Pool
- Suitable supervision
- Training and advice on de-escalation techniques
- Summoning assistance, including the police, where necessary

31.11 Safe working arrangements will be monitored and reviewed regularly to ensure that they remain effective.

31.12 The Education Act 1996, Section 547 allows the Head Teacher to remove certain people from the school premises. Police assistance should be requested in any case of trespass and nuisance which involves violence or threats of violence. Physical force should not be used other than in extreme circumstances.

31.13 In the case of persistent trespass, the school or LA can consider the possibility of seeking an injunction.

31.14 Weapons are not to be brought onto school premises.

32 Nut Free School

32.1 Some children and adults in our school have severe nut allergies which can be life-threatening. We expect parents to let us know if their children have nut or other food allergies so that we can provide appropriate care as and when needed. We have taken advice from health authorities, education authorities and the parents of some of our nut allergy sufferers in drawing up these instructions.

32.2 Nut allergies can differ for different people. The allergy could be activated by eating nuts, or just by touching nuts. For some nut allergy sufferers, the allergy is airborne which means that the sufferer doesn't have to touch or eat the nuts for a lethal reaction to occur.

32.3 GRANBY IS A NUT FREE SCHOOL. This means that we do not have any nuts, or

food containing nuts, on school premises. The only snack brought into school should be fruit. Lunch boxes should not contain chocolate, sweets, peanut butter or chocolate spread because these items tend to contain high concentrations of nuts and nut oils. Lunch boxes should not contain chocolate or sweets as these are treats that should be saved for when children are at home. If biscuits, cakes, cereal bars and such like are included in lunch boxes please check the ingredients to make sure that these items do not contain nuts. DO NOT SEND ANY FOOD INTO SCHOOL WHICH CONTAINS NUTS.

32.4 Our children are naturally generous and want to share. However, we hope you will join us in discussing the importance of NOT sharing the food they bring into school. Our message is, "Your food is for you; it has been especially chosen, bought and packed, just for you. Food that is safe for you, might not be safe for someone else." WE DO NOT SHARE FOOD AT GRANBY.

32.5 In addition to asking parents for their support in this way, we will be working with all children to raise awareness of the dangers, educate them about food allergies, and support them to monitor and manage risky situations. We know that Granby parents will want to take this issue very seriously and help us to make sure that all children are kept safe whilst at school.

33 Outdoor Play Equipment

33.1 Granby primary school playground, provides opportunities for young people to engage in active play in addition to experiencing quiet and environmental areas.

Opportunities for balancing, climbing, hanging and swinging are planned both within the physical education curriculum and during play breaks outside.

33.2 Children are supervised at all times whilst using outdoor play equipment. Risk assessments are conducted to determine the appropriate number of people required to supervise play areas. (This should take into account observation points, line of sight etc.)

Supervising staff must be familiar with the equipment, the rules for use and of the ability of the children.

33.3 The pupils are educated about the use of climbing equipment.

- Staff/supervisors on duty ensure that outdoor play equipment is visible and can be appropriately supervised when in use.
- Staff/supervisors on duty have a responsibility to make regular checks for defects and report them as appropriate.

- A rota for use, taking into consideration the age and number of children using it at any one time, ensures that there are not too many children competing for the equipment at any one time.

- Staff/supervisors have a responsibility to ensure appropriate behaviour

- Consideration is given to weather conditions. Outdoor play equipment should not be used during wet or icy conditions. The blue floor area is coned off in ivy conditions when it can become very slippery.

- Apparatus must only be used at appropriate times when supervised. Parents are informed and frequently reminded that the apparatus is for school aged children only and not to be used before and after school.

33.4 Suitable clothing should be worn. Hazards can arise from unfastened coats, woollen gloves, scarves, ties, etc.

Appropriate footwear must be worn. Hazards arise from slippery soles, open toed and sling back sandals, heels and untied laces, etc.

33.5 All **new** outdoor play equipment must be designed, constructed, installed and maintained in accordance with European standards BS EN 1176 and BS EN 1177.

These European standards are not retrospective or a legal requirement, but represent good practice in the event of an accident claim. Play equipment which was considered safe under BS 5696 will still be safe under the new standards.

The independent competent person carrying out annual inspection and maintenance will advise whether any alterations need to be made.

Only manufacturers/contractors with appropriate play industries registration or ROSPA membership are used in the planning or installation of new outdoor play equipment. Companies must have API (Association of Play Industries) or BSI registration for equipment manufacture and installation.

Scrambling and climbing elements must not exceed 3 Metres, for children below 5, height should be a maximum of 1.6M.

Height should not be the dominant feature on any item of equipment. Interest, challenge and enjoyment should be achieved without the need for height itself.

Structures must be spaced clear of each other to prevent one activity interfering with another, they must also be clear of walls, fences etc.

Suppliers of new equipment must supply information relating to surfacing requirements, intended age range, risk assessment, installation instructions,

servicing and maintenance instructions

33.6 **All** products must meet the appropriate BS EN Standards. Both **portable** and **fixed** climbing equipment that has a fall height of 600mm **must** be on an impact-absorbing surface if used outside. (Fall height is the distance from the clearly intended Board support to the impact area)

Although impact absorbing surfaces cannot prevent accidents they may reduce the level of injury. There are a range of surfaces available which provide impact attenuation including rubber mats and tiles, bark etc.

The extent of surfacing around static equipment is dependent on the fall height, this should extend at least 1.75M beyond the outermost points of the base of the frame.

When considering so called safety surfaces their likely effectiveness, durability, practicality and management should be taken into account. The type of surface under play equipment is just one of the design elements in a successful play area.

Materials such as top soil and turf do have limited impact absorbing properties.

Where bark is used this area should be a minimum of 300mm deep with a recommended particle size of 38mm max and 12mm min. Loose materials will spread if not suitably contained and will need to be topped up from time to time, thus it is important to have additional bark available to top up to the original level.

33.7 For new equipment a post installation inspection must be arranged.

BS EN 1176 recommends that all outdoor play equipment be inspected and maintained on a regular basis. Such inspection and maintenance is at 3 levels.

Level 1 checks – Daily / pre use checks by staff (these do not require formal recording)

Concentrating on the following points:

- No evidence of obvious wear / damage
- Area safe from health hazards e.g. needles, glass, faeces etc.
- Impact absorbing surfaces no cuts, tears, wear or unstuck areas
- All fastening tightly secured
- No broken chains, stretched links or loose or twisted shackles
- Uprights unbroken and firm in the ground

Where any defects / hazards are identified appropriate steps must be taken to prevent use until problems have been satisfactorily resolved.

Level 2 checks – termly inspection in house

A more thorough check of the equipment to be conducted termly and these records kept on site.

Level 3 checks – annual inspection
A detailed certified inspection by an independent competent person capable of inspecting to BS EN 1176 and 1177 these checks must be formally recorded and records kept on site. ROSPA can be used for this.

Such checks ensure safety and identifies any improvements required in terms of the European standards

The competent person conducting the annual inspection will advise on the extent of surfacing required for both static and moving equipment

34 Portable Electrical Equipment

34.1 It is the responsibility of managers to ensure that portable electrical equipment is tested and inspected in line with this document in any area under their management.

34.2 A suitable and sufficient risk assessment must be undertaken for any portable electrical appliance. Permission must be sought from the Site Manager, Business Manager or Head Teacher before any portable electrical appliance in brought into school.

34.3 Portable electrical equipment used in school will be subject to maintenance, including visual inspection, combined inspection and PAT testing. Our site manager and ICT Technician are qualified PAT testers. Their instructions must be followed. PAT testing will be conducted irrespective of the age of the appliance.

34.4 Portable electrical equipment includes:

- Power tools, e.g. drills, grinders, saws;
- Domestic appliances, e.g. irons, hair dryers;
- Catering appliances, e.g. kettles, mixers, blenders, toasters;
- Ventilation and heating equipment, e.g. fans, heaters and dehumidifiers;
- Office equipment, e.g. photocopiers, personal computers, desk lamps and shredders;
- Extension cables and leads, transformers and battery chargers.

It can also mean an appliance, such as a hair dryer or iron where the flex is hard wired into a fused spur outlet. The reason these appliances are classed as portable electrical equipment is that they are meant to be moved when in use. The idea that a hard wired appliance is classed as a portable appliance is often missed. These appliances are not PAT tested but they should be subject to visual inspections.

34.5 Extension cables and multi-gang sockets must not be used without the express permission of the Site Manager, ICT Technician, Head teacher or Business Manager.

35 Body Fluid Spillages

35.1 Board fluid spillages must be cleared up immediately and this can be done by the staff in situ. Board Fluid Spillage Cleaning Kits can be found in the Penny Suite and in the cleaners' cupboard by the main entrance. Red mops are used for toilets; blue mops are used for classrooms. Blue mops should be disposed of in the wash bin in the Site Manager's yard after use. Gloves should always be worn. Aprons and other personal protective equipment (PPE) are available if required.

35.2 Urine should be mopped up, disinfected and dried. If on a carpet, it should be carpet shampooed and disinfected.

35.3 Faeces, where solid, should be picked up and flushed away. Any soft or liquid faeces should be wiped up with paper towel. If on a carpet, it should be washed with soapy water, carpet shampooed and disinfected. On a hard floor, it needs to be mopped.

35.4 Vomit should be covered with specialist vomit absorbent, and then cleaned in the same way as faeces.

35.5 Blood should be disinfected and mopped if on a hard floor. The mop head should be permanently disposed of if there is a lot of blood. Blood on a carpet should be dealt with as faeces.

36 Visitors

36.1 All visitors and contractors coming in to the school must report to Reception. A folder of information contains everything that visitors and contractors need to know and a leaflet provides a useful summary of this information.

36.2 Visitors will be asked to sign in and will be issued with a photo ID badge that must be worn prominently so that staff and pupils can see it. Visitors will also be asked to produce their DBS certificate and/or other forms of photographic identification.

36.3 Regular visitors to school will need to sign in on each occasion. If their organisation provides them with a clearly definable badge we may decide that this is adequate and a visitors pass will not be issued. Visitors must make sure that they wear this badge and that it is clearly visible to staff and pupils.

36.4 The emergency procedure for visitors is as follows:

- Your host will explain what to do in the case of emergencies and fire alarms.
- The alarm is a continuous bell. You must leave the building by the nearest exit.
- Stay with your host as they will escort you to the assembly point and ensure that you are recorded present by the administration staff.
- The assembly point is the playground.

- Do not take any personal risks.
- You must not re-enter the building until told it is safe to do so.

36.5 If visitors need first aid or feel unwell they should go to the office for help and attention

36.6 Contractors must ensure that they are fully conversant with the safety rules and regulations to be observed by contractors working on site. As a visitor to our school it is essential that contractors follow any health and safety guidelines that may apply. This will assist us in meeting the requirements of the Health & Safety at Work Act 1974.

36.7 Visitors and contractors must sign out when they leave the premises.

36.8 Adults visiting or working on the school site play an important part in the life of the school. They can play a part in keeping pupils safe whilst working at, or visiting, the school by observing the following guidelines:

- Visitors must not initiate verbal or physical contact with pupils unless it is appropriate and a part of the agreed reason for the visit.
- Visitors must not give any personal information to pupils, such as their mobile number or address. Visitors must not provide pupils with their personal email address, and only provide professional work email if it is necessary as part of the reason for their visit.
- Visitors must not give pupils details of their personal social network accounts or engage in any communication with pupils using social networking sites.
- If visitors have any concerns that a pupil may be at risk of harm, report it immediately to a designated safeguarding lead (Karen Carr, Dale Cross, Jane Swift or Sue Foreman) who can be contacted via the main school office. Do not discuss your concerns with the pupil, and do not carry out an investigation.
- If a pupil makes a disclosure to you, do not promise confidentiality. Explain that you will need to talk to someone else. Inform the designated senior person for child protection (Karen Carr, Dale Cross, Jane Swift or Sue Foreman) of your concerns immediately.

37 Water hygiene

37.1 A water hygiene risk assessment should be carried out by an appropriate Board at least every two years, including a Legionella risk assessment. All deficiencies and hazards identified by this risk assessment should be addressed through a planned programme of remedial works.

37.2 Maintenance checks are carried out routinely, results are logs and returns submitted in line with statutory requirements. This includes water outlets (hot, cold and blended); temperatures from the calorifier and return pipes; hot water tap temperatures; descaling and disinfecting of tap outlets and shower heads;

37.3 Hot water tap outlet temperatures accessible to children should be below 43 degrees C; and for children under 6 years old, below 39 degrees C.

37.4 All tap outlets and shower heads must be descaled and disinfected every 3 months. Showers must be run for at least 2 minutes every week.

37.5 Little or unused outlets must be regularly flushed; and always after a long period when the water system has not been in use, such as after school holidays.

37.6 Appropriate training will be provided for personnel responsible for water hygiene monitoring and testing.

38. E Safety

38.1 We recognise that learning is a life long process and that e-learning is an integral part of it. Ensuring that we provide pupils with the skills to make the most of information and communication technologies is an essential part of our curriculum. The school is committed to the continuing development of our ICT infrastructure and embracing new technologies so as to maximise the opportunities for all pupils, staff, parents and the wider community to engage in productive, cooperative and efficient communication and information sharing.

38.2 However, as in any other area of life, children are vulnerable and may expose themselves to danger, whether knowingly or unknowingly, when using the internet and other technologies. Additionally, some young people may find themselves involved in activities which are inappropriate, or possibly illegal. E-safety seeks to address the issues around using these technologies safely and promote an awareness of the benefits and the risks.

This statement sets out clearly our expectations on pupils, staff, parents and members of the wider community to ensure best practice.

38.3 Physical Safety: All electrical equipment in the school is tested annually to ensure that it is safe to use. Pupils are taught about the dangers of electricity as part of the science and PSHE curriculum. We expect pupils to behave appropriately near electrical sockets and appliances.

All the projectors in our school have the recommended light levels, which are adjusted depending upon the light levels in the room and according to the Government's health and safety guidance. Pupils are taught that they should not look directly at strong light sources such as the sun, lasers or data projectors. We expect all users to not look directly into the light beam when working on the interactive whiteboards.

Workstations are cleaned and sanitised regularly and a record is maintained by the Premises Manager. We expect all users to refrain from eating and drinking when working at a computer. Health and safety guidance states that it is not healthy to sit at a computer for too long without breaks. Pupils are taught correct posture for sitting at a computer and that sitting for too long at a computer can be unhealthy. We expect all users to take responsibility for their own physical well-being by adopting good practices.

Computers and other ICT equipment can be easily damaged. Pupils are taught the correct way to use ICT equipment. We expect pupils to respect ICT equipment and take care when handling and using.

38.4 Network Safety: All users need to log on using a username and password. We expect all users to only logon using their own log-on details.

Each user is given an allocation of disk space for the storage of their work. Pupils are taught how to save their work into their "My documents" area. We expect pupils to save and keep their work to build up a portfolio of evidence.

Access to other users' "My documents" areas are restricted by the network. Pupils are taught not to access another user's work without permission. We expect pupils to respect the privacy of all other users and to make no attempt to access or interfere with another user's work.

On the network there are "Public Drive" areas where many different groups of users can save work so that it is available to others. Pupils are taught how to access and save to these shared resource areas. We expect pupils to respect the contributions of others, not to delete or alter others' work and to ensure that they only save work to shared areas with permission.

Each staff user is given an allocation of printer credits. The default print setting is for black and white. Pupils are taught to only print when necessary to save resources for financial and environmental reasons. We expect pupils to only print out work when directed by staff to do so.

The network software prevents changes being made to computer settings. Pupils are taught that making changes may prevent the computer from working properly. We expect all users to make no attempt to alter the way the computer is set up.

Only the network administrators are permitted to install software on to computers. Pupils are taught that the network or an application may not function properly if other programmes are installed. We expect all users to make no attempt to load or download any programme onto the network. Our ICT technician keeps a record of all software updates.

All users of the network can be monitored remotely by the network administrators. Pupils are taught that their use of the network can be monitored. We expect all users to understand that their use is subject to monitoring.

38.5 Internet Safety: When using a network workstation all access to the Internet is protected by a number of different filters. These filters are designed to prevent accidental or deliberate access to unsuitable materials. In addition, the network administrators can manually add site addresses which are considered to be unacceptable. However, no system is 100% safe and we expect users to behave responsibly.

Pupils are taught that the Internet contains many websites that are useful but that there are also websites that are unpleasant, offensive, not child-friendly or can damage your computer. School invests in software to capture screen shots where inappropriate material is accessed or

where inappropriate searches are sought. We expect pupils to make no attempt to access a website that they know to be unsuitable for children and/or containing offensive language, images, games or other media.

Pupils accessing the Internet at home are subject to the controls placed upon them by their parents. However, any home use of the Internet made in connection with the school or school activities, any of its staff, pupils and governors or any partnership organisation will be subject to this policy and any breach dealt with as if the event took place at school. We expect all members of our school community to behave as positive ambassadors of the school in all school related activities made through the Internet.

The school website contains school policies, newsletters and other information. We expect all persons accessing the school web site to treat the content with respect and make no attempt to reproduce, use or alter any part in any way with malicious intent. No part can be reproduced for commercial reasons without written permission from the school.

38.6 Email Safety: Some classes have a class email address which pupils can use for sending messages to other classes, schools and other appropriate recipients. The class teacher monitors the pupils' use of this email address and receives a copy of all incoming email. Pupils are taught that emails sent from their class should have a clear learning purpose and be written in a polite style which is appropriate to the person that will receive it. We expect all users to communicate appropriately through email.

Some pupils will have their own webmail accounts at home. As these are independent of the school they do not necessarily come with the safeguards that we set for email usage. Therefore we do not permit the use of personalised email accounts by pupils at school or at home for school purposes. Pupils are taught that using a personalised webmail account in school or for school use is not permitted. We expect pupils to use school issued email accounts only.

38.7 E-Bullying: The school takes bullying very seriously and has robust procedures for identifying and dealing with it. E-bullying is the use of any communication medium to offend, threaten, exclude or deride another person or their friends, or any protected characteristics. Pupils are taught about bullying as part of the PSHE curriculum. We expect all members of our community to communicate with each other with respect and courtesy. Bullying of any type will not be tolerated by the school and will be dealt with under the procedures within the relevant policies.

38.8 Digital Images: Digital still and video cameras are used for recording special events as well as being essential tools for everyday learning experiences across the curriculum. Parents are asked to sign a consent form for images of their children to be used for school purposes. Some images celebrating the work of pupils involved in everyday and special event activities may be selected to be shown on the school website, or the school's social media sites. On the website we never associate names with images.

Digital images are only shared with partner schools and organisations as part of collaborative

learning projects. This can include live video conferencing. All such use is monitored and supervised by staff. Pupils are taught to seek permission before copying, moving, deleting or sending any images taken within school. We expect all pupils to seek permission from staff before sharing images outside of the school environment.

Children taking photographs or video footage will always be supervised. Any images taken and used by school will be kept in accordance with the Data Protection Act 1998.

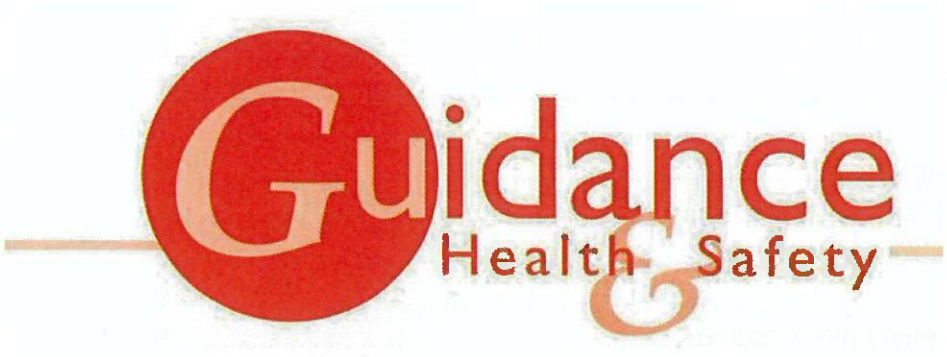
39. Absconding children

We have a procedure for the management of absconding children who leave the premises without permission, based on our responsibility to keep children safe whilst at school. If a child leaves the premises in such circumstances, it is likely that they will be distressed, angry, aggressive and unwilling to return to the building when asked. With this in mind, it is important not to add to the child's distress as this could result in further risk, injury or death (for example, if a child were to run out into the road).

In this event, the procedure is as follows:

- DSP is informed as soon as possible
- If seen by a lunchtime supervisor, the red card will be used to summon help
- In the event of a teacher following a child, provision will be made to cover their class
- The DSP will make contact with parents/carers as appropriate
- DO NOT CHASE THE CHILD - follow calmly from a distance, at walking pace
- If verbal contact can be made, reassure the child and ask them to return to school where problems can be sorted out in a safe environment

Guidance No 36A



Martin Southam, Health and Safety Team Leader September 2014

Key Managers of Children Services

Administration of Medicines and Healthcare Needs in Schools, Early Years and Youth Settings

FROM 1ST OCTOBER 2014 THE LAW WILL CHANGE to allow schools to hold stocks of asthma inhalers containing salbutamol for use in an emergency by persons trained to administer them to pupils who are known to require such medication.
From this date onwards, schools can buy inhalers and spacers from a pharmaceutical supplier in small quantities provided it is done on an occasional basis and is not for profit.

