**RIVINGTON PRIMARY SCHOOL**

**Protocol for Children with Medical Needs**



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# JOINT PROTOCOL FOR SUPPORTING PUPILS AT SCHOOL

**WITH MEDICAL NEEDS**

## 1.0 Aims

* 1. The aim of this protocol is to ensure that wherever reasonably practicable pupils with medical needs can have those needs met within a school setting, with the support of relevant agencies.
	2. This protocol has also been developed to clarify the roles and responsibilities of local agencies in ensuring that the requirements of the DfE Statutory Guidance Supporting Pupils at School with Medical Conditions: Statutory Guidance for Governig Bodies of Maintained Schools and Proprietors of Academies in England (April 2014) can be met.

## 2.0 Scope

* 1. This protocol represents a voluntary agreement between:
		1. St Helens Clinical Commissioning Group
		2. St Helens Council
		3