A supplier will need a request signed by the principal or head teacher (ideally on appropriately headed paper) stating:

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

Employees carrying out or assisting with any form of medical procedure who are acting within the scope of their employment, acting responsibly and to the best of their ability within the confines of this guidance and any specified training provided - are indemnified by Leicester City Council against any legal action that may arise which alleges negligence.

MANAGING MEDICINES AND HEALTHCARE NEEDS IN SCHOOLS, EARLY YEARS AND YOUTH SETTINGS

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PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUCTION WITH THE WHOLE DOCUMENT

MANAGING MEDICINES AND HEALTHCARE NEEDS IN SCHOOLS, EARLY YEARS AND YOUTH SETTINGS

INTRODUCTION

Children with Medical Needs

Children with medical needs have the same rights of admission to a school or setting as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis.

Others may require medicines in particular circumstances, such as children with severe allergies who may need an adrenaline injection. Children with severe asthma may have a need for daily inhalers and additional doses during an attack.

Most children with medical needs can attend school or a setting regularly and take part in normal activities, sometimes with some support. However, staff may need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk.

An individual health care plan can help staff identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk. If a plan is necessary, the school/setting should prepare this plan and may seek help and advice from health professionals.

Access to Education and Associated Services

Some children with medical needs are protected from discrimination under the Equality Act 2010 The Equality Act replicates the disability provisions in the former Disability Discrimination Act (DDA) in defining a person as having a disability if he has a physical or mental impairment which has a substantial and long-term adverse effect on his abilities to carry out normal day-to-day activities. **It is recommended that this document is accessed and read.**
https://www.gov.uk/government/publications/equality-act-2010-advice-for-schools

Under the Equality Act, responsible bodies for schools (including nursery schools) **must not** discriminate against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips and school clubs and activities. Schools should be making reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in their practices and procedures and in their policies.

Schools are also under a duty to plan strategically to increase access, over time to schools. This should include planning in anticipation of the admission of a disabled

pupil with medical needs so that they can access the school premises, the curriculum and the provision of written materials in alternative formats to ensure accessibility.

Early years settings not constituted as schools, including childminders and other private, voluntary and statutory provision are covered by Part 3 of the DDA. Part 3 duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child. This includes disabled children with medical needs. Like schools, early years settings should be making reasonable adjustments for disabled children including those with medical needs. However, unlike schools, the reasonable adjustments by early years settings will not include alterations to the physical environment, as they are not covered by the Part 4 planning duties.

Support for Children with Medical Needs

The Department of Education has issued a guidance document supporting pupils at school with medical conditions June 2014
https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3 **it is recommended that this document is read and incorporated into school policies. Also available here is a D of E templates document to support this new guidance.**

Parents have the prime responsibility for their child's health and should provide schools and settings with information about their child's medical condition. Parents, and the child if appropriate, should obtain details from their child's health adviser if needed. This would be the aligned Community Paediatrician (school doctor) or School Health Adviser (school nurse) or a health visitor or possibly a GP. Specialist voluntary bodies may also be able to provide additional background information for staff.

The school health service can provide advice on health issues to children, parents, maintained early years staff and education officers. NHS Primary Care Trusts and NHS Trusts, Local Authorities, Early Years Development and Childcare Partnerships and governing bodies should work together to make sure that children with medical needs and school and setting staff have effective support.

Local Authorities and other employers, schools (including community nursery schools) should consider the issue of managing administration of medicines and supporting children with more complex health needs as part of their accessibility planning duties. It will greatly assist the smooth integration of children into the life of the school or setting.

There is no legal duty that requires school or setting staff to administer medicines. NB it is not any part of a teacher's contract of employment.

Staff managing the administration of medicines to children/pupils/students with specific medical needs as highlighted in the appendices, together with those who administer these medicines should receive appropriate training and support from

health professionals. Where employers' policies are that schools and settings should manage medicines, there should be robust systems in place to ensure that medicines are managed safely. There must be an assessment of the risks to the health and safety of staff and others and measures put in place to manage any identified risks.

Some children and young people with medical needs have complex health needs that require more support than regular medicine. It is important to seek medical advice about each child or young person's individual needs.

Introducing a Policy

A clear policy understood and accepted by staff, parents and children provides a sound basis for ensuring that children with medical needs receive proper care and support in a school or setting.

The employer has the responsibility for devising the policy. However schools and settings, acting on behalf of the employer, should develop policies and procedures that draw on the employer's overall policy but which are amended for their particular provision. **All schools and settings where the local authority is the employer are required to comply with this guidance**. Policies should, as far as possible, be developed in consultation with heads and with governing bodies where they are not the employer. All policies should be reviewed and updated on a regular basis.

Policies should aim to enable those children with medical needs to attend schools/settings as regularly as is practicable. Formal systems and procedures in respect of administering medicines, developed in partnership with parents and staff should back up the policy.

A policy needs to be clear to all staff, parents and children. It could be included in the prospectus, or in other information for parents.

Parents should provide full information about their child's medical needs, including details on medicines their child needs.

Foreword

Medicines should only be taken to schools or settings when essential – that is where it would be detrimental to a child's health if the medicine were not administered during the school or setting day.

Only medicines that have been prescribed by a doctor, dentist, and nurse prescriber or pharmacist prescriber should be administered. Medicines from any other source, e.g. over the counter medicines, should not be administered by staff. It will be necessary for parents/guardians to administer this prior to the child's attendance at the school/setting or to arrange to be present in order to administer it on site. Medicines must always be provided in the original container as dispensed by the pharmacist and include the prescriber's instructions for administration.

Schools and settings should never accept medicines that have been taken out of the container as originally dispensed, nor make changes to dosages on parental instructions.

The medicines standard of the National Service Framework (NSF) for children, recommends that a range of options in respect of medicines are explored including:

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

b) Prescribers should consider providing two prescriptions, where appropriate, and practicable, for a child's medicine – one for home, and one for use in the school or setting, avoiding the need for repackaging or re-labelling of medicines by parents/guardians.

1 GENERAL

1.1 Children who are acutely ill and who require a short course of medication e.g. antibiotics, will normally remain at home until the course is finished. If it is felt by a medical practitioner that the child is fit enough to return to school, the dosage can be adjusted so that none is required at lunchtime. If however this is not possible a general care plan for in school administration of medicines should be instigated in accordance with this guidance (see appendix 1 for forms).

1.2 <u>No medicine</u> should be administered unless clear <u>written</u> instructions to do so have been obtained from the parents or legal guardians and the school has indicated that it is able to do so (see sample proforma – Appendix A). Schools and other settings may need to offer support in the completion of this form where parents have literacy problems or where English is not their first language.

1.3 All medicines must be clearly labelled with the child's name, route i.e. mode of administration oral/aural etc., dosage, frequency and name of medication being given. The parents or legal guardians must take responsibility to update the school of **any** changes in the administration for routine or emergency medication and maintain an in-date supply of the medication. If this is not the case the previous instructions must be followed.

A child under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.

1.4 As children grow and develop, they should be encouraged to participate in decisions about their medicines and to take responsibility. Older children with a long-term illness should, whenever possible, seek complete responsibility under the supervision of their parents. Which children have the ability to take responsibility for their own medicines varies. 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.

Where it is agreed by the parents and teachers some medications or related products e.g. inhalers or Creon will be carried by the child for self-administration. These may be carried in "bum bags" or swimming pouches.

All other medicines, except emergency medication, should be kept securely.

If children can take their medicines themselves, staff may only need to supervise.

1.5 The Headteacher/Head of Setting is responsible for making sure that medicines are stored safely. **All emergency medicines such as asthma reliever inhalers/adrenaline autoinjectors should be readily available to children and should <u>not</u> be locked away.**

All other medicines except emergency medications and inhalers should be kept securely. Large volumes of medicines should not be stored Oral medication should be in a childproof container. Medicines should be stored strictly in accordance with product instructions. Some medication needs to be stored in a refrigerator in order to preserve its effectiveness – this will be indicated on the label. In order to meet the requirement for security, it is suggested that medication is stored in a locked cash box within a refrigerator. If a refrigerator is not available, medication may be kept for a short period in a cool box or bag with icepacks, provided by the parent/guardian. If stored in a cool box with ice packs <u>do not</u> store medicine in direct contact with ice packs as efficacy may be hindered. All medication should be kept out of direct sunlight and away from all other heat sources. Any unused or time expired medication must be handed back to the parents or legal guardians of the child for disposal. Where children have been prescribed **controlled drugs**, staff need to be aware that these should be kept in safe custody. Children could access them for self-medication if it is agreed that it is appropriate.

1.6 Medicines should be administered by a named individual member of school or setting staff with specific responsibility for the task in order to prevent any errors occurring. Where practicable a witness should be present who should also sign the appropriate box on appendix A-1. All children who require medication to be given during school/setting hours should have clear instructions where and to whom they report. Staff should only store, supervise and administer medicine that has been prescribed for an individual child.

1.7 **Emergency medication and reliever inhalers must follow the child at all times.** Inhalers and emergency treatment medication must follow the child to the sports field, swimming pool etc. Children may carry their own emergency treatment, but if this is not appropriate, the medication should be kept by the teacher in charge in a box on the touchline or at the side of the pool. The school may hold spare emergency medication if it is provided by the parents or guardians in the event that the child loses their medication. In these circumstances the spare medication should be kept securely in accordance with the instructions above. It is the parents' responsibility to ensure that medicines are in date and replaced as appropriate.

1.8 Advice for school/setting staff on the management of conditions in individual children (including emergency care) may be provided through the School Nurse or School Doctor or Health Visitor on the request at the outset of the school/setting consideration of the need for medication. Similarly any difficulties in understanding about medication usage should be referred to the School Nurse, School Doctor or Health Visitor for further advice.

1.9 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 in respect of the individual child. Parents should be informed of the refusal on the same day, and if the refusal to take medicines results in an emergency, the school or setting's emergency procedures should be followed, which is likely to be calling an ambulance to get the child to hospital.

2 RECORD KEEPING

2.1 All schools and other settings **must** keep written records of all medicines administered to children. A copy of the record slip or similar written record should be sent to parents recording medicines administered that day.

2.2 Incorrect Administration of Dosage - individual protocols/health plans will contain emergency actions in respect of this happening. The incident must be notified to the department using Form SO2. In the event of an excess dose being accidentally administered or the incorrect procedure being carried out, the child concerned must be taken to hospital as a matter of urgency.

3 HYGIENE AND INFECTION CONTROL

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

OFSTED guidance provides and extensive list of issues that Early Years Providers should consider in making sure that all settings are hygienic.

4 LONG TERM MEDICATION

4.1 The medicines in this category are largely preventative in nature and it is essential that they are given in accordance with instructions, see paragraph 1.3 – page 5, otherwise the management of the medical condition is hindered. (NB specific requirements: e.g. it is important that reliever inhalers are immediately accessible for use when a child experiences breathing difficulties or when specifically required prior to exercise and outings).

4.2 It is important to have sufficient information about the medical condition of any child with long term medical needs.

Schools and settings need to know about any particular needs before a child is admitted, or when a child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. It is also helpful to have a written healthcare policy for such children, involving the parents and relevant health professionals. A healthcare plan should be in place for children with more severe and complex conditions.

Early Years Settings **must** keep written records each time medicines are given. Schools should also arrange for staff to complete and sign a record each time they give medicine to a child. Good records demonstrate that staff have exercised a duty of care. In some circumstances, such as the administration of Rectal Diazepam, it is good practice to have the dosage and the administration witnessed by a second adult. APPENDIX A –1, Record of Medicine Administered to an Individual Child – should be used for this purpose.

4.3 In addition, the parents/guardians must be informed that they must use the attached proforma **(Appendix A)** to report any changes in medication to the school. Schools and settings may need to offer support in the completion of this form where parents have literacy problems or where English is not their first language.

4.4 With parental/guardian permission, it is sometimes necessary to explain the use of medication to a number of pupils in the class in addition to the affected child so that peer group support can be given.

5 INJECTIONS

5.1 There are certain conditions e.g. diabetes mellitus, bleeding disorders or hormonal disorders which are controlled by regular injections. Children with these conditions are usually taught to give their own injections, and where this is not possible, they should be given by their parents or a qualified nurse (**currently employed in a nursing capacity**). It is not envisaged that it will be necessary to give injections in school unless the child is on a school visit (see section 9 - page 11). **Appendix E gives detailed guidance on the management of diabetes mellitus.**

6 EMERGENCY TREATMENT/PROCEDURES

6.1 As part of general risk management processes, all schools and settings should have arrangements in place in dealing with emergency situations. This could be part of the first aid policy and provisions. Other children should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. All staff should also know who is responsible for carrying out emergency procedures in the event of need. **A member of staff should always accompany a child to hospital by ambulance and should stay for as long as is reasonably practicable.** In the event of an emergency/accident, which requires a child to be treated by health professionals (doctor/paramedics) or admitted to hospital, the latter are responsible for any decision on medical grounds when and if the parents are not available.

When emergency treatment is required, medical professionals or ambulance should always be called immediately. The National Standards require Early Years settings to ensure that contingency arrangements are in place to cover such emergencies. On those occasions where an injury is not life threatening but staff consider that medical treatment is required, parents/carers should always be informed.

i) No emergency medication should be kept in the school except those specified for use in an emergency for an individual child. (See 1.7 – page 6).

ii) Advice for school and setting staff about individual children may be provided by the nurse, health visitor, school doctor or General Practitioner on request at the outset of planning to meet the child's needs.

iii) In the event of the absence of trained staff, it is essential that emergency back-up procedures are agreed **in advance** with the parents and school/ setting.

iv) Storage must be in accordance with 1.5 on page 5. These medications must be clearly labelled with the child's name, the action to be taken with the route, dosage and frequency (as in Section 1.3 – on page 5) and the expiry date.

v) If it is necessary to give emergency treatment, a clear written account of the incident must be given to the parents or guardians of the child, and a copy retained in the school/setting.

6.2 In accordance with 6.1 above:

i) If it is known that an individual child is hypersensitive to a specific allergen e.g. wasp stings, peanuts, etc. a supply of antihistamines and pre-prepared adrenaline autoinjectors, (when specifically prescribed) should always be made available. **Immediate treatment needs to be given** before going to the nearest emergency hospital/ or calling an ambulance. Notes regarding the protocol for establishing the administration of adrenaline autoinjectors and relevant forms are included in **Appendix B.**

ii) A supply of 'Factor Replacement' for injection should be kept in school and setting where it is required for children suffering from bleeding disorders. If injection is necessary, it is usual for the child to be able to give their own injections. If this is not the case, the parents should be contacted immediately. If contact cannot be made, emergency advice can be obtained between 0900 and 1700 by telephoning the Bleeding Disorders Clinic, Leicester Royal Infirmary on 0116 258 6500.

iii) A small supply of rectal diazepam may be kept in schools/settings for administration to specifically identified children suffering from repeated or prolonged fits and may, occasionally, be administered in other settings. Rectal diazepam where prescribed, should be readily available for use by a qualified nurse (currently employed in a nursing capacity) or medical staff in an emergency. Where specific training has been undertaken, members of school staff may administer rectal diazepam in accordance with this Bulletin and with the prior knowledge and the prior agreement of the child's medical advisers and parents. The expectation is that two members of staff will be present when rectal diazepam is administered. Where this emergency treatment has been administered by staff, arrangements must be made for the child to go to the nearest hospital receiving emergencies immediately after treatment has been given.

Appendix C gives detailed guidance about the administration of rectal diazepam including Agreement Form procedures, flow chart, an Agreement Form for completion by the doctor, parent and school and a Report Form.

iv) A small supply of buccal midazolam may be kept in school for administration to specifically identified children suffering from repeated or prolonged fits. Where this emergency treatment has been administered by staff, arrangements must be made for the child to go to the nearest hospital receiving emergencies immediately after treatment has been given.

Appendix D gives detailed guidance about the administration of buccal midazolam including Agreement Form procedures, flow chart, an

Agreement Form for completion by the Consultant, parent and school, and a Report Form.

Under extremely RARE circumstances a child may not be using the aforementioned rescue medication and may have been prescribed rectal paraldehyde by a Consultant Paediatrician Neurologist. In these cases this should be discussed with your Community Paediatrician (school doctor).

v) A supply of glucose (gel, tablets, drink, Hypostop etc) for the treatment of hypoglycaemic attacks should be provided by parents/guardians and kept in schools and settings where any pupil suffers from diabetes mellitus. If a second attack occurs within 3 hours, repeat the treatment and the child must go to the nearest hospital receiving emergencies. **Appendix E gives detailed guidance on the management of diabetes mellitus.**

vi) It is important for children with asthma that reliever inhalers are immediately accessible for use when a child experiences breathing difficulties.

vii) For children who have reduced hormonal responses to stresses, it may be that they require an emergency dose of oral hormone replacement. The arrangements for the prescribed medication will be developed within a general care plan (Appendix A).

7 DRAWING UP A HEALTH CARE PLAN

7.1 The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short written agreement from parents may be all that is necessary.

Early years settings should be aware that parents might provide them with a copy of their family service plan, a feature of the Early Support Family Pack, promoted through the Governments' Early Support Programme. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual health care plan devised by the setting.

8 OFF SITE EDUCATION/WORK EXPERIENCE STAFF

8.1 Schools are responsible for ensuring, under employees overall policy, that work experience placements are suitable for students with a particular medical condition. Schools are responsible for pupils with medical needs who are educated off-site through another provider, such as the voluntary sector. Schools must ensure that a risk assessment is in place for a young person who is educated off-site or who has a work experience placing. They must also ensure that any special/medical needs are made known to and discussed with the

providers. If the risk assessment is carried out by an approved agency e.g. WEXA, this information must be made known to them.

8.2 Responsibilities for risk assessments remain with the school. Where students have special medical needs, the school need to ensure that such risk assessments take into account those needs. Parents and pupils must give permission before relevant medical information is shared, on a confidential basis, with employers.

9 OFF SITE TRIPS/VISITS

9.1 It is good practice for schools to encourage children with medical needs to participate in safely managed visits. Schools and settings should consider what **reasonable adjustments** they might make to enable children with medical needs to participate fully and safely in visits.

9.2 Staff supervising excursions should always be aware of any medical needs and relevant emergency procedures. Arrangements for taking any relevant medicines will also need to be taken into consideration. A copy of any healthcare plans should be taken on visits in the event of the information being needed in an emergency.

9.3 Detailed advice and guidance regarding school visits is given in Health & Safety Bulletin No 11 (Crisis Line) and the DfES Document 'Health and Safety of Pupils on Educational Visits' (HASPEV).

9.4 Advice on school trips and visits is given in Health and Safety Bulletin No. 33.

9.5 A school consent form from the child's parent or guardian must be received PRIOR to participation in any school trip. Any medical problems must be highlighted by the parent/guardians on the consent form.

9.6 Where insurance cover is obtained, medical conditions must be disclosed; otherwise insurance cover may be refused.

9.7 A named person must be identified to supervise the storage and administration of medication (see 1.6 - page 6).

9.8 Wherever possible children should carry their own reliever inhalers or emergency treatment (see 1.7 – page 6), but it is important that the named person (see 9.7 – page 11) is aware of this.

9.9 **Regardless of the setting, where the local authority is the employer, it requires the standards and good practice contained within the above DfES guidance (9.3) and local authority Bulletin 33 (9.4) to be adhered to.**

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10 HOME TO SCHOOL TRANSPORT

10.1 Local authorities arrange home to school transport and where legally required to do so, they must make sure that pupils are safe during the journey. Pupils with special needs and/or medical needs will be assessed by the Risk Assessor of Operational Transport who will allocate appropriate transport and escort where required.

10.2 Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines, but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they **must** receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles and responsibilities and liabilities.

10.3 All drivers and escorts should have basic first aid training. Additional trained escorts may be required to support some pupils with complex medical needs.

NOTE: It is not part of a teacher's contract to accompany a child to/from school.

11 ROLES AND RESPONSIBILITIES

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

12 PARENTS AND CARERS

12.1 Parents, as defined in section 6 of the Education Act 1996, include any person who is not a parent of the child, but who has parental responsibility for or care of a child. In this context, the phrase 'care of the child' includes any person who is involved in the full time care of a child on a settled basis, such as a foster parent, but excludes babysitters, childminders, nannies and school staff.

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

12.3 It is important that professionals understand who has parental responsibility for a child. The Children Act 1989 introduced the concept of 'Parental Responsibility'. The Act uses the phrase 'Parental Responsibility' to sum up the collection of

rights, duties, powers, responsibilities and authority that a parent has by law, in respect of a child. In the event of family breakdown, such as separation or divorce, both parents will normally retain parental responsibility for the child and the duty on both parents to continue to play a full part in the child's upbringing will not diminish. In relation to unmarried parents, only the mother will have parental responsibility, unless the father has acquired it in accordance with the Children Act 1989. When the child makes a residence order in favour of a person who is not a parent of the child, for example a Grandparent, that person will have parental responsibility for the child for the duration of the order.

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

12.5 Some parents may have difficultly understanding or supporting their child's medical condition themselves. In some circumstances this may be result of language barriers. Local health services can often provide additional assistance in these circumstances.

13 THE EMPLOYER

13.1 Under the Health and Safety at Work Act 1974, employers, including local authorities and school governing bodies, **must** have a health and safety policy. This should incorporate managing the administration of medicines and supporting children with complex health needs, which will support schools and settings in developing their own operational policies and procedures.

13.2 In most instances, the local authority, the school, or an early years setting will directly employ staff. However, some care or health staff may be employed by a local health trust or social care setting, or possibly through the voluntary sector. In such circumstances, appropriate shared governance arrangements should be agreed between the relevant agencies.

13.3 Employers should satisfy themselves that training has given staff, who volunteer to administer medicines, understanding, confidence and expertise and that arrangements are in place to update training on a regular basis.

13.4 NHS Primary Care Trusts (PCT) have the discretion to make resources available for any necessary training. Employers must arrange training for staff in the management of medicines and policies in the administration of medicines. This should be arranged in conjunction with local health services or other health professionals (school nurse or doctor in the first instance). Managing medicines

training could also be provided by local authorities, regional consortia, pharmacists and other training providers.

14 THE GOVERNING BODY

14.1 Individual schools should develop policies to cover the needs of their own school. The policies should reflect those of their employer. The governing body has responsibility for all of the school's policies, even when it is not the employer.

15 THE HEADTEACHER OR HEAD OF SETTING

15.1 The Headteacher/Head of Setting is responsible for putting the employer's policy into practice and for developing detailed procedures. Day to day decisions will normally fall to the Head or to whom so ever they delegate this to, as set out in their policy.

15.2 The employer must ensure that staff, who have volunteered to administer medicines, receive proper support and training where necessary. Equally, Headteachers/Head of Settings have a responsibility to ensure that their staff receive the training. As the manager of staff, it is likely to be the Head who will agree when and how such training takes place.

15.3 The Headteacher/Head of Setting should make sure that all parents and all staff are aware of the policy, and procedures for dealing with medical needs. The Head should also make sure that appropriate systems for information sharing are followed and that all staff, including temporary staff, supply teacher, etc. who are working with children with medical needs, have the necessary information. The policy should make it clear that parents should keep children at home when they are unwell. The policy should also cover the approach to taking medicines at schools or in a setting.

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

15.5 If those staff, who have volunteered to administer medicines, act in accordance with their training and follow guidelines contained in this bulletin they will be covered by the employers' liability insurance. Registered persons are required to carry public liability insurance for day care provision.

16 TEACHERS AND OTHER STAFF

16.1 Some staff may be naturally concerned for the health and safety of a child with a medical condition, particularly if it is potentially life threatening. Staff with children

with medical needs in their class or group should be informed about the nature of the condition, when and where the children may need extra attention. The child's parents should provide this information.

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

17 SCHOOL STAFF GIVING MEDICINES

17.1 Any member of staff who agrees to accept responsibility for administering the prescribed medicines to a child should have the appropriate training and guidance. The type of training necessary will depend on the individual case.

18 HEALTH SERVICES

18.1 Most schools will have contact with the health service, school nurse or doctor. The school nurse or doctor may help the schools draw up individual health care plans for pupils for with medical needs, and may be able to supplement information already provided by the parents and the child's GP. The nurse or doctor may also be able to advise on training for school staff on administering medicines, or take responsibility for other aspects of support. In the Early Years setting, including nursery schools, the health visitor usually provides the support.

19 OFSTED

19.1 During an inspection, OFSTED will check that day-care providers have adequate policies and procedures in place regarding the administration of medicines. Regulations require that parents give their consent to medicines being given to their child and that the provider keeps written records. From September 2005, Local Authority services will be inspected in multi inspectorate joint area reviews of children's services. Inspectors propose to assess that steps are taken to provide children and young people with a safe environment, including that the safe storage and use of medicines is promoted.

20 IMPLEMENTATION AND REVIEW

20.1 This document constitutes the approved guidance of Leicester City Council's Education and Children Services. It came into effect from the commencement of October 2009 and supersedes guidance previously given in Health and Safety Bulletin No. 36A (December 2011).

PLEASE ENSURE THAT EACH SECTION IS READ IN CONJUCTION WITH THE WHOLE DOCUMENT

21 DOCUMENTATION

21.1 Appendix A - Request for Administration of Medicines
Record of Medicine Administered to an Individual Child

21.2 Appendix B - Guideline for Non-Medical Staff to Administer Pre-Prepared Adrenaline Autoinjectors in Response to Anaphylaxis:
Process, Emergency Action Plans (Antihistamine, EpiPen. Jext and old style EpiPen) and Report Form

21.3 Appendix C - Administration of Rectal Diazepam:
Advice Protocol, Individual Care Plan (Agreement) and Administration Report Form

21.4 Appendix D - Administration of Buccal Midazolam:
Advice Protocol, Individual Care Plan (Agreement) and Administration Report Form

21.5 Appendix E - Guidance for the Management of Diabetes Mellitus

22 ADVICE ON MEDICAL CONDITIONS

Parents or guardians of children suffering from the following conditions should be advised from their GP, the school health professionals (parents should ask the school for the name and contact number) or from the bodies detailed below. The following bodies can also supply leaflets regarding the conditions listed. If schools/settings obtain advice/information from the following sources, the local health professionals who normally provide specialist advice in respect of these conditions, will not be responsible if this advice/guidance is followed.

Asthma at school – a guide for teachers National Asthma Campaign Summit House 70 Wilson House London EC2A 2DB	Asthma Helpline: 0845 701 0203 Website: www.asthma.org.uk Email: info@asthma.org.uk
Guidance for Teachers concerning children who suffer from fits The British Epilepsy Association New Anstey House, Gate Way Drive Yeadon Leeds LS19 7XY	Tel: 0113 210 8800 Website: www.epilepsy.org.uk Email: epilepsy@epilepsy.org.uk

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Guidelines for HIV and AIDS Department for Education and Skills Sancutary Buildings Great Smith Street Westminster London SW1P 3BT	Tel: 0870 000 2288 Website: www.dfes.gov.uk Email: info@dfes.gsi.gov.uk
Haemophilia The Haemophilia Society First Floor, Petersham House 57A Hatton Garden London EC1N 8JG	Tel: 020 7831 1020 Website: www.haemophilia.org.uk Email: info@haemophilia.org.uk
Allergy to Peanuts and Other Nuts Asthma & Allergy Research Unit Glenfield Hospital Groby Road Leicester LE3 9QP	Tel: 0116 258 3557
Thalassaemia UK Thalassaemia Society 19 The Broadway Southgate Circus London N14 6PH	Tel: 020 8882 0011 Freephone Helpline: 0800 731 1109 Website: www.ukts.org Email: office@ukts.org
Sickle Cell Disease The Sickle Cell Society 54 Station Road Harlesden London NW10 4UA	Tel: 0208 961 7795 Website: www.sicklecellsociety.org Email: info@sicklecellsociety.org
Cystic Fibrosis and School **(A guide for teachers and Parents)** Cystic Fibrosis Trust 11 London Road Bromley Kent BR1 1BY	Tel: 0208 464 7211 Website: www.cftrust.org.uk Email: enquiries@cftrust.org.uk
Children with Diabetes **(Guidance for teachers and schools staff)** Diabetes UK Central Office Macleod House 10 Parkway London NW1 7AA	Tel: 0207 424 1000 Diabetes Careline: 0845 120 2960 Website: www.diabetes.org.uk Email: info@diabetes.org.uk

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Appendix

A

APPENDIX A

REQUEST FOR ADMINISTRATION OF MEDICINES (GENERAL CARE PLAN)

To: Headteacher of .....School / Academy

From: Parent/Guardian of.....Full Name of Child

DOB: XX XX XXXX My child has been diagnosed as having:

.....(name of condition)

He/She has been considered fit for school but requires the following prescribed medicine to be administered during school hours:

.....(name of medication)

I consent/do not consent for my child to carry out self administration (delete as appropriate)

Could you please therefore administer the medication as indicated above

.....(dosage) at.....(timed).....(intervals) Strength of medication: .....

With effect from..... .....Until advised otherwise.

The medicine should be administered by mouth/in the ear/nasally/other.....
.....(delete as applicable)

I consent/do not consent for my child to carry the medication upon themselves (delete as appropriate)

I undertake to update the school with any changes in medication routine use or dosage.

I undertake to maintain an in date supply of the prescribed medication.

I understand that the school cannot undertake to monitor the use of self administered medication carried by the child and that the school is not responsible for any loss of/or damage to any medication.

I understand that if I do not allow my child to carry the medication it will be stored by the School and administered by staff with the exception of emergency medication which will be near the child at all times

I understand that staff will be acting in the best interests of .....Childs Name whilst administering medicines to children.

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

Name of parent (please print).....

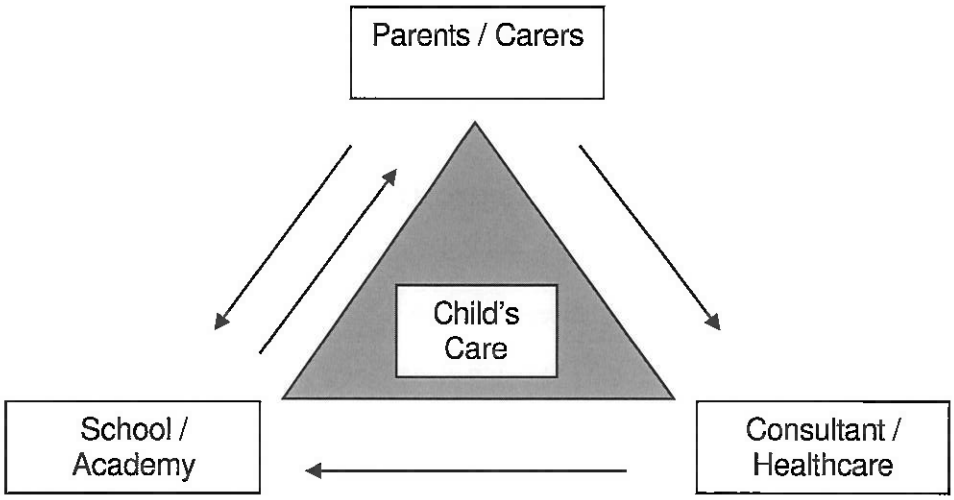
Contact Details:

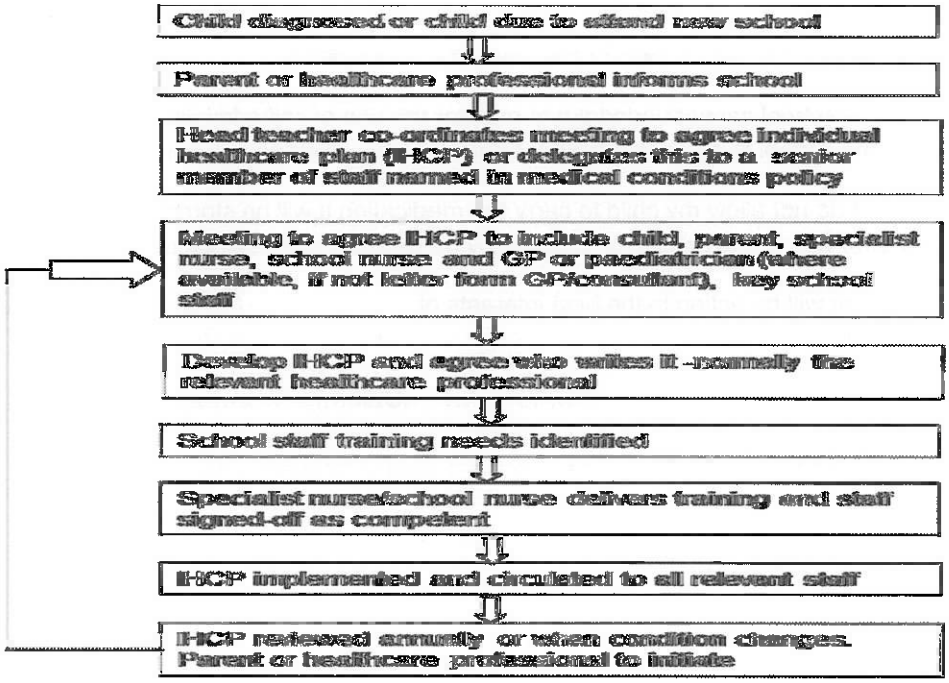
Home.....Work:.....Mobile:.....

Headteacher (PRINT NAME): .....

or Healthcare – Social care Professional:.....

Individual Health Care Plan (IHCP) = Specific information on individual pupil requirements. Written recorded plan will ensure that their needs are met whilst in school and any treatment needed to be administered by members of staff will be fully understood. Plan to be agreed by Headteacher and parents. THIS MUST BE FORMALLY RECORDED AND REVIEWED AT REGULAR INTERVALS.





APPENDIX A - 1

RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD

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

Staff signature .....

Signature of parent .....

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

Continued overleaf

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

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

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

Appendix

B

Revised July 2013

APPENDIX B

GUIDELINE FOR NON-MEDICAL STAFF TO ADMINISTER PRE-PREPARED ADRENALINE AUTOINJECTORS IN RESPONSE TO ANAPHYLAXIS

PROCESS

1. When a child needs a pre-prepared adrenaline autoinjector as emergency treatment for anaphylaxis in a non-health setting (e.g. school, nursery, respite facility), then the prescribing doctor will discuss this with the parents or carers and with their agreement pre-prepared adrenaline will be prescribed.

2. It is the parent's responsibility to raise the issue with the head of the setting e.g. head teacher, nursery manager.

3. When a child is able to self administer the head of the setting with the parents will decide whether training of volunteers is required. *It is recommended that in all settings where there is a child who may require a pre-prepared adrenaline autoinjector, that (a) volunteer(s) are trained to administer a pre-prepared injection should a situation arise where a child is too ill/unable to self administer.* If training is not required a general administration of medicines form must be completed. A child who has self administered must report to a member of staff as they will need to be reviewed in hospital.

4. When the child is unable to self administer the head then identifies (a) volunteer(s) to undertake training and subsequent administration of the prepared adrenaline autoinjector.

5. If no volunteers are identified the parent should be informed and it is the parent who should inform the prescribing doctor. The prescribing doctor and parent may wish to reconsider and identify an alternative management plan.

6. If (a) volunteer(s) is/are identified they should read their setting's policy/guidelines on the administration of medicines. The head of the setting should then liaise with the health professional e.g. School Health Nurse/Health Visitor, to arrange a mutually convenient date for training. The standard anaphylaxis training pack available across Leicester, Leicestershire and Rutland should be used.

7. The parents need to request that page 2 of the emergency action plan of the relevant form is completed by the doctor who prescribed the pre-prepared adrenalin device.

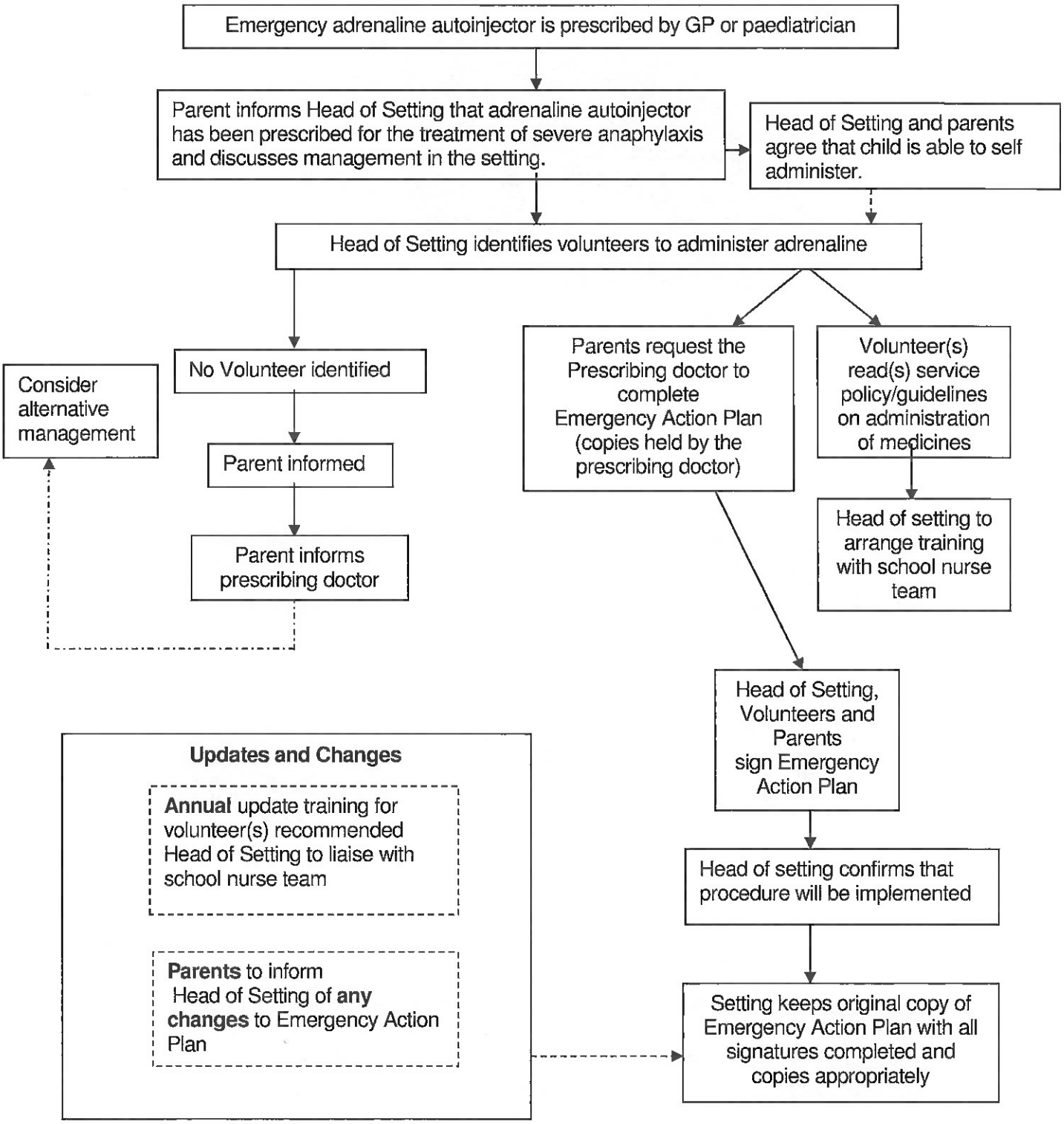
8. The health professional training the volunteer(s) will discuss with the volunteer(s) the Emergency Action Plan for the administration of pre-prepared adrenaline autoinjectors by non-medical and non-nursing staff for a specific child. Following the training the volunteer(s) sign(s) the Training Record and the Emergency Action Plan. The head of the setting then signs the Emergency Action Plan. The original remains within the setting.

9. If any details in the Emergency Action Plan change, it is the parent's responsibility to inform the head of the setting. If a new Emergency Action Plan is required then the process above must be discussed by those parties and the Emergency Action Plan completed as appropriate.

10. It is recommended that update training of volunteers should take place on an annual basis. The head of the setting will request and negotiate this with the appropriate health professional.

Appendix B1

FLOW-CHART OF PROCESS TO ENABLE NON-MEDICAL STAFF TO ADMINISTER PRE-PREPARED ADRENALIN AUTOINJECTORS IN RESPONSE TO ANAPHYLAXIS



Types of Adrenaline Autoinjector Devices

EpiPen®

Jext®

Old Style EpiPen®

Allergy: Emergency Action Plan with *Antihistamine*

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo

Parent / Carer details:

1) ☎

2) ☎

Mild to Moderate Reaction:

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

ACTION:

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

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

Watch for signs of ANAPHYLAXIS (Severe allergic reaction):

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

If ANY ONE of these signs are present:

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

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

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

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA) – www.allergy.org .au

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

MUST BE COMPLETED BY HEALTH CARE PROFESSIONALS (WITH THE EXCEPTION OF OTHER SIGNATORIES)

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

PARENT/GUARDIAN

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

Signature: ..... Date _____/ _____/ 20_____

Emergency telephone contact number.....

HEAD OF ADMINISTERING SETTING

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

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

Signature: ..... Date _____/ _____/ 20_____

Designation .....

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

Allergy: Emergency Action Plan with *EpiPen®*

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo

Parent / Carer details:

1) ☎

2) ☎

Mild to Moderate Reaction:

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

ACTION:

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

<2yrs	2.5mg	2.5m
2-6yrs	5mg	5ml
6+yrs	10mg	10ml o 1 table

Watch for signs of ANAPHYLAXIS (Severe allergic reaction):

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

If ANY ONE of these signs are present:

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

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

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

How to give EpiPen®

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

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

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

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

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

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA) – www.allergy.org .au

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850

Allergy: Emergency Action Plan with *EpiPen®*

MUST BE COMPLETED BY HEALTH CARE PROFESSIONALS (WITH THE EXCEPTION OF OTHER SIGNATORIES)

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

PARENT/GUARDIAN

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

Signature: ..... Date _____/_____/ 20_____

Emergency telephone contact number.....

HEAD OF ADMINISTERING SETTING

NAME: .....

Signature: ..... Date _____/_____/ 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND EPIPEN®

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

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

Signature: ..... Date _____/_____/ 20_____

Designation .....

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

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

Allergy: Emergency Action Plan with *Jext®*

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo

Parent / Carer details:

1) ☎

2) ☎

Mild to Moderate Reaction:

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

ACTION:

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

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

Watch for signs of ANAPHYLAXIS (Severe allergic reaction):

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

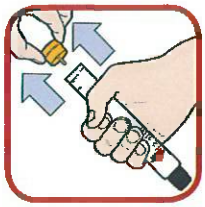
If ANY ONE of these signs are present:

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

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

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

How to give Jext®



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

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

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

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

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

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA) – www.allergy.org .au

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850

Allergy: Emergency Action Plan with *Jext®*

MUST BE COMPLETED BY HEALTH CARE PROFESSIONALS (WITH THE EXCEPTION OF OTHER SIGNATORIES)

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

PARENT/GUARDIAN

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

Signature: ..... Date _____/_____/ 20_____

Emergency telephone contact number.....

HEAD OF ADMINISTERING SETTING

NAME: .....

Signature: ..... Date _____/_____/ 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND JEXT®

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

NAME: .....

Signature: ..... Date _____/_____/ 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

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

Signature: ..... Date _____/_____/ 20_____

Designation .....

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

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

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

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

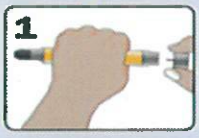
Photo

Parent / Carer details:

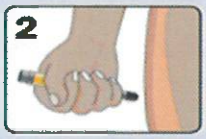
1) ☎

2) ☎

How to give EpiPen® or EpiPen® Jr



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



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

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

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

Mild to Moderate Reaction:

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

ACTION:

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

<2yrs	2.5mg	2.5m
2-6yrs	5mg	5ml
6+yrs	10mg	10ml o 1 table

Watch for signs of ANAPHYLAXIS (Severe allergic reaction):

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

If ANY ONE of these signs are present:

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

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

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

Please complete Report Form (appendix B3), giving clear account of events and fax it to 0116 225 3850

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

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA) – www.allergy.org .au

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

MUST BE COMPLETED BY HEALTH CARE PROFESSIONALS (WITH THE EXCEPTION OF OTHER SIGNATORIES)

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

PARENT/GUARDIAN

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

Signature: ..... Date _____/ _____/ 20_____

Emergency telephone contact number.....

HEAD OF ADMINISTERING SETTING

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND EPIPEN®

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

NAME: .....

Signature: ..... Date _____/ _____/ 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

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

Signature: ..... Date _____/ _____/ 20_____

Designation .....

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

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

Appendix B3

REPORT FORM

Following administration of antihistamine and emergency pre-prepared adrenalin autoinjectors in response to anaphylaxis

NAME OF CHILD: Date of birth:	Date of allergic reaction: ____/____/_____ Time reaction started: _____:_____ hrs Time 1st dose adrenalin given: _____:_____ hrs Time 2nd dose adrenalin given: _____:_____ hrs* *If prescribed
NB ***Please copy this form and send to hospital with child if possible.***	Time ambulance called: _____:_____ hrs Time ambulance arrived: _____:_____ hrs

Trigger for reaction (i.e. food type / bee-sting)

Description of symptoms of reaction:

Any other notes about incident (e.g. child eating anything, injuries etc.)

Witnesses to incident:
(Position in setting)

Please circle the prescribed devise used: **Anapen 150** **Epipen Auto-injector 0.3mg** **Anapen 300** **Epipen Jr Auto-injector 0.15mg** **Anapen 500** **Jext 300mcg** **Jext 150mcg**	Adrenalin given by: Site of injection: Problems encountered:

FORM COMPLETED BY:

NAME (print): .....SIGNATURE: .....

Job title: .....Telephone no: .....

DATE: ___/ ___/ 20____

Please complete this Report Form, giving clear account of events and fax it to 0116 225 3850

Please send copy to hospital with child if possible

Please keep original copy in setting records and give copy to parent

Appendix

C

ADMINISTRATION OF RECTAL DIAZEPAM

School Nurses are able to undertake the training of volunteers identified by schools to administer Rectal Diazepam to identified children in accordance with the emergency treatment section of this bulletin.

The issue of the potential for the administration of Rectal Diazepam to be administered in the school setting will initially be raised with the parents by the supervising doctor. If the parents are agreeable to this, the doctor will complete the appropriate parts of the Agreement Form, sign it and obtain the parents' signature(s). The parents will then be in a position to bring the Agreement Form to the Headteacher, such that s/he may identify a volunteer. The Headteacher would then be in a position to contact the School Nurse to arrange appropriate training for the volunteer if they had previously not received training.

On completion of the training, the Agreement Form would then be signed by both the person authorised and trained to administer Rectal Diazepam and the Head of the school.

Also enclosed is a flow diagram to assist schools in understanding the procedures that should be followed in the completion and development of the Agreement Form.

If emergency treatment is given, a clear written account of the incident should be given to the parents and a copy retained in school. To this end a specific Report Form has been developed. Also attached is a flow diagram for the use of the Report Form.

ADMINISTRATION OF BUCCAL MIDAZOLAM

When a child would benefit from receiving buccal midazolam in a non-health setting e.g. school, nursery, respite facility, then the Consultant Paediatrician will discuss this with the parent.

If the parent is in agreement, the Consultant Paediatrician will complete an agreement form for the administration of buccal midazolam by non-medical and non-nursing staff in conjunction with the parent, indicating that administration in a non-health setting e.g. school respite centre, is dependent on volunteers being available from that agencies' staff. Both the Consultant Paediatrician and parent should sign the agreement form – along with the child if appropriate.

It is the parent's responsibility to then raise the issue with, and take the agreement form to, the head of the administering agency e.g. Headteacher, Senior Social Worker. The Head teacher can then identify (a) volunteer(s) to undertake training in the administration of buccal midazolam.

If no volunteers are identified the parent should be informed and it is the parent who should inform the Consultant Paediatrician. The Consultant Paediatrician and parent may wish to reconsider the need for buccal midazolam to be administered in non-home settings at a later date and restart the process.

If (a) volunteer(s) is/are identified they should read their service policy/guidelines on the administration of medicines. The head of the administering agency should then liase with the health professional e.g. School Health Nurse, to arrange a mutually convenient date for training.

The health professional will carry out a training programme incorporating epilepsy awareness, first aid for seizures, the administration of buccal midazolam and documentation to the volunteers. The health professional will discuss with the volunteers the agreement form for the administration of buccal midazolam for non-medical and non-nursing staff for a specific child.

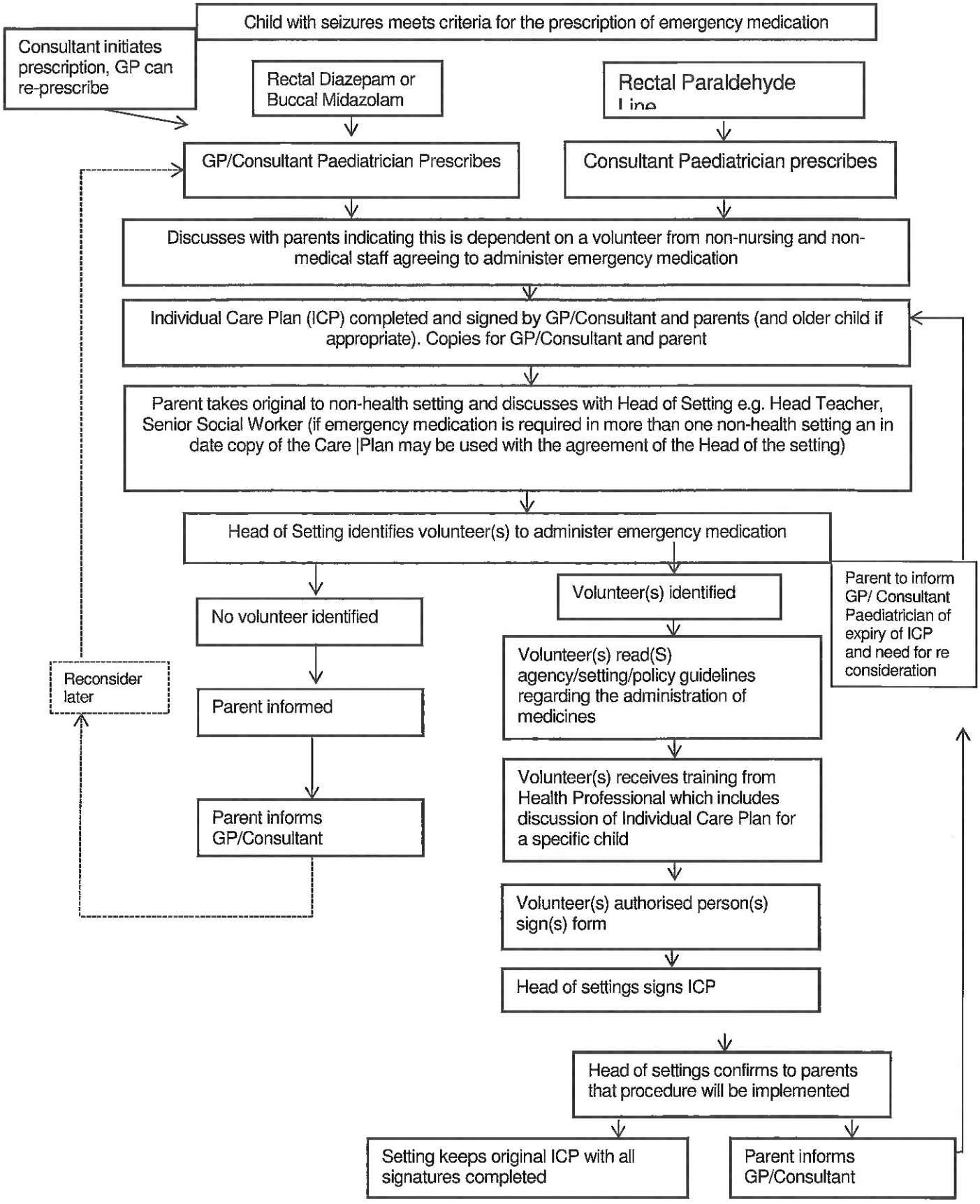
Following the training the volunteer(s) sign(s) the training agreement form and the administration agreement form. The administration agreement form then becomes a contract between the Consultant, the parent and the administering agency e.g. school, respite agency. The health professional is responsible only for providing the training of the volunteers – not for the administration of buccal midazolam and not for identifying volunteers.

The administering agency therefore holds the original copy of the administration agreement form complete with the signatures of parent, Consultant Paediatrician, volunteers and administering agency head. The parents are responsible for informing the Consultant Paediatrician and GP that volunteers have been trained to administer buccal midazolam.

Parents are responsible for highlighting the expiry date on the agreement form to the Consultant Paediatrician to review and renew the agreement form when necessary.

ADMINISTRATION OF RECTAL DIAZEPAM, BUCCAL MIDAZOLAM OR RECTAL PARALDHYDE IN RESPONSE TO EPILEPTIC SEIZURES/FITS/CONVULSIONS

Protocol for Health Staff to Support Non-Medical and Non-Nursing staff



INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINSTRATION OF RECTAL DIAZEPAM AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON HEALTH STAFF

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

NAME OF CHILD: .....DOB.....Hosp no.....
Address:.....
...

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

*lasting.....minute ☐

Or *repetitive over minutes

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

The dose of Rectal Diazepam should be_____mg(s)

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

1 **The normal reaction to this dose is that the seizure should stop.**
2 **This should occur in 5 – 10 minutes.**

3 **If the seizure does not stop, then phone 999 for ambulance.**
4
Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

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

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

The parents will be responsible for:

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

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature..... Date .....

PARENT/GUARDIAN (Block Capitals) .....Tel No.....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER RECTAL DIAZEPAM

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINSTRATION OF BUCCAL MIDAZOLAM (10mg/ml) AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON HEALTH STAFF

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

NAME OF CHILD: .....DOB..... Hosp no.....
Address:.....
.....

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

*lasting .....minutes ☐

Or *repetitive over.....minutes ☐
without regaining consciousness

*delete as appropriate

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

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

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

5 **If the seizure does not stop, then phone 999 for ambulance.**
6
Particular things to note are: **Respiratory depression in which case phone 999 for ambulance.**

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

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

The parents will be responsible for:

1. informing anyone who needs to know, if buccal midazolam has been given
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose / type.
4. Sorting out the review of the Individual care plan.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature..... Date .....

PARENT/GUARDIAN (Block Capitals) .....Tel No.....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER BUCCAL MIDAZOLAM

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINISTRATION OF BUCCOLAM OROMUCOSAL SOLUTION AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-HEALTH STAFF

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

NAME OF CHILD:..... D.O.B..... Hosp.no.....
Address:.....

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

*lasting .....minutes ☐

Or *repetitive over.....minutes without regaining consciousness ☐

*delete as appropriate

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

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

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

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

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

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

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

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

The parents will be responsible for:

1. Informing anyone who needs to know if **Buccolam** has been given.
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose/type.
4. Sorting out the review of the ICP every 12 months.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature ..... Date .....

PARENT/GUARDIAN (Block Capitals) ..... Tel No: .....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM
NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINISTRATION OF BUCCOLAM OROMUCOSAL SOLUTION AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-HEALTH STAFF

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

NAME OF CHILD:..... D.O.B..... Hosp.no.....
Address:.....

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

*lasting .....minutes ☐

Or *repetitive over.....minutes
without regaining consciousness ☐

*delete as appropriate

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

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

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

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

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

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

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

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

The parents will be responsible for:

1. Informing anyone who needs to know if **Buccolam** has been given.
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose/type.
4. Sorting out the review of the ICP every 12 months.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature ..... Date .....

PARENT/GUARDIAN (Block Capitals) ..... Tel No: .....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM
NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINISTRATION OF BUCCOLAM OROMUCOSAL SOLUTION AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-HEALTH STAFF

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

NAME OF CHILD:..... D.O.B..... Hosp.no.....
Address:.....

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

*lasting .....minutes ☐

Or *repetitive over.....minutes without regaining consciousness ☐

*delete as appropriate

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

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

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

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

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

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

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

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

The parents will be responsible for:

1. Informing anyone who needs to know if **Buccolam** has been given.
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose/type.
4. Sorting out the review of the ICP every 12 months.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature ..... Date .....

PARENT/GUARDIAN (Block Capitals) ..... Tel No: .....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM
NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINISTRATION OF BUCCOLAM OROMUCOSAL SOLUTION AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON-HEALTH STAFF

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

NAME OF CHILD:..... D.O.B..... Hosp.no.....
Address:.....

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

*lasting .....minutes ☐

Or *repetitive over.....minutes without regaining consciousness ☐

*delete as appropriate

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

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

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

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

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

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

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

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

The parents will be responsible for:

1. Informing anyone who needs to know if **Buccolam** has been given.
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose/type.
4. Sorting out the review of the ICP every 12 months.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature ..... Date .....

PARENT/GUARDIAN (Block Capitals) ..... Tel No: .....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER BUCCOLAM
NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

INDIVIDUAL CARE PLAN (ICP) FOR THE ADMINSTRATION OF RECTAL PARALDEHYDE AS TREATMENT FOR EPILEPTIC SEIZURES/FITS/CONVULSIONS BY NON HEALTH STAFF

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

NAME OF CHILD:
.....DOB.....HOSP NO
.....

Address
.....
.....

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

*lasting minutes

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

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

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

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

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

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

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

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

The parents will be responsible for:

1. Informing anyone who needs to know if rectal paraldehyde has been given.
2. maintaining adequate and in-date supply of medication at the setting
3. Notifying the setting if there are any changes to medication dose/type.
4. Sorting out the review of the ICP every 12 months.

This care plan has been agreed by the following:

PRESCRIBER (CLINICIAN) (Block Capitals).....

Signature..... Date .....

PARENT/GUARDIAN (Block Capitals) .....Tel No.....

Signature ..... Date .....

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

Signature ..... Date .....

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

Signature ..... Date .....

AUTHORISED PERSON(S) TO ADMINISTER RECTAL PARALDEHYDE

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

NAME (Block Capitals) .....

Signature ..... Date .....

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

REPORT FORM FOR THE ADMINISTRATION OF RECTAL DIAZEPAM

NAME OF CHILD:			DOB:
DATE OF SEIZURE/CONVULSION:			
TIME SEIZURE/CONVULSION STARTED:			
ACTIVITY WHEN SEIZURE/CONVULSION BEGAN:			
DESCRIPTION OF SEIZURE/CONVULSION:			
TIME RECTAL DIAZEPAM GIVEN	DOSE GIVEN	MG	GIVEN BY
ANY DIFFICULTIES IN ADMINISTRATION:			
TIME SEIZURE/CONVULSION STOPPED:			
TIME CHILD TAKEN TO HOSPITAL:			
ANY OTHER NOTES ABOUT THE INCIDENT (e.g. injuries to child or other parties, child sleepy):			
FORM COMPLETED BY (AUTHORISED PERSON): NAME (print): SIGNATURE: JOB TITLE: CONTACT TEL. NO: DATE:			
WITNESS: NAME (print): SIGNATURE:			

Original to Child's Setting Record
c.c. Hospital with child (where possible)
Parent
Other (specify)

RECTAL DIAZEPAM ADMINISTRATION REPORT FORM

NAME OF CHILD:	DOB:
DATE OF SEIZURE/CONVULSION:	

TIME SEIZURE / CONVULSION STARTED:

ACTIVITY WHEN SEIZURE/CONVULSION BEGAN:

DESCRIPTION OF SEIZURE/CONVULSION:

TIME RECTAL DIAZEPAM GIVEN:	DOSE GIVEN:	MGS:	GIVEN BY:
1. _____	_____	_____	_____
2, _____	_____	_____	_____

ANY DIFFICULTIES IN ADMINISTRATION?

TIME SEIZURE / CONVULSION STOPPED:

TIME CHILD TAKEN TO HOSPITAL:

ANY OTHER NOTES ABOUT INCIDENT (e.g. injuries to child or other parties, child sleepy)

SIGNED (authorised person): NAME(print):

DATE:

DESIGNATION:

BUCCAL MIDAZOLAM ADMINISTRATION
REPORT FORM

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

RECTAL PARALDEHYDE ADMINISTRATION
REPORT FORM

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

TRAINING AGREEMENT FOR VOLUNTEERS IDENTIFIED BY HEAD OF SETTING TO ADMINISTER RECTAL DIAZEPAM

NAME: _____

SETTING: _____

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

Practical

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

Other (specify):

Declaration

I.....confirm that I have been trained to use Rectal Diazepam as detailed overleaf.

Signed _____

Date _____

Training given by:

Name _____

Designation _____

Agency _____

Date _____

Review date _____

Copies to: Authorised Person
Health Professional
Head of setting

TRAINING AGREEMENT FOR VOLUNTEERS IDENTIFIED BY HEAD OF SETTING TO ADMINISTER RECTAL PARALDEHYDE

NAME: _____

SETTING: _____

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

Practical

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

Other (specify):

Declaration

I.....confirm that I have been trained to use Rectal Paraldehyde as detailed overleaf.

Signed _____

Date _____

Training given by:

Name _____

Designation _____

Agency _____

Date _____

Review date _____

Copies to: Authorised Person
Health Professional
Head of setting

Appendix

D

Authors: James Greening, Consultant Paediatric Diabetologist
Michelle Mottershaw, Children's Diabetic Specialist Nurse
Maureen Burnett, Medical Adviser to CYPS (Education)
Leicester, Leicestershire and Rutland
May 2010.

APPENDIX D

GUIDANCE FOR SETTINGS ON THE MANAGEMENT OF DIABETES MELLITUS

Please ensure this appendix is read in conjunction with the rest of the Health and Safety Bulletin No 36A particularly section 6.2 (v).

Introduction

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

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

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

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

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

Background

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

The duties of SENDA are anticipatory and include planning for a pupil with medical needs. The settings managing medicines policy should show what procedures are in place to allow a pupil requiring medication during the school day, including insulin, to have access to it and for children that don't have the independence or maturity to give their own injections of insulin to

be supported in this practice. This may mean your setting recruits staff with healthcare experience and/or trains volunteering staff to meet the needs of prospective pupil's medical conditions, including diabetes (2).

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

Process

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

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

In order for a patient to have blood glucose testing, results recording and insulin administered by a setting's volunteer, all documentation, as specified, will have to completed in full and be up to date. An ICP will be developed during consultation **with the doctor at the diabetes clinic**. Blood glucose testing times and result reporting requirements will be stated. The type of insulin injector equipment, dose and times of insulin and injection site will be stated. **Any changes to the regime agreed between the patient and the doctor will be documented in an updated ICP and the doctor or diabetes specialist nurse** (Diabetes Support Team) **will inform the authorised volunteers.** The ICP will be reviewed at least yearly to see if it continues to be appropriate e.g. discontinued if self administering (use Appendices E1 and E2).

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

Setting **staff** managing the blood testing or administration of insulin should receive appropriate **training** and support from health professionals. To support setting staff with this it is envisaged that the local Diabetes Support Team and Diabetes UK: East Midlands (5) will hold regular training and awareness sessions for setting staff working with children with diabetes (4). Once the head of the setting has identified volunteers the school should contact the Diabetes Specialist Nurse (see note 3) who will arrange the training. This would also be the process for training of new staff. Refresher sessions should be planned annually to keep staff up to date (Appendix E10).

Volunteers will be trained to the standard **to carry out the protocol** (see Appendices E8 and E9). They will keep a **copy of the appropriate protocols after their training** and their training will be **confirmed by the authorised trainer and the prescribing doctor** (Appendix E11).

Notes

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

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

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

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

   Sessions will cover:-

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

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

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

References

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

APPENDIX D1

AGREEMENT FOR SELF TESTING FOR BLOOD GLUCOSE IN THE SETTING

Child or Young Person's Name .....

Child or Young Person's DOB .....

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

1) All test equipment is supplied from home.

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

   Time(s).....

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

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

5) Standard hygiene procedures are applied at all times.

6) *The child or young person self tests independently

   *The child or young person self tests with minimal supervision

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

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

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

9) The child or young person independently

   *interprets the results and acts accordingly or

   *contact (*insert details*).....to interpret the results and give instructions

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

* delete as appropriate.
[1] discuss with School Nurse or local Diabetes Support Team

pto

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

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

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

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

Signed ..... Date .....

Name of student *(if appropriate)* .....(please print)

Signed ..... Date .....

Name of Parent .....(please print)

Emergency Contact Details

Name .... Tel Home .....

Tel Work ..... Mobile No .....

Head of Setting

Name.....

Signed ..... Date .....

Setting has original
cc Parents

As a minimum updated annually

APPENDIX D2

AGREEMENT TO SELF-INJECTION OF INSULIN FOR CHILDREN OR YOUNG PEOPLE WITH DIABETES MELLITUS

Full Name of Child or Young Person ..... Date of Birth .....

This person has been diagnosed as having Diabetes Mellitus. He/she requires insulin

injections during school hours at the following times.....

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

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

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

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

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

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

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

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

Signed ..... Date .....

Name of student *(if appropriate)* .....(please print)

Signed ..... Date .....

Name of Parent .....(please print)

Emergency Contact Details

Name .... Tel Home .....

Tel Work ..... Mobile No .....

Head of Setting

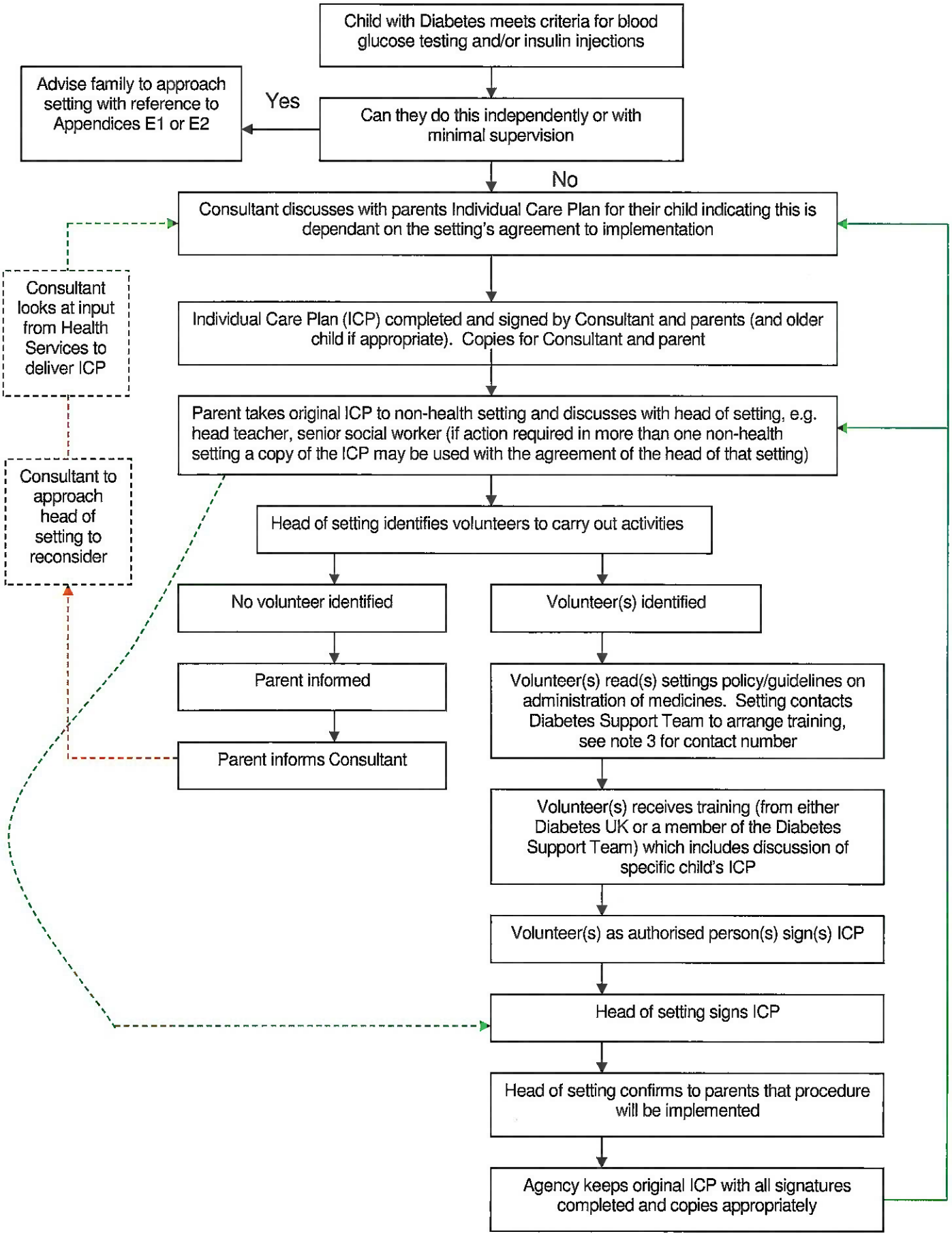
Name.....

Signed ..... Date .....

**delete as appropriate or if none applicable use Individual Care Plan*
Setting has original
cc Parent
As a minimum updated annually

APPENDIX D3

PROCESS FOR ESTABLISHING OR REVISING AN INDIVIDUAL CARE PLAN FOR THE MANAGEMENT OF DIABETES MELLITUS IN NON-HEALTH SETTINGS



APPENDIX D4

INDIVIDUAL CARE PLAN FOR THE MANAGEMENT OF DIABETES MELLITUS BY NON-MEDICAL AND NON-NURSING STAFF

TO BE COMPLETED BY A CONSULTANT, PARENT, THE HEAD OF THE SETTING AND THE AUTHORISED PERSON.

NAME OF CHILD: ..... DOB: .....

This plan been agreed by the following: (BLOCK CAPITALS)

CONSULTANT

NAME.....Tel No.....

Signature.....Date.....

PARENT / GUARDIAN

NAME.....Tel No.....

Signature.....Date.....

Emergency Contact Number

OLDER CHILD / YOUNG PERSON (if appropriate)

NAME.....

Signature.....Date.....

HEAD OF SETTING

NAME.....

Signature.....Date.....

Authorised person(s) to *test blood glucose and/or *administer pre-prepared insulin injection

Name (Block Capitals) .....

Signature .....Date .....

Name (Block Capitals) .....

Signature .....Date .....

* delete as appropriate

Copies of this should be held by the parents, the consultant and the setting and ***updated at least annually.***

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and supplies at the setting.

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

If the child or young person refuses testing do not progress but immediately inform the parent.

BLOOD GLUCOSE TESTING

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

□ Check the blood glucose level at *(insert times or activities)*

.....

Dispose of test strip and pricker into sharps bin.

Record on the Record Sheet.

*Report result to.....Tel.....

□ Check the blood glucose level prior to insulin being given.

Dispose of test strip and pricker into sharps bin

Record on the Record Sheet.

Within the range .....give insulin dose recorded in the individual care plan.

Outside the range immediately report result to:

Name .....Tel .....

Give insulin dose advised by the above person on this occasion only.

Record dose on Record Sheet.

□ *if testing required tick one only box*
* *delete as appropriate*

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

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and medication at the setting.

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

If the child or young person refuses injection do not progress but immediately inform the parent.

INSULIN INJECTION

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

The type of insulin is prescribed as: Penfill cartridge injection ☐
Insulin bolus via pump ☐

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

Particular things to note are .....

Action to take .....

Dispose of needle into sharps bin
After administration of insulin, please complete the Record Sheet

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

UPDATED - Signed ..... NAME ..... Designation .....
cc: retained by health professional, given to parents. Original to setting

BLOOD GLUCOSE TEST AND/OR INSULIN ADMINISTRATION RECORD SHEET

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

* delete as appropriate

Original retained at setting

c.c. Parent on request
Diabetes Support Team on request

APPENDIX D5

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and supplies at the setting.

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

If the child or young person refuses testing do not progress but immediately inform the parent.

BLOOD GLUCOSE TESTING

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

□ Check the blood glucose level at *(insert times or activities)*

……..

Dispose of test strip and pricker into sharps bin.

Record on the Record Sheet.

*Report result to……Tel……..

□ Check the blood glucose level prior to insulin being given.

Dispose of test strip and pricker into sharps bin

Record on the Record Sheet.

Within the range ……give insulin dose recorded in the individual care plan.

Outside the range immediately report result to:

Name …….....Tel …….

Give insulin dose advised by the above person on this occasion only.

Record dose on Record Sheet

□ *if testing required tick one only box*
* *delete as appropriate*

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

UPDATED - Signed …… NAME …….... Designation ……

cc: retained by health professional, given to parents. Original to setting

The parents will be responsible for informing anyone who needs to know regarding the management process and for maintaining an in-date supply of equipment (including a sharps bin) and medication at the setting.

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

If the child or young person refuses injection do not progress but immediately inform the parent.

INSULIN INJECTION

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

The type of insulin is prescribed as: Penfill cartridge injection ☐
Insulin bolus via pump ☐

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

Particular things to note are .....

Action to take .....

Dispose of needle into sharps bin
After administration of insulin, please complete the Record Sheet

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

UPDATED - Signed ..... NAME ..... Designation .....
cc: retained by health professional, given to parents. Original to setting

APPENDIX D7

BLOOD GLUCOSE TEST AND/OR INSULIN ADMINISTRATION RECORD SHEET

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

* delete as appropriate

Original retained at setting

c.c. Parent on request
Diabetes Support Team on request

APPENDIX D8

PROTOCOL FOR BLOOD GLUCOSE TESTING

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

SAMPLE

APPENDIX D9

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

PROTOCOL FOR ADMINISTRATION OF INSULIN

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

SAMPLE

APPENDIX D10

Diabetes Awareness Training for School Staff
– Wednesday 14 November 2007

Programme

09.00 - 09.05	**Welcome and Introduction** Julie Orrey, East Midlands Regional Manager, Diabetes UK
09.05 - 09.20	**Disability Equality Duty update** Liz Mangle, Assistant SEN Officer, Nottinghamshire LEA
09.20 - 09.40	**Basic overview of diabetes in children** Josie Drew, Paediatric Consultant
09.40 - 10.00	**What support is available to schools** Helen Marsh, Paediatric Diabetes Specialist Nurse
10.00 - 10.20	**Refreshments**
10.20 - 10.40	**Hypo management** Vreni Verhoeven, Paediatric Diabetes Specialist Nurse
10.40 - 11.00	**Food & activity** Anna Clark, Dietician *Split into 2 groups for practical demonstrations*
11.00 - 12.00 (30 minutes each session)	**Pens & insulin administration** Helen Marsh, Paediatric Diabetes Specialist Nurse **Meters & blood testing** Vreni Verhoeven, Paediatric Diabetes Specialist Nurse
12.00 - 12.30	**Panel Q & A session**
12.30	**Close**

SAMPLE

APPENDIX D11

RECORD OF COMPLETION OF TRAINING FOR BLOOD GLUCOSE TESTING AND/OR INSULIN ADMINISTRATION BY NON-MEDICAL AND NON-NURSING STAFF

To: Head of Setting

RE: Name of person.....

Date of Birth: .....

Name of setting working at .....

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

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

AUTHORISED TRAINER .....(Block Capitals)

Designation.....

Signature ..... Date.....

Agency..... .....Contact Number.....

CONSULTANT .....(Block Capitals)

Signature ..... Date.....

I confirm I have attended the training as recorded above:

AUTHORISED PERSON(S) NAME ..... (Block Capitals)

Signature ..... Date.....

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

TRAINING SHOULD BE UPDATED ANNUALLY

D2

APPENDIX E

Leicestershire Partnership NHS
NHS Trust

Policy and Procedure for Managing Medicines In Schools

This Policy and Procedure describes the process to follow when managing medicines in school setting. It includes ordering, obtaining, storage, administration, return and records associated with the above.

Key Words:	Medicines School	
Version:	1.0	
Adopted by:	Clinical Governance Committee – FYPC Division	
Date adopted:		
Name of originator/author:	Tejas Khatau, Maggie Clarke, Des Anderton.	
Name of responsible committee:	Clinical Governance Committee – FYPC Division	
Date issued for publication:		
Review date:		
Expiry date:		
Target audience:	School nurses needing to manage medicines in school setting	
Type of Policy (tick appropriate box)	Clinical √	Non Clinical
NHSLA Risk Management Standards if applicable:	6.10	
State Relevant CQC Standards:	9	

Leicestershire Partnership NHS
NHS Trust

CONTRIBUTION LIST

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Circulated to the following individuals for comments

Name	Designation

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
0.1	March 2014	New Policy

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself?
Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

For further information contact:

Maggie Clarke (Clinical Team Leader and Senior School Nurse) - 07557498007

Desley Anderton (Clinical Team Leader) - 07766440612

Lead Pharmacist for FYPC Division - 0116 295 8308

Definitions and abbreviation that apply to this Policy

CD	Controlled Drug. The Misuse of Drugs Regulations categorise CDs into Schedules 2-5.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
MAAR	Medication Authorisation and Administration Record. This consists of an authorisation to give a medicine plus record of what was administered (or omitted). It can be paper or electronic.

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development, review and implementation.

1.0 Summary of Policy

The Leicestershire Medicines Code describes how activities around medicines should be carried out. Where possible this Code must be adhered to.

It has been recognised that School Nurses within schools need to work slightly differently as it is not a health environment yet they are still required to provide care with medicines.

2.0 Introduction

The Leicestershire Medicines Code describes how activities around medicines should be carried out. Where possible this Code must be adhered to.

FYPC Division employ school nurses who work in schools to provide care to children that require medicines, including controlled drugs. Schools are under the remit of the Local Authority. Due to school nurses working in non-healthcare premises, it was deemed necessary to provide additional guidance to ensure that medicines are managed as safely and consistently as possible.

3.0 Purpose

The principle objectives of this policy are to:

1. Ensure all processes involving medicines are managed safely and consistently across the Service;
2. Ensure robust processes are in place;
3. Ensure robust documentation is in place;
4. Work closely with Local Authority to ensure that the need for secure medicines management is balanced with the type of setting and resources available to the school;

4.0 Duties

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 FYPC Divisional Director and service lead is responsible for ensuring that there are appropriate resources provided within their service area to implement and adhere to the policy.

4.3 Managers and Team leaders will be responsible for:

- Ensuring this policy is implemented in their area of responsibility.
- Medicines managed in line with this policy
- Ensuring that their staff are appropriately trained in line with the requirements of this policy;

4.4 Responsibility of Staff:

It is the responsibility of staff that manage medicines to ensure that they are familiar with this policy and adhere to it.

4.5 Responsibility of parents:

(a) Read, sign and return the "contract";
(b) Timely supply of medicines in their original container;
(c) Authorisation of medicines that need to be administered;
(d) Communicate with school nurses if there is any change to child's therapy.

5.0 Policy and Procedure for Managing Medicines In School

5.1 Ordering Medicines

5.1.1 Medicines are ordered from patient's parents. This can be done via telephone message, slip, ChatHealth School Nurse Messaging Service.

5.1.2 Medicines should be ordered 7 days prior to running out to prevent delay in receiving further supply. An estimate is required with regards to how much liquid or inhaler is left. Bear in mind that some "specials" medicines can take longer to order so more notice is needed;

5.1.3 Details of what was ordered, when, from whom and method of communication must be documented in patient records (e.g SystmOne);

5.1.4 Responsibility for ordering the prescription and obtain the medicines from a prescriber rests with the parent(s);

5.1.5 If there is a delay in the school receiving medication, school nurse should notify the head teacher.

5.2 Receipt of Medicines

5.2.1 Upon receipt of medicines the following must be checked to ensure it is correct and acceptable:

- Name of medicine, strength and formulation on the box, bottle/strip and pharmacy label is consistent with request;
- Patient's name on the pharmacy label;
- Manufacturer's expiry date. If the expiry date is shorter after opening, this needs to be borne in mind and noted. If in doubt, contact the dispensing pharmacy(details on the label);
- Medication remains in original container or that decanted by pharmacist;
- Date on pharmacy label. Any medicines dispensed over 3 month ago should be questioned with the parent (to make sure that the therapy remains current) with the possible exception of "prn" medicines.

5.2.2 In addition to the above, for controlled drugs (CDs):

- Which are sent via a third party (i.e. transport), ensure that CDs are supplied in a sealed envelope with quantity supplied written on the outside;
- Open seal and verify physical quantity with that stated outside;
- For schedule 2 CDs, make a record in a bound CD register (one new page for every preparation) detailing date, time, name of patient, name of medicine, strength, formulation quantity received and running balance;
- There is no need to keep a written record for schedule 3-5 CDs.

5.3 Storage of Medicines

5.3.1 All medicines (including schedule 3-5 CDs) should be stored in a locked cupboard or drug trolley intended for medicines only. If a drug trolley is used, this must be secured such that it's movement is restricted when not in use. Schedule 2 CDs should be stored in a CD cabinet;

5.3.2 Whilst security of medicines is important, consideration should be given to having easier access to emergency medicines;

5.3.3 Keys giving access to the medicines must be kept with the health care professional at all times. When not needed, keys must be stored in a locked receptacle (such as a draw or filling cabinet);

5.3.4 There is no requirement to do stock checks, except with schedule 2 CDs or if there is a security concern. Stock check with schedule 2 CDs must be done and recorded at least once on each working day during term time. A stock check is done by ensuring that the physical quantity and written quantity correspond;

5.3.5 "Prn" CDs that are not routinely used (such as midazolam and diazepam) should be placed in a tamper evident pouch and a stock check should be done by ensuring that the seal number remains the same as before (appendix 1). If the seal number is different to that recorded previously, that implies that the pouch has been opened and therefore staff need to establish the circumstances around this;

5.3.6 Expiry date check must be carried out once in each term. A note of medicines expiring before the next check must be made to ensure that it is not used after the expiry date. Where the expiry date is stated as month and year, the product can be used until the last day of that month;

5.3.7 Given the infrequency at which medicines requiring refrigeration is received, a pharmacy grade refrigerator is desirable but not essential in this setting. Refrigerated items must be placed in a lockable refrigerator or an un-lockable refrigerator that is in a locked room. Refrigerator temperature must be checked and recorded daily when there is medicine inside (appendix 2). Notice can be placed by the plug to prevent it being inadvertently being switched off. If the temperature falls outside 2-8 °C, advice needs to be sought from pharmacy before using;

5.4 Authorisation (to administer medicines)

5.4.1 Only medicines that have a signed authorisation from the parent/legal guardian can be administered;

5.4.2 Staff are advised to use the MAAR completed by the parents in the first instance. If this is not possible or the MAAR returned is incomplete/ ambiguous, staff can transcribe the information onto the MAAR;

5.4.3 Ensure that the authorisation is legible and details the name of drug, dose, frequency, signature of parent and date.

5.4.4 Ensure that the details on the authorisation correlates with the details on the pharmacy label and details on the medicine box/strip/bottle;

5.5 Administration of Medicines

5.5.1 Ideally, administration of medicines should be carried out in a setting that is free from distraction. Privacy and dignity of the child should also be considered when administering medicines;

5.5.2 When transporting medicines within the school, a drug trolley or an alternative suitable device must be used to ensure safety and security of the medicines;

5.5.3 Generally, "Administering Medicines in the Community Setting - Standard Operating Procedure" must be followed when administering medicines in school setting. This is available on the intranet;

5.5.4 If the child is not known, their identity must be confirmed by asking the child to confirm their name, date of birth and looking at their photograph in their care plan. If the child cannot confirm their identity, the photograph alone should be used;

5.5.5 Photographs must have a date when it was taken. Photographs need to be updated annually, ideally at the start of each new academic year;

5.5.6 Staff member must make sure that the instruction on the authorisation corresponds to that on the pharmacy label. If there is a discrepancy, staff must ask parent for further information (such as hospital letter etc....) verifying the actual drug regimen;

5.5.7 With the exception of "prn" drugs, staff should ensure that the medicine has been dispensed recently (i.e. in the last 3 months). This routine practice will help ensure that the patient is receiving the most up-to-date treatment;

5.5.8 If the child is scheduled to be away from school (e.g. school trip) around the time of medicines administration, school staff will assume responsibility to administer the medicines;

5.5.9 A record should be made of medicines administered or omitted. A record of administration can simply be an initial against the relevant time, day and medicine on the MAAR. In addition to the above, the time of administration should be recorded if the medicine was administered over an hour either side of the required time or if there are other reasons where this information would be useful (e.g. "prn" medicines, hand-over for parent etc..); Batch number and expiry date also needs to be documented, at least once each month in the spaces provided on the MAAR;

5.5.10 For missed doses/omissions, reason for omission must be recorded and parent contacted;

5.5.11 For schedule 2 CDs, in addition to the above the following must also be recorded in the appropriate page of the CD register: (a) date (b) time (c) dose administered (d) dose wasted (e) running balance (f) staff signature.

5.6 Medication Error

5.6.1 If a medication error occurs, staff should follow the Trust Medication Error Policy which is available on the intranet;

5.6.2 The head teacher must also be notified.

5.7 Disposal and Return of Medicines

5.7.1 Any obsolete medicines must be returned to the parent as soon as possible to reduce confusion;

5.7.2 Any un-used medicines must be returned to the parent at the end of the academic year.

5.7.3 CDs sent back via a third party (i.e. transport) must be placed in a sealed envelope with the quantity returned written on the outside;

5.7.4 Small quantity of medicines (e.g. 1-2 tablets) that are dropped or spat out can be disposed of in a domestic bin;

5.8 Communicating with Parents

5.8.1 Timely communication with parents is vital and can be done using complement slips, telephone call or text message;

6.0 Management and Implementation

This policy will be implemented and disseminated throughout the organisation, in accordance to the post ratification process. Following approval the policy will be catalogued in the Trust register of Policies and posted on the intranet.

It is the responsibility of the Service Lead to ensure that staff are familiar and compliant with this policy and have documented evidence of this.

7.0 Monitoring Compliance and Effectiveness

At least an annual inspection will be carried out for a line manager using the audit tool in appendix 3.

8.0 Due Regard

During the development of this policy the Trust has considered the needs of each protected characteristic as outlined in our equality statement with the aim of minimising and if possible remove any disproportionate impact on employees. If staff become aware of any exclusions that impact on the delivery of this policy, processes are in place to mitigate any risk.

Refresher training is provided every three years to support staff in the implementation of this policy.

References and Associated Documentation

1. Administration of Medicines in the Community – Standard Operating Procedure
2. Medication Error Policy
3. Managing Medicines in School and Early Years Settings, 2005 (DoH)
4. Leicestershire children and young people's services - Administration of Medicines (Leicestershire County Council)
5. Managing medicines and healthcare needs in school, early years and youth settings (City Policy)

Appendix 1 **Tamper-evidence Check**

Name of Patient.....

Name of Drug.....

Date	Seal Number	Comments

Appendix 2

Royal Pharmaceutical Society of Great Britain

Refrigerator Temperature Record

Month: **Year:**

Date / Day	Max Temp C	Min Temp C	Action taken if outside range 2-8 C	Checked by (initials)	Thermometer reset (tick)

Please record the date(s) the fridge was defrosted:

Review:

Has the fridge temperature been checked every day? ☐ Yes ☐ No

Has any necessary action been taken? ☐ Yes ☐ No

If yes, what was the action?

Reviewed by: ..... Date:.....

If the fridge temperature is outside of the stated range (+2°C and +8°C) then assess the integrity of the stock in the fridge seeking manufacturer's advice where appropriate.

Appendix 3 **Compliance with Policy – Audit Tool**

Purpose of this document is to ascertain level of compliance with the Policy. Information should be gathered by examining documentation, availability of paperwork and visual inspection.

Date of inspection:.....

Name of staff completing inspection:.....

		Level of Compliance			
Criterion	**Standard**	**Full**	**Partial**	**Non**	**N/A**
Proof of ordering medicines via one of the approved methods	Full Compliance (100%)				
Authorisation for every medicine present on the day					
Authorisation, pharmacy label and medication correspond					
All medicines stored in a lockable cupboard located inside a lockable room					
All medicines in-date					
No obsolete medicines present					
Refrigerator (lockable or not) located inside a lockable room					
Keys to the cupboards/room kept on the individual or in a safe place					
Presence of photo identification for children requiring medicines administration					
CD entries fully completed					
Weekly check of tamper evident seal for "prn" CDs					
Completion of appendix 1 for refrigerated medicines					
Full documentation of administration/omission					
Presence of sealable envelopes for transportation of CDs					

Leicestershire Partnership NHS
NHS Trust

Medication Authorisation & Administration Record in school - 12 months

Drug & formulation:	Time ↓	Dose ↓	Route:
Additional information:			Start Date:
Parent/Carer name and signature:			End Date:

Patient Details		Allergy Details	
Name:	DOB:	Drug	Reaction
	NHS Number:		
Address:	Weight:		
	Height:		
GP Name:	BMI:		
	BSA:		

Medication not administered

For medication not administered enter the appropriate code on the administration record. Note details in the patients notes.

1. Allergic Reaction
2. Patient unable to take
3. Patient refused
4. Medication unavailable
5. Patient unavailable
6. Inappropriate/unclear prescription
7. Patient self-administered
8. Family/carer administered
9. Other - state reason below

Date	Reason

Medication administered

Month ↓	Time ↓	Dose ↓	Batch No. ↓	Exp Date ↓	Date 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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New authorisation required

Version 1

Leicester
City Council

Stress Management
Health & Safety Management Standard
Issue 2 (June, 2009)

Part D:
Stress and Sickness Absence

This document should be read in conjunction with Parts A, B, and C of the Stress Management Health & Safety Management Standard.

Introduction

This guidance has been developed in response to concerns that individual managers can sometimes be unsure how to respond when an individual experiences medium or long-term stress related absence. Although this document is primarily focused on medium/long-term sickness absence, the relevant principles (reporting, Stress Action Plans, deciding on changes/adjustments, etc.) can also be applied to short-term stress related sickness absence.

This document should also be read in conjunction with the Council's Attendance Management Policy.

Actions

1. **Make sure you report stress-related absences**
   It is a reasonable expectation that an employee should notify you of their absence and why they are absent. They may not be willing or able to go into medical details, but it is a reasonable expectation that they tell you if their absence is stress-related and if they think it is work-related.

   Ensure you always complete and return the pink Sickness Absence Report Form.

   If the employee feels that their stress is work-related, ask them to complete an SO2 Incident Report Form. You can send the form to their home, or if they say they feel unable to complete it, complete one on their behalf.

Be aware that other terms may be used for stress related absence (e.g. anxiety, depression, hypertension, panic-attacks).

2. **Ask the individual to complete a Stress Action Plan as soon as possible**
   As soon as you know that absence is stress related, you should ask and encourage the individual to complete Part 1 of the Stress Action Plan.

If the employee feels there are work issues it is essential that these are identified as quickly as possible and responded to. If not, it will be far less likely that the individual will return to work quickly. Via a referral, OH may be able to provide information on the individual's issues (if the employee consents to release that information - see section 5), but the Stress Action Plan process should still take place in parallel with an OH referral.

If an individual refuses to speak to you about their issues, and there are no medical reasons for delaying the risk assessment process (which OH will be able to advise on), you will need to be honest with the individual that you won't be in a position to consider any adjustments to help them back to work.

3. **Meet with the employee as soon as possible and maintain contact**
It is essential that you try to keep in touch. Managers can be hesitant about this in case they say the wrong thing or are perceived to be 'hassling' – where in reality individuals may be more concerned by a lack of contact. If there is little or no communication, misunderstanding and barriers can quickly arise. Then the employee may then feel that they are not missed or valued and this can exacerbate already low self-esteem.

Arrange to meet with the individual as soon as possible, ideally as soon as you become aware that the absence is likely to last longer than two weeks. **Just because the individual is absent from work, should not prevent a meeting from taking place – often this is key to an early return to work being achieved.**

The meeting should take place at their normal workplace, or if necessary a 'neutral' location. The aim of the meeting should be to identify the cause of the absence (e.g. any work-related issues) and provide support to facilitate an early return to work.

- Give the employee chance to explain the problem and what is happening
- Ask if there is anything you can do to help
- Avoid putting pressure on them to divulge personal or medical information
- Remind the person that a confidential counselling scheme can be accessed
- Depending on the severity of the illness (and the operational context of the service), explore if a temporary half-way house between work and absence would help to achieve a full return to work. E.g. working from home for a few hours a day.

Don't know what to say?

- Ask open questions about what is happening, how they are feeling and what solutions they think there might be.
- How long have they felt like this? Is this an ongoing issue or something that immediate action might put right?
- Are there problems outside work that they might like to talk about or that it would be helpful for you to know about? (Recognise that they might prefer to talk to a confidential counsellor rather than yourself about non-work issues.)
- Are they aware of possible sources of support, e.g. confidential counselling.
- Is there any aspect of their medical care or condition that it would be helpful for you to know about? For example, side effects of medication that might impact on their work. (While you have no right to this information, the employee should be aware that you can not make reasonable adjustments if you are not informed about the problem.)
- Do they have any ideas about short or longer-term adjustments to their work that may be helpful? (See 'Decide what changes you can accommodate' below.)

4. **Do not assume the employee wants no contact**
It is not uncommon for an individual to request no contact. The worst thing a manager can do is assume that this is the case, or accept it at face value and sever all contact with the individual. Research clearly shows that no contact hinders a person's recovery and reduces the chances of a return to work. It is essential that you try to keep in touch.

An individual may request no contact because they feel embarrassed about they way that they feel or are behaving – a sympathetic manner and treating the person normally can help overcome that. Sometimes the request for no contact arises because you, the manager, are perceived to be a factor.

In such circumstances consider offering the **temporary** services an intermediary such as a colleague or another manager, but also ensure the employee is made aware that they will need to re-engage with you at some point in the process.

Even if an individual is refusing contact with their manager, they may be in touch with their TU representative. You should consider speaking to the relevant TU representative to see if they can encourage the individual to maintain contact with the workplace.

5. **Make an early referral to Occupational Health**
In cases of stress-related absence, a referral to OH should be made by the **3rd week of absence**. Therefore, you will need to make a referral as soon as you are aware that the absence will be more than one week (e.g. by referring to the timeframe given on their GP's 'sick note').

NB. The current Attendance Management Policy advises that normally a meeting should take place with the employee to discuss the referral and that the employee should be given opportunity to sign the referral form. Recognising the need for a quick referral in stress-related cases, if this is not possible, the employee should still be sent a copy of the referral form by their manager.

NB. If a Stress Action Plan has been completed (or even only partially completed) include a copy with the referral. This should include the manager's response ('Part 2') if it is available.

Questions to consider asking OH include:

- What is the prognosis for their condition and how long is it anticipated to last?
- Is the individual receiving and following the correct treatment for their condition?
- What is the likelihood of a return to work within the next 'X' weeks/months? (A specific time period based on how long you can manage with the individual being absent, or the point at which employment decisions will have to be considered.)
- What is the effect of the condition on the individual, and their ability to carry out their job?
- In relation to the individual's condition (if any), please confirm:
    - What effect the condition has on the employee?
    - Is that effect substantial?
    - Is that effect long-term?
    - What effect it has on the individual's day-to-day activities?

- In respect of their medical condition, what adjustments could be made to help the employee return to work?
- Would these adjustments be short or long-term? When should they be reviewed?
- Are there any management or work-related issues that the employee feels need to be resolved?
- Would a 'phased return to work' assist (or speed-up) a return to work?
- In respect of a phased return, if the nature of the job can accommodate working from home would it assist the employee's return to work?

OH's stress questionnaire process

The Council's OH provider (Heales Medical) uses a stress risk assessment process, which is separate but complimentary to the Stress Action Plan process.

When a referral is made for a stress-related condition:

- OH may decided to send confidential questionnaires to both the employee and their line manager.
- Once these questionnaires have been returned to OH, OH will arrange a referral appointment with the employee.
- **NB.** OH will chase the questionnaires twice, at 5 day intervals. If the questionnaires are not returned OH will notify HR, who will be asked to encourage the return of the questionnaires.

On completion of the questionnaire process, the information back to the manager from OH will usually cover:

- An objective view on whether the individual's stress is work-related, not work-related, etc.
- Whether counselling (or other relevant treatment, such as Cognitive Behaviour Therapy) would be beneficial.
- Any suggested adjustments that should be considered (e.g. adjustment to working hours) and whether these adjustments are temporary or permanent.
- Whether there are management issues that need to be discussed with the employee.

What if a suggested adjustment can't be accommodated?

- Ultimately it is a management (not medical) decision about whether an adjustment can reasonably be accommodated.
- If a suggested amendment cannot be accommodated the manager can go back to OH, explaining why the adjustment can't be accommodated, but identifying any similar adjustments that could be accommodated.
- OH will then review their opinion and advise back on the likelihood of a return to work being achieved.

Will OH tell me what the employee thinks is the cause of the stress?

- If the employee gives consent, OH will provide the employee's perceptions of what is causing their stress.
- If there are work-related issues, as a minimum OH will advise in their referral report that: 'There are work-related issues that need to be discussed with the employee. In order to achieve an early return to work, a meeting or meditation with the employee should take place.'

6. **Don't avoid talking about any work-related issues**
As part of normal attendance management processes, a meeting should be arranged with the individual to discuss the outcome of the referral to OH. As identified earlier, the individual's absence from work should not prevent a meeting taking place. (See Section 3 for further information.)

Often it is not medical issues, but work-related or management issues that delay the return to work. Via the Stress Action Plan process, meetings with the individual, and/or the referral to OH (or a combination of all) the employee should be asked to identify any work-related issues and how they would want these issues resolved.

In some cases, it may be useful to consider if formal mediation could help to achieve resolution to the issues involved. Amica (the Council's counselling provider) can provide further advice on the suitability of, and processes for, mediation.

7. **Decide what changes you can (or can't) accommodate**
You should consider any factors that have contributed to their absence, which could reasonably be changed or accommodated. Where the individual's condition falls under the DDA (see 'questions to OH' above) there is a legal duty to consider reasonable adjustment. However, even where this is not the case, managers should consider if it is better to make some reasonable adjustments that will get the person back to work.

You will need to be honest about the things you can change and those you can't, as well as adjustments you can make in the short-term (e.g. to assist a return to work) and what you are able to accommodate in the longer-term. Avoid automatically refusing adjustments; make sure you give potential adjustments proper consideration.

Some organisational factors will be out of your control. But can they be mitigated?

Most adjustments are based on common sense about what might be helpful and what is possible. Remember you are not bound by external opinions (e.g. GP, OH) and you can query any OH advice you receive. The decision on what is 'reasonable' ultimately rests with management, although it is always preferable to try to seek agreement with the individual, even if ultimately agreement can't be reached.

The Stress Action Plan process should be largely complete by this stage. Write down what changes and adjustments can and can't be accommodated on that form.

8. **Plan the return to work**
Almost no-one is ever fully fit when they return to work after an illness (whether physical or mental). Waiting for people to be 100% fit for their work before allowing them back can therefore be unrealistic – it lengthens absences unnecessarily and may ultimately compromise their future employability.

Before the individual returns to work, discuss with them any adjustments needed to help their return. You can also discuss how their progress will be monitored.

As a manager you need to think about:
- Opportunities to work from home as part of the phased return to work
- Asking the individual about coming back into the workplace before they begin their 'formal' return to work (e.g. to attend team meetings).
- Allowing time-off to attend any therapeutic sessions.

- Exploring different work options such as part-time, job-share, flexible working around agreed outputs.
- How long you can accommodate any changes or adjustments.

OH input can be useful when planning a return to work. Questions to consider asking OH are shown in Section 5.

Be realistic about workloads – for example some people will wish to prove themselves and may offer to take on too much. Set achievable goals that make them feel they are making progress, but that are incrementally aimed to get them back to 'business as usual'.

Avoid not dealing with their work whilst they have been off. Check whether a backlog of unfinished work has built up.

9. **Maintain contact when they return to work**
When the individual returns, set aside time to brief them on what's been happening at work.

Take the opportunity to have frequent informal chats so there is an opportunity to discuss progress/problems without a formal (and possibly intimidating) session.

10. **Review how the return to work is progressing**
Talk to the employee about options or ideas for further adjustments. Then talk realistically with the employee about the best way to move forward. For example if all reasonable adjustments have been made in their current post, it may be necessary to consider transfer to another job. (**NB.** Always seek HR advice if this is becoming a consideration)

As part of this process review the stress action plan, to ensure the identified actions are in place.

11. **Don't remove adjustments you've put in place without stopping to think**
You may have put adjustments in place while the person is progressing to 'business as usual'. Avoid withdrawing these adjustments (where short or long term) without first speaking to the individual and seeking further advice from HR or OH as necessary.

12. **Try to avoid delaying disciplinary and/or capability proceedings**
Stress-related absence can occur either during the investigation phase or because of an impending hearing. If disciplinary/capability processes are the cause of a stress-related absence, delaying the process further is unlikely to resolve the cause of stress.

Please refer to the Council's disciplinary procedure and speak to HR for further guidance and information.

If OH advice is necessary, questions to consider asking OH (making sure you explain the circumstances of the referral) include: • Is the individual medically fit to attend an investigation/hearing? • If they are not currently medically fit, when are they likely to be? • How may their illness affect their ability to participate in the investigation/hearing? • What steps could be taken to accommodate the employee's illness in respect of the disciplinary investigation/hearing?

13. Is it a health issue or a performance issue?

Use normal procedures if it is a performance, attendance or conduct issue (as opposed to one primarily related to health or disability). If the matter cannot be resolved you may have to use the relevant formal procedure (e.g. capability, attendance, etc.), which ultimately could lead to redeployment or termination.

Leicester
City Council

Stress Management
Health & Safety Management Standard
Issue 2 (June, 2009)

Part C:
Individual Reactive Stress Risk Assessments – 'Stress Action Plans'

This document should be read in conjunction with Parts A, B, and D of the Stress Management Health & Safety Management Standard.

Responsibilities

It is the responsibility of managers to ensure that risk assessments are carried out within their area of control. Managers can either carry out risk assessments themselves, or delegate this task to individuals within their area of responsibility. If a manager delegates the task of carrying out a risk assessment, they must ensure that the person(s) is competent to carry out the assessment and takes all reasonable care when doing so.

Investigating stress in individuals

The Stress Action Plan process is a reactive tool for investigating the perceived causes of stress in individuals. The process is not intended to be used proactively/preventatively, on a group/team basis - the 'Stress at Work - Assessment of Good Management Practice' should be used for that purpose.

There may be occasions when it is necessary to reactively investigate the causes of an individual's stress. For example:

- When investigating the causes of sickness absence due to stress, or when planning a phased return to work after sickness absence due to stress (particularly long-term sickness absence).
- As a result of a proactive team/section based 'Stress at Work - Assessment of Good Management Practice' being carried out, which has highlighted potential stress issues in particular employees.
- During a line manager's incident investigation, following an individual reporting they are experiencing work-related stress or clearly exhibiting signs of stress.

Management issues

Occasionally in cases of work related stress, employees may refuse to cooperate with their manager, or the council's other arrangements for investigating the causes of stress. In these circumstances every effort should be made to encourage the employee to enter into dialogue with their manager. If the individual refuses to talk to their manager, the individual can suggest an alternative person who they feel confident in talking to, or ask someone to mediate in the process. In such cases the manager should contact HR to identify an alternative party to undertake discussions with the employee (e.g. HR, OH, another manager, etc.).

Overview of the Stress Action Plan process

The 'Stress Action Plan' tool is taken from a successful approach used by Bradford MD Council. This approach is not intended to address the medical aspects of stress (e.g. clinical depression), which should be addressed through an Occupational Health referral. However, it is intended to help identify and address personal and work issues that have led to the individual's perceptions of stress.

The overall aim of the process is for the individual employee and their manager to investigate the causes of (and solutions to) stress together. It is not a blaming opportunity but rather a chance to reflect upon the situation and the circumstances around it, and to identify how to reach a satisfactory outcome (e.g. employee is able to return to work). Approaching it in the manner described below means the employee plays a major part in identifying the issues involved in their feelings of stress and how they may be addressed.

NB. Additional guidance is provided on stress and sickness absence in Part D, including OH's role in carrying out stress risk assessments.

Stage 1 – The employee's perceptions

The first stage of the process is for the employee to complete Stage 1 of the Stress Action Plan form. Guidance for employees is provided on page 2 of the form.

Stage 2 – The manager's response

- **Agreeing specific actions**
  The manager should first consider their response to the issues raised. A face-to-face meeting should then be arranged between the individual employee and their manager (and if necessary HR) to discuss the actions to be taken. The purpose of this meeting should be to allow open and constructive communication between the two parties and enable a two-way sharing of views in an open and positive way. If there is a valid reason why a face-to-face meeting is not appropriate, then the manager should respond in writing detailing the actions to be taken, including an offer to have a face-to-face meeting.

  The manager should give objective consideration to the employee's ideas on how they wish to see any work-related issues resolved, including clarifying them with the employee where this is necessary.

Both the employee and manager must recognise that the manager needs to balance the individual's wishes with; the needs of the business, the potential effect on co-workers and the reasonable expectation that the employee should be able to cope with the normal pressures of the job. In making their decisions, the manager should ensure they take account of any issues arising from the Disability Discrimination Act (see Part D).

Although the individual's requests cannot be guaranteed, in most cases many requests can be achieved or a reasonable compromise or outcome reached. Managers should however, not agree to support unrealistic measures that cannot be sustained.

- **Documenting actions and review**
  Following the meeting with the individual, the manager should document the actions agreed and the reasons where they are unable to take action. A copy of the document should also be provided to the employee. The manager and employee should also agree review dates (no more than one month after the creation of the Stress Action Plan) to discuss and review progress against the actions agreed.

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Part B:
Team-Based Preventative Stress Risk Assessments

This document should be read in conjunction with Parts A, C, and D of the Stress Management Health & Safety Management Standard.

Responsibilities

It is the responsibility of managers to ensure that risk assessments are carried out within their area of control. Managers can either carry out risk assessments themselves, or delegate this task to individuals within their area of responsibility. If a manager delegates the task of carrying out a risk assessment, they must ensure that the person(s) is competent to carry out the assessment and takes all reasonable care when doing so.

'Good Management Practice' Risk Assessment

The LCC 'Stress at Work - Assessment of Good Management Practice' form should be used to carry out group/team based, preventative stress risk assessments. The risk assessment covers the seven sources of work-related stress identified by the HSE.

The 'Management Practice' stress risk assessment can be completed via a number of routes. For example; at team meetings, on away-days, using individuals' views collated from appraisals, 1-2-1s, etc. By whatever route the risk assessment is carried out, managers should communicate any remedial actions arising from the stress risk assessments to the group/team. Managers should also discuss the findings of the risk assessment with their immediate line manager.

It must be recognised that individuals may have difficulty raising their personal concerns in a group setting. If the risk assessment is completed in a team or group setting, managers should ensure that individual employees are aware that they can raise personal issues with their manager on a 1-2-1 basis.

Please note. The 'Stress at Work - Assessment of Good Management Practice' form is not designed to be used to carry out reactive and/or personal stress risk assessments. If a personal stress risk assessment is necessary, a 'Stress Action Plan' should be developed.

HSE Management Standards Indicator Tool

An alternative approach to team-based stress risk assessment is to use the HSE's Stress Indicator Tool. The Tool is an on-line questionnaire for confidential completion by individuals. The questionnaire phase is then followed up by focus groups of employees to discuss the findings of the survey and identify practical improvements.

Background information is available from the HSE's website. Managers considering using the Tool should contact their H&S team for further advice and support.

Reviewing Stress Risk Assessments

Team based stress risk assessments must always be reviewed:

- As soon as there are developments to suggest that they are no longer valid (e.g. an individual reports absence due to stress).
- Where there has been a significant change to the work environment (e.g. at the early stages of a new organisational review involving the team).

It is advised that stress risk assessments are formally reviewed at least once every eighteen months, unless they are reviewed sooner. Review does not necessarily mean carrying out a new risk assessment, but checking the existing one to ensure it is still valid and that any changes are reflected in the risk assessment.

Leicester
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Part A:
Principles, Responsibilities and Practical Actions

Introduction

This document contains corporate standards and guidance on the management of stress at work. It is the responsibility of line managers to ensure that stress related issues are managed in line with this document in any area under their control.

Structure

This document is divided into four parts:

- **Part A:** Principles, Responsibilities and Practical Actions
- **Part B:** Team-Based 'Preventative' Stress Risk Assessments
- **Part C:** Individual 'Reactive' Stress Risk Assessments – 'Stress Action Plans'
- **Part D:** Stress and Sickness Absence

Managers' Checklist – Stress Management

1. Are you aware of your role in the prevention and management of stress?

2. Has a preventative group/team based 'Stress Risk Assessment been carried out? (See Part B)

3. Do you understand how to recognise the signs and symptoms of stress in individual employees?

4. Are you aware of the mechanisms and interventions available to support individual employees experiencing pressure or stress?

5. Are you aware of the reporting mechanisms for work-related stress?

6. Are you aware of the processes for carrying out 'reactive' stress risk assessment for individual employees? (See Part C)

7. Are the six Health & Safety Executive (HSE) management standards in place and being delivered?

Policy and Principles

Stress management policy

Leicester City Council is responsible for the health, safety and welfare of its employees and recognises that employee well-being is important to its performance and service delivery, together with supporting people as valued employees.

The council aims to take positive measures to manage stress effectively and to create an environment where stress is prevented so far as is reasonably practicable; and that where it becomes an issue for individual employees, they are encouraged to seek support.

This policy is primarily concerned with stress arising from work, but the Council also recognises that events occurring outside work may also lead to stress that may have an impact on an employee's work. Therefore, employees should be given appropriate assistance whatever the cause.

Supporting principles

The following principles apply to LCC's approach to managing stress:

- The management of stress should be dealt with in a way that is non-discriminatory and in accordance with LCC's equal opportunities policy.
- Employees should be dealt with fairly and consistently across the organisation.
- There should be a positive and preventative approach to stress, rather than a punitive one.
- Individual confidentiality will be respected.
- Open communication between managers and employees should be encouraged and promoted.

HSE management standards

As part of the Council's policy and approach to stress, the HSE's stress 'Management Standards' is recognised as being the desired goal for the prevention, minimisation and management of stress issues in LCC. Managers should work towards ensuring that the 'states to be achieved' identified in the standards are achieved within LCC. The HSE's stress management standards can be found on the HSE's website.

Defining Stress

Stress and pressure

The HSE defines stress as:

> *'the adverse reaction people have to excessive pressure or other types of demand placed on them'.*

Pressure, in one form or another, will be present in all jobs. Pressure and challenge, even when high, can be motivating and stimulating. Pressure that can be responded to effectively is a factor in achieving job satisfaction. However, pressure at a level and a time where an individual cannot cope can lead to stress, as can too little pressure or challenge.

It should also be noted that individuals do not have a predisposition to stress. An individual's response will depend on the amount of pressure and their ability to cope at the time, and will therefore differ from person to person. However, no one can be regarded as being 'immune'.

Roles and Responsibilities

Elected Members and senior managers

- Demonstrate their commitment and support to this policy, by ensuring that the principles and approaches to managing stress are implemented.
- Reflect the policy's principles and approaches in their management practice.
- Ensure that resources are available to ensure that stress management arrangements are implemented.
- Provide adequate support to line managers in the implementation of this policy.

Managers (at all levels)

- Conduct and implement the recommendations of risk assessments within their area of control.
- Ensure good communication between themselves and staff, particularly where there are organisational changes.
- Ensure staff are fully trained to undertake their duties and are provided with meaningful developmental opportunities.
- Ensure that employees have access to appropriate training on recognising stress and manage pressure.
- Monitor workloads, working hours and whether staff are taking leave.
- Attend training as requested in good management practice and health & safety.
- Ensure that bullying and harassment is not tolerated within their area of responsibility
- Offer support to employees who are experiencing stress outside work.

Individual employees (including all managers)

- Support LCC's stress actions and initiatives.
- Recognise that they themselves may be a cause of stress to others, accept responsibility and take action to deal with this.
- Attend appropriate training so that they are better able to recognise and manage pressure and stress in themselves and others.
- Communicate openly and honestly with their manager and colleagues.
- Identify causes of stress in the workplace and report them appropriately to their line manager.
- Make use of opportunities to access confidential counselling when relevant or recommended.

Trades Union representatives

- Help promote and support stress initiatives in the workplace and to encourage full participation by everyone.
- Make employees aware of support mechanisms available to them.
- Support the monitoring and review of this policy (e.g. via H&S committees).

Practical steps for managers

Practical actions relevant to managers at all levels, which can help to avoid and minimise the impact of stress are given below. In addition, the 'Stress at Work - Assessment of Good Management Practice' form provides examples of practical actions that can help to avoid and minimise the impact of stress.

1. Speak to your staff.
   - Do all your staff have equal access to information, briefings, etc.? Consider any home workers, temp and part time staff.
   - Do you share information with your staff and ensure you don't keep 'bad news' secret?
   - Do you remember to pass on all the briefings and information that you receive?

2. Make sure team meetings happen.
   - Only rearrange them if absolutely necessary. Never cancel them without rearranging.

3. Make sure all staff have their appraisal.
   - Do you know how to undertake an appraisal? Consider your own training needs in this area.
   - Do you consider the individual's training needs at their appraisal?
   - Do you ask about things that stop them working as effectively as they could?
   - Are you and the individual clear about priorities? Do you and the individual understand how their priorities relate to the overall priorities of the team and service?

4. Have regular '1-2-1s' with individuals.
   - Ensure you allocate time for '1-2-1s' to take place.
   - Only rearrange them if absolutely necessary. Never cancel one without rearranging.
   - Always cover workload issues, and discuss and clarify priorities.

5. Know what to do if an employee tells you they are 'stressed'.
   - Make sure you know how to use the 'Stress Action Plan' tool.

6. Intervene quickly and positively if someone is absent due to stress.
   - **Do not** avoid contact with employees who are off work due to stress.
   - Quickly starting and maintaining contact with absent staff is especially important if their stated reason for absence is stress.
   - If they are unwilling to be in contact with you, speak to HR about alternative contact arrangements.

7. Be flexible.
   - If someone has something going on in their home life that is affecting their work, consider what LCC could do to help, even if on a short-term or temporary basis.

Signs of Stress

Some of the common signs of stress are:

- Persistent or recurrent moods – anger, irritability, detachment, worry, depression, guilt or sadness.
- Changed behaviour – difficulty concentrating or remembering things, inability to switch off, loss of creativity, making more errors, double checking everything, eating disorders, covering up mistakes by lying, increased use of alcohol, tobacco or drugs.
- Physical sensations/effects – aches and pains, raised heart rate, increased sweating, dizziness, blurred vision, skin or sleep disorders.

Managers should also be aware of the following possible signs of stress in individuals:

- Increase in overall sickness absence – particularly frequent short-term absences.
- Poor work performance – less output, lower quality, poor decision making.
- Relationships at work – conflict between colleagues, poor relationships with clients or other stakeholders.
- Staff attitude and behaviour – loss of motivation or commitment, poor time-keeping, working longer hours but with diminishing effectiveness.

Where managers have concerns they should discuss these with the individual concerned (see Part C).

Stress Interventions

Support for managers and employees
The following support mechanisms are available:

- **HR teams** – To provide support and guidance to managers and employees in dealing with stress, and in the use of related policies and procedures.
- **Health & Safety Services** – To provide support and guidance on risk assessment processes.
- **Occupational Health (OH)** – To provide medical advice and guidance on the impact of stress on individuals' health and their work, and what steps LCC and/or the employee may take.

Confidential counselling – Employee Assistance Programme
A free, confidential counselling service is available to LCC employees, provided by Amica. As well as support to individuals, Amica are also able to provide support and advice to managers, including how to deal with a critical incident / adverse event.

Work-life balance (WLB) and flexible working options
Personal or home issues may reduce the individual's ability to cope with normal work pressures and vice versa. Therefore, even if the primary cause is not thought to be work-related, appropriate support should be provided to the employee. This support may include looking at how the organisation can help the employee achieve a better work-life balance, either on a temporary or permanent basis. Further information on flexible working options is available from Insite or from HR.

Training
Specific courses aimed at individual employees and managers are available, free of charge via City Learning.

Physical/environmental factors
Employees may report that physical or environmental factors are a potential cause of stress. Issues of this type should be addressed through the requirements of existing relevant legislation (e.g. the Workplace or Display Screen Equipment Regulations) with further advice from your H&S team.

Violence
Stress arising from violence at work issues should be addressed through LCC's guidance on violence at work, with further advice from your H&S team as appropriate.

The role of other policies and arrangements
Many other existing policies and arrangements relate, directly and indirectly, to the management of stress. These include:

- **Appraisal, Supervision and '1-2-1s'** - These provide employees and managers with a valuable opportunity to get together and discuss work related issues.
- **Grievance Procedures** - All LCC employees have a right to raise any grievance relating to their employment and have it settled fairly and without undue delay.
- **Harassment and Discrimination Procedure** - Employees who feel they have been harassed or discriminated against in relation to their employment have a right to raise their complaint under the Harassment and Discrimination procedure.
- **Attendance Management Policy (AMP)** - The AMP sets out the Council's approach to managing absence. See also 'Stress and Sickness Absence' below.
- **Organisational & Staffing Change Protocol** - 'Appendix R' sets out protocol for organisational reviews, including the required arrangements for consultation and communication during periods of reorganisation.
- **Capability Procedure** - The purpose of the procedure is to provide a fair process for reviewing an employee's capability and dealing with any problems identified. The emphasis is not be on punishment, but on helping employees to do their jobs to the required standards.
- **Code of Conduct** - Includes potentially relevant information, including relationships with colleagues and other expected standards of behaviour at work.

Reporting Incidents of Work-Related Stress

If an employee feels they are experiencing work-related stress, managers should ensure that the individual reports it on the LCC 'SO2' Incident Report Form. As part of their investigation, the line manager should:

- Review any previous stress risk assessments carried out (whether team or individual risk assessments).
- Ask the employee to provide reasons and examples of why they feel they are experiencing work-related stress (this should lead on to the creation of a 'Stress Action Plan'.
- Identify any further actions to be taken (e.g. reviewing existing stress risk assessments, undertaking a Stress Action Plan, etc.) and record the actions to be taken on the Incident Report Form.

  Absence from work due to stress (whether work or non-work related) must also be reported in accordance with LCC's sickness absence reporting procedures.

Leicester City Council

Stress at work
H&S Employee Information Sheet
Issue 2 (June, 2009)

Introduction

This document contains general information and guidance for employees on the management of stress at work.

What is work related stress?

There is a difference between stress and pressure. We all experience pressure on a daily basis, and need it to motivate us and enable us to perform at our best. It's when we experience too much pressure without the opportunity to recover that we start to experience stress. The HSE definition of stress is 'the adverse reaction a person has to excessive pressure or other types of demand placed upon them'.

We can all feel stressed at times when we feel as though everything becomes too much, when things get on top of us, or when we feel as though we are unable to cope. It affects us in different ways at different times and is often the result of a combination of factors in our personal and working lives.

Work related stress can be tackled by working with the employer to identify issues at source and agreeing realistic and workable ways to tackle these.

Recognising stress

Some of the common signs that may be linked to stress in individuals are:

- Persistent or recurrent moods – anger, irritability, detachment, worry, depression, guilt and sadness.
- Physical sensations/effects – aches and pains, raised heart rate, increased sweating, dizziness, blurred vision, skin or sleep disorders, frequent colds and infections, indigestion, diarrhoea, or constipation.
- Changed behaviour – increased absence levels, difficulty concentrating or remembering things, inability to switch off, loss of creativity, making more errors, double checking everything, eating disorders, by lying to cover up mistakes, an increased use of alcohol, tobacco or drugs, becoming insular, being easily bored or fatigued.

How can I help tackle workplace stress?

As an employee, you have a duty to take reasonable care of yourself and others with regard to health and safety at work.

You should:

- Familiarise yourself with the Stress management standard
- Support LCC's stress initiatives.
- Communicate openly and honestly with your manager and colleagues.
- Attend appropriate training which can help you recognise and manage pressure and stress in yourself and others.
- Support your colleagues if they are experiencing work related stress and encourage them to talk to their manager, HR or trade union representative.
- Identify causes of stress in the workplace and report them appropriately to your line manager.

What should I do if I'm becoming stressed?

- Try to identify the causes and what you can do to make things better.

- Ideally, speak up if you're experiencing a problem, and talk to your manager to find a solution. If your stress is work related, this will give them the chance to help and prevent the situation getting worse. Even if it isn't work related, they may be able to do something to reduce some of your pressure.

- Help your manager to help you. To put effective plans in place, your manager will need information from you, so take an active part in any discussions, and complete stage one of the Stress action plan to aid any discussions.

If the source of pressure is your line manager, you can talk to someone you feel confident in talking to, or ask someone to mediate. Other alternatives may be HR, another manager or a trade union representative for example.

You may be reluctant to talk about stress at work from fear that you may be seen as weak, but stress is not a weakness, and it can happen to anyone.

A free, confidential counselling service is available to LCC employees. The service is provided by AMICA, an external counselling organisation. They provide telephone and face-to-face counselling and can be contacted by ringing 0116 254 4388.

It is important to take action at a personal level and to review your lifestyle to see if you can identify any contributing factors. These might include:

- eating on the run;
- smoking, or drinking excessively;
- rushing, hurrying, being available to everyone;
- doing several jobs at once;
- missing breaks, taking work home with you;
- having no time for exercise and relaxation.

In some cases, prolonged stress can lead to physical and/or mental ill health. If you think you are currently experiencing stress-related ill health you may benefit from a discussion with your GP.

Further information

Additional information on stress can be found on the following websites:

www.hse.gov.uk/stress/
www.nhsdirect.nhs.uk/

Leicester
City Council

Work At Height
Health & Safety Management Standard
Issue 3 (April 2011)

Introduction

This document contains corporate standards and guidance on the management of risks arising from work at height. It is the responsibility of managers to ensure that any activities or operations involving working at height are managed in line with this document, in any area under their control.

This document must be read in conjunction with any additional guidance specific to Divisional issues or activities.

Managers' Checklist – Work At Height

The checklist below identifies key actions involved in managing the health and safety risks arising from work at height. Further information on each of these points is contained in this document.

1. Have all work at height activities and operations been identified?
2. Have risk assessments of these activities/operations been carried out?
3. Has adequate consideration been given to avoiding work at height?
4. If it is not possible to avoid a work at height activity/operation, has appropriate work equipment been selected and provided, and other control measures put in place to prevent falls from height?
5. If the risk of a fall cannot be eliminated, has appropriate work equipment been selected and provided, and other controls put in place to minimise the distance and consequences of a fall should one occur?
6. Is work at height activities/operations properly planned and organised?
7. Has the use of ladders and stepladders been minimised?
8. Is supervision carried out to ensure unsuitable access methods and equipment are not in use?
9. Are the risks from fragile surfaces properly controlled?
10. Is equipment used for work at height periodically inspected and maintained by a competent person?
11. Is there provision in place for equipment repairs to be carried out by a competent person?
12. Are inspection and maintenance records kept?

Defining 'Work At Height'

When considering how to manage work at height, the first step is to identify the work at height activities and operations that are carried out.

Work at height is work in any place (including a place at or above ground level) where a person could be injured if they fell from that place. Access and egress to a place of work (e.g. climbing a ladder to get to a higher point) can also be work at height.

Examples of work that is classified as work at height include:

- Working on a flat roof.
- Working from a ladder or stepladder.
- Working at ground level adjacent to an open excavation.
- Work near or adjacent to fragile materials (e.g. roof materials).
- Work from scaffolding.
- Work from a mobile elevated working platform (MEWP).
- Work on or from open sided vehicles.

Examples of where the Work at Height Regulations don't apply include:

- Walking up and down stairs in a building. However, work on stairs (e.g. maintenance or decorating activities) would be classified as work at height.
- Working in the upper floors of a building.
- An operator sitting in the seat of a vehicle.
- Sitting in a chair.
- Slips and trips on the same level.
- Caving or climbing involved in sport and recreation activities.

The Work at Height Regulations provide a 'hierarchy of control' for determining how to manage the risks arising from work at height:

(a) Avoid work at height.

(b) Where work at height cannot be avoided, use work equipment or other measures to prevent falls.

(c) Where the risk of a fall cannot be eliminated, use work equipment or other measures to minimise the distance and consequences of a fall should one occur.

It is not necessary to implement all parts of the hierarchy if the risks are adequately controlled by one part. For example, in the case of a fully boarded and guarded scaffold platform, employees would not be expected to also wear personal fall-arrest equipment.

Work At Height Risk Assessments

After identifying work at height activities and operations, the next stage is to carry out a risk assessment. Within LCC, a documented risk assessment is required for all work at height activities/operations, except those that pose only low or minor risks (e.g. using of a kick-step to access shelves in an office). However, work at height activities that involve only low or minor risk should be included in the general risk assessments for the section / unit.

Within LCC it is the responsibility of managers to ensure that risk assessments are carried out within their area of control. Managers can either carry out risk assessments themselves, or delegate this task to individuals within their area of responsibility. If a manager delegates the task of carrying out a risk assessment, they must ensure that the person(s) is competent to carry out the assessment and takes all reasonable care when doing so. The manager remains responsible for the risk assessment and its implementation.

To assist in this process, a Work at Height Risk Assessment form is provided with this document.

Avoiding Work At Height

It may not be possible to avoid work at height, but consideration should always be given to whether avoidance is possible. For example, some window-cleaning firms now use extendable cleaning poles to avoid the use of ladders, and automatic 'sheeting' equipment can be fitted to large vehicles.

Preventing Falls From Height

If it isn't reasonably practicable to avoid work at height, the next consideration is whether equipment or other measures can be taken to prevent falls. E.g. by using working platforms with guardrails, or access equipment such as MEWPS (Mobile Elevating Work Platforms such as cherry pickers, scissor lifts, etc.).

Falls from over 2 metres
Previously there was a distinction between potential falls above and below 2 metres, and the actions required to prevent falls (e.g. fitting of guardrails to scaffolding). Although the previous '2 metre rule' is not contained in the Work at Height Regulations, there should be no dilution of existing safe working practices for work above 2 metres.

Where the potential fall height is 2 metres or more, the Health & Safety Executive will always expect action to be taken to prevent falls. When deciding on access equipment, the expectation is that guardrails and working platforms will be used, unless the risk assessment identifies that other equipment or measures will provide a better level of protection.

Falls from less than 2 metres
Although the '2 metre rule' has been removed, the Work at Height Regulations still requires a sensible risk based approach to preventing falls. For example, the handrails on a tower scaffold should not be deliberately removed just because the platform is less than 2 metres high.

If the risks are minor, it is not reasonably practicable to take extensive precautions. Therefore, the only action that may need to be taken is to provide relevant information, instruction or training for those carrying out the activity/operation.

Minimising Falls From Height

If it isn't possible to avoid work at height, or implement controls to prevent falls from occurring, then further steps must be taken to minimise the distance and consequences of a fall. This may be achieved though the adoption of systems such as safety nets, fall arrest, work-restraint, work positioning, rope access and positioning techniques, etc.

Your allocated H&S Team is able to advise on the suitability of controls.

Selecting The Right Equipment

One of the intended outcomes of carrying out a risk assessment is that the right equipment will be selected for that particular activity/operation. When selecting work equipment for use when working at height, the following factors need to be taken into account:

- The working environment: What are the ground conditions? Are there likely to be space constraints? Are other people working in the same area? Is it in a public area?
- The duration and frequency of use: Is the work activity of short duration? Is it repetitive?
- Emergency and rescue procedures: Can a timely evacuation and/or rescue be instigated?
- The distance and consequences of a potential fall: Can a fall occur? If so does it have the potential to cause injury?
- In the case of access and egress, what is the distance to be travelled?
- Are there any additional risks posed by the installation, use, dismantling or removal of the work equipment?
- Are the dimensions of the work equipment adequate to ensure a safe working area and safe access/egress?
- Is the equipment adequate for the potential loadings of people, equipment and materials?
- Is the equipment appropriate for the nature of the work to be undertaken?

Not all of these factors will be relevant to all work at height activities/operations. Further advice on these issues is given in the relevant sections of this document.

Collective And Personal Control Measures

When deciding on appropriate control measures, it must be remembered that collective control measures always take priority over personal control measures. Collective measures (such as scaffolding, airbags and safety nets) protect more than one person at any one time and are usually passive, i.e. they require no action by the user to work properly. Personal control measures (e.g. fall-arrest harnesses) rely upon personal protective equipment and only protect the user. They are also usually active, i.e. the user has to do something for the equipment to work, (e.g. clipping on an anchorage point).

Planning And Supervision

Work at height activities/operations need to be planned and organised **in advance** of the activity. If the activity or operation is not high risk and occurs regularly, it may be possible to document a 'standard' safe system of work or procedure, rather than create a formal plan each time the task is carried out.

The safe system of work should take account of:

- Any supervision that may be necessary. For example, the use of fall arrest equipment will require a higher level of supervision.
- Restrictions arising from weather conditions. For example, carrying out maintenance on an icy roof, or working in windy and/or rainy conditions on a slippery surface.
- Any emergency or rescue procedures that may be required. For example, if a person falls while using a fall-arrest system how will they be rescued?

Unsuitable Equipment and Methods

All work at height must be properly planned whether it is a major project or just accessing a shelf at high level. Part of the planning is the selection of the appropriate access equipment. It is all too easy, and common - place, for someone to use access equipment or methods that are not only inappropriate but also puts the user at risk.

Unsuitable access methods include:

- Standing on a chair.
- Standing on a table, desk or other office furniture.
- Standing on a box or other similar object.
- Using damaged stepladders or ladders.
- Using stepladders and ladders that are not long enough.
- Straddling between a stepladder or ladder and another object.
- Sitting on someone's shoulders.
- Etc.

Suitable footwear

Those working at height must wear suitable footwear; this means a decent non-slip sole and preferably ankle support. Where appropriate safety, footwear must be worn. Inappropriate footwear includes, open toed sandals, flip-flops, high heels, footwear with laces undone, etc.

Ladders And Stepladders

The Work at Height Regulations do not ban the use of ladders and stepladders, but they do require that careful consideration is given to their use.

It is likely that any work at height carried out below 2 metres will be done by using a ladder or stepladder. The risk assessment will determine if this is the correct choice, as a suitable method of access, if this is the case guidance issued by the HSE should be followed.

It should also be remembered that the HSE define a ladder or stepladder as a means of access and not a working platform, however by following the HSE guidance short-term work is allowed.

Ladders should only be used where the use of other equipment (such as tower scaffolds, podium steps or temporary stairs) is not possible or appropriate. Where ladders and stepladders are used they should only be used for light and short duration work.

Work activities involving the carrying of heavy loads should never be carried out from a ladder. When using a ladder, three points of contact should be maintained (i.e. two feet and a hand). Therefore, if a task requires both hands, ladders (and stepladders without a purpose designed standing platforms) are not the right equipment for the task.

Fragile Surfaces

Controls should be in place to ensure that employees and others (e.g. contractors) do not go onto or near any fragile surface through which they could fall. The only exception to this rule is where it is the only reasonably practicable way for the work to be carried out safely, having fully considered the demands of the task, equipment and working environment.

All fragile surfaces should be identified with prominent warning notice fixed at approaches to the danger zone (see the example safety sign opposite). Roof spaces, roof coverings and skylights are often fragile surfaces. Please contact your Divisional H&S Team or Property Consultant for further advice on identifying fragile surfaces.

If work on or near a fragile surface is unavoidable:

- It must be ensured that suitable platforms, covering, guardrails, etc, are provided and are used.
- If the risk of a fall still remains, the distance and effect of a fall must be minimised (see previous sections).
- It must be carried out under a "Permit-to-Work".

Falling Objects

The risk of falling materials should be minimised by keeping working platforms clear of loose materials. In addition, toe boards, solid barriers and/or brick guards should be provided at open edges. If scaffolding is erected in a public place; debris nets, fans or covered walkways (as appropriate) should also be provided.

Where material needs to be dropped or removed from a platform the method should be decided during planning, so that it can be done in a controlled manner. For example using a chute into a receiving area that is clearly marked (e.g. with clear warning signs) and barriered to prevent people going into it.

Checks And Inspections

Checks
The user or operator must always carry out checks on every occasion before the work at height activity/operation begins. E.g. visually inspecting the surface on which access equipment will be placed, checking any existing edge or fall protection, the actual access equipment, etc.

Inspections
Whereas 'checks' may be just a visual examination of equipment before it is used, the Work at Height Regulations identifies inspections as being a more formal process. Inspections must be carried out by a competent person for the following types of equipment:

- Scaffolding and other working platforms fitted with handrails, toe-boards, barriers, etc.
- All types of personal fall protection and fall arrest systems.
- Ladders and stepladders.
- Mobile elevated working platform
- Inspections should be carried out:
- Each time it is assembled or installed.
- At intervals so that any deterioration can be detected and remedied in good time.

Where inspections are necessary, systems must also be in place to formally record that they have been carried out. If you use any of the types of equipment that require formal inspections, your Divisional H&S Team are available to advise on competency issues, inspection frequencies and record keeping.

Repairs

During the formal inspections it may be identified that the ladder or stepladder is damaged or faulty and is in need of repair. Repairs must be carried out by a competent person who has been trained to do so. Repairs that are done must be recorded for future reference.

Alternatively during the inspection it may be identified that the ladder or stepladder is beyond economical repair, in which case the ladder or stepladder must be withdrawn from use, secured to prevent it from being used and ultimately destroyed.

Leicester
City Council

COSHH – Hazardous Substances
Health & Safety Management Standard
Issue 2 (September, 2010)

Introduction

This document contains corporate standards and guidance on the management of risks arising from the use of hazardous substances. It is the responsibility of managers to ensure hazardous substances are managed in line with this document in any area under their control.

This document must be read in conjunction with any additional guidance specific to Divisional issues or activities.

Managers' Checklist – Hazardous Substances

The checklist given below identifies key actions involved in managing the health and safety risks arising from the use of hazardous substances. Further information on each of these points are contained in this document.

1. Have all hazardous substances been identified?
2. Are any Divisional-specific arrangements for purchasing hazardous substances known and understood?
3. Has a risk assessment been carried out on all hazardous substances?
4. Is it possible to prevent exposure to hazardous substances?
5. If it is not possible to prevent exposure to hazardous substances, have appropriate controls been identified that will adequately control exposure?
6. Has any need for exposure monitoring or health surveillance been identified?
7. Have individuals who use, or are exposed to, hazardous substances been provided with adequate information, instruction and training?
8. Are there arrangements in place to monitor the use of control measures?
9. Are COSHH risk assessments regularly reviewed?
10. Have the issues arising from contractors and their use of COSHH substances been considered?

Identifying COSHH Substances

The acronym 'COSHH' stands for 'Control of Substances Hazardous to Health'. The purpose of the COSHH Regulations is to prevent ill health cause by exposure to hazardous substances at work.

Under the COSHH Regulations there are a range of substances regarded as being hazardous to health:

- **Substances classified as dangerous to health under the Chemicals (Hazard, Information and Packaging for Supply) Regulations (CHIP)**
  Substances covered by CHIP can be identified by a square orange warning symbol displayed on the packaging label. Suppliers must provide a Safety Data Sheet (SDS) if the substance is covered by CHIP. Some of the most common CHIP labels are shown below.

- **Substances with Workplace Exposure Limits (WELs)**
  A WEL is the maximum concentration of an airborne substance, averaged over a known period of time, that individuals may be exposed to. Substances with WELs are listed in the Health and Safety Executive (HSE) publication EH40 and will also be detailed on the SDS.

- **Biological agents (bacteria and other micro-organisms)**
  Biological agents are covered by COSHH if they are directly connected with work or if exposure is incidental to work. Examples of activities in which there may be this kind of exposure are health care, refuse disposal, agriculture and work involving contact with sewage.

- **Dust concentrations**
  Any kind of dust, if its average concentration in the air exceeds the levels specified by COSHH, is considered to be hazardous to health. (10 mg/m^3 of inhalable dust, or 4 mg/m^3 of respirable dust. Please contact your allocated Health & Safety (H&S) Team for further advice if airborne dust levels are thought to be a potential issue.)

- **Any other substance that creates a risk to health**
  For technical reasons these may not be covered by CHIP. These substances include; asphyxiants (i.e. gases such as argon and helium, that while not dangerous in themselves can endanger life by reducing the amount of oxygen available to breathe), some pesticides, medicines, cosmetics and substances produced in chemical processes. Also included would be other substances that may be a cause of occupational asthma (these would be assigned either R42 or R42/43 as risk phrases on the SDS).

Do different forms of the same substance present different hazards?
A substance may be hazardous in one form but not in another. For example, a piece of hardwood poses no risk in itself. However, hardwood dust created during sanding does present a hazard. Therefore, if a substance is not being used in a form that is hazardous to health and the work process does not create by-products that are hazardous to health; it does not need a COSHH assessment.

What substances are not covered by COSHH?
Not all substances are covered by the COSHH Regulations. For the vast majority of commercial chemicals the presence (or not) of a CHIP warning label will normally indicate whether the substance is covered by the COSHH Regulations. For example:

- There is no warning label on water based marker pens, 'pritt-stick' type glue pens or ordinary household washing-up liquid. Therefore, the COSHH Regulations do not apply.
- However, there is a CHIP warning symbol on many types of bleach, so the requirements of COSHH do apply to those types of bleach.

Other substances that are not covered by the COSHH Regulations are:

- Asbestos and lead, which have their own regulations.
- Substances that are hazardous only because they are; radioactive, at high pressure, at extreme temperature, or have explosive or flammable properties. (Other regulations apply to these risks.)
- Biological agents if they are not directly connected with work and they are outside the employers' control, such as catching a cold from a work colleague.

If you are unsure if a substance is covered by COSHH please obtain a SDS from the supplier, or contact your allocated H&S Team.

Purchasing Hazardous Substances

Some LCC Divisions operate purchasing systems that control what can be purchased. These arrangements may include the purchasing of commercial chemicals that may be covered by COSHH.

Employees Bringing In Hazardous Substances
Employees are not permitted to bring in their own substances to use at work. If a substance is required for work purposes, the line manager should ensure that it is supplied and risk assessed wherever necessary.

Carrying Out COSHH Risk Assessments

After identifying the hazardous substances that employees will use (or which they will be exposed to) the next stage is to carry out a COSHH risk assessment.

Within LCC it is the responsibility of managers to ensure that COSHH risk assessments have been carried out on hazardous substances within their area of control (see 'Purchasing Hazardous Substances'). Managers can either carry out COSHH risk assessments themselves, or delegate this task to individuals within their area. If a manager delegates the task of carrying out a risk assessment, they must ensure that the

person(s) is competent to carry out the assessment and takes all reasonable care when doing so.

To assist in this process, a COSHH Risk Assessment form is provided with this document. Please note that the form is primarily intended for the assessment of commercial chemicals.

COSHH risk assessment training courses by H&S Services are available via City Learning. Records of training should be kept in accordance with Divisional Procedures.

Preventing Exposure

For any hazardous substance, the first control measure that must be considered during the risk assessment is to prevent exposure. Prevention of exposure may be achieved by:

- Replacing the hazardous substance with a non-hazardous substance.
- Changing the method of work, so that the task or operation that involves exposure is no longer necessary.
- Modifying the process, to eliminate the production of hazardous by-products or waste products.

In many areas it will not be possible to eliminate hazardous substances completely. Where the use of hazardous substances is necessary, consideration must still be given to reducing the risks to employees by using;

- an alternative less hazardous substance; or
- a different form of the same substance (e.g. pellets instead of powder); or
- a different work process.

Suppliers will often be able to provide advice on non-hazardous and less hazardous alternatives that are available (see 'Purchasing Hazardous Substances').

Controlling Exposure

If it is not reasonably practicable to prevent exposure (i.e. all the costs of preventing exposure outweigh all the potential health benefits) the exposure to the substance must be controlled to a level that will not harm health (e.g. below any relevant WEL for the substance).

Control measures appropriate to the activity should be considered and put in place, including (in order of priority) one or more of the following:

- Put appropriate work processes, systems and engineering controls in place, and provide suitable work equipment and materials (e.g. use processes that minimise the amount of substance used or produced).
- Control exposure at source (e.g. use local exhaust ventilation) and reduce the number of employees exposed to a minimum, the level and duration of their exposure, and the quantity of the hazardous substance used or produced.
- Provide Personal Protective Equipment (e.g. gloves, face masks, etc.), but only as a last resort and wherever possible in combination with other control measures. (Please note that separate guidance is available on the selection and maintenance of PPE. See also 'Ensuring Control Measures Are Used And Maintained' below.)

Occupational asthma
The COSHH Regulations require additional controls for substances that can cause occupational asthma. If a substance is identified as being a cause of asthma (check for the risk phrases R42 and R42/43 on any relevant SDS) please contact your allocated H&S Team for further advice.

Carcinogenic and mutagenic substances
The COSHH Regulations require additional controls for carcinogenic and mutagenic substances. If a substance is identified as being carcinogenic and mutagenic (check for the risk phrases R45, R46 and R49 on any relevant SDS) elimination of the substance must be achieved if at all practicable. Please contact your allocated H&S Team for further advice.

Monitoring Exposure

Under COSHH, employers are required to measure the concentration of hazardous substances in the air, in any of the following circumstances:

- Where the failure or deterioration of controls could result in a serious health effect.
- When measurement is necessary to ensure that the WEL for the substance is not being exceeded.
- As an additional check on the effectiveness of any control measures.
- Where changes in the nature of employees' exposure could mean that existing controls are not adequate (e.g. change in work method, increase in the amount of a substance used).

If you think that exposure monitoring may be necessary, please contact your allocated H&S Team for further information.

Health Surveillance

The Health and Safety Executive give the following definition of health surveillance:

> 'Health surveillance is about putting in place systematic, regular and appropriate procedures to detect early signs of work-related ill health among employees exposed to certain health risks; and acting on the results.'

Under the COSHH Regulations health surveillance is required where:

- Employees are exposed to a substance linked to a particular disease or adverse health effect, and there is a reasonable likelihood of disease or ill health occurring.
- Or, an employee is working in certain processes that are specified in Schedule 6 of the COSHH Regulations (none of which apply to activities carried out by LCC at this time).

Further advice on health surveillance is available in the separate Corporate H&S Management Standard, or from your allocated H&S Team.

Information, Instruction And Training

The COSHH Regulations require that employees who use or who are exposed to hazardous substances, are provided with suitable information, instruction and training. The information, instruction or training that is provided should address the following issues:

- The names of the substances and the risks to health.
- Any relevant WEL.
- The precautions to be taken by employees.
- The results of any exposure monitoring.
- The purpose and collective results of any health surveillance.
- The importance of good hygiene standards.
- Relevant information arising for risk assessment being reviewed.
- Procedures for dealing with accidents, incidents and emergencies (see 'Emergency Procedures' below).

The extent of information, instruction and training that is necessary will depend on the level of risk involved. Practical ways in which employees can be provided with information and instruction:

- Involve staff in undertaking or reviewing COSHH Risk Assessments.
- Discuss the findings of COSHH Risk Assessments at team meetings.
- Ensure copies of COSHH Risk Assessments (and relevant Safety Data Sheets) are kept in a known and accessible location.
- Ensure COSHH Risk Assessments are viewed by employees prior to a new substance being used for the first time.

Attached to this document is a blank 'COSHH - User Information Sheet'. If no other system is in place to provide information to employees, the 'COSHH - User Information Sheet' should be completed for each hazardous substance and a copy provided to the employees involved.

Records of information, instruction or training should be kept in accordance with Divisional Procedures.

Ensuring Control Measures Are Used And Maintained

COSHH requires that employees make proper use of control measures and report any defects. It is the responsibility of managers and supervisors to take all reasonable steps to ensure that they do. For example, if an employee is not using PPE provided, the reason for it not being worn should be discussed with the employee and a remedy found (e.g. providing a different size if it is too small or large).

If engineering controls are used (e.g. local exhaust ventilation) the equipment must be regularly inspected, tested and maintained. Regular testing of equipment such as local exhaust ventilation is especially important, as it is the only way to ensure that the equipment is working properly.

Please note. All non-disposable types of PPE have a limited lifespan. For example, respiratory protective equipment should be examined and tested at regular intervals. The

manufacturer or supplier will have provided information about the examination, testing and replacement of PPE. If you are unsure please contact the PPE supplier or your allocated H&S Team.

Reviewing COSHH Risk Assessments

The risk assessor needs to decide how often a risk assessment should be reviewed. Review does not necessarily mean carrying out a new risk assessment, but checking over the existing risk assessment to ensure it is still valid and that any changes are documented on the risk assessment.

COSHH risk assessment should always be reviewed immediately:

- When there is evidence that it may no longer be valid (e.g. as a result of monitoring exposure, from the results of health surveillance, where the WEL has changed, etc.).
- Where there has been a significant change to the work or activity (e.g. change of process or method of work, the volume used, changes of substance involved in the process, etc.).

Risk assessment reviews should always re-consider if it is practicable to prevent exposure or use a less hazardous substance. Reviews should also reconsider the control measures that are in place and whether they can be improved.

Contractors And COSHH

Like any employer, contractors are required to ensure that their use of hazardous substances does not harm their employees or other people who may be exposed (e.g. LCC employees or service users if the substances are being used on in an LCC premises).

Managers in control of premises should ensure that they are aware of any COSHH substances that contractors will be using on the premises, so that they:

- Are satisfied that the contractors' control measures will protect LCC employee, service users, pupils, etc. (E.g. by asking for copies of the COSHH risk assessments for any hazardous substances they are using on the site.)
- Can provide LCC employees with information about any hazardous substances being used by contractors.
- Can reassure LCC employees that any exposure to hazardous substances and any risks to their health are being properly controlled.

If a manager is concerned that a contractor is working in an unsafe manner (e.g. not in accordance with the contractor's own risk assessments or method statement) they should:

- Raise their concerns as soon as possible with the contractor's representative on site.
- If concerns remain, contact the Property Help Desk (Ext. 8080) for further advice.

Emergency Procedures

The COSHH Regulations require that formal emergency procedures are developed when incidents involving hazardous substances could lead to exposure well beyond the normal day-to-day levels. Examples of events that would need formal emergency procedures are:

- Serious process fires that would give rise to serious risk to health.
- Serious spillages of floods of corrosive agents liable to make contact with employees' skin.
- Any acute process failure that could lead to a sudden release of chemicals.
- Any significant over-exposure to a substance with a WEL, e.g. as the result of failure of an LEV system or other controls.

If any of these apply to processes or activities in your area, please contact your allocated Safety Team for further advice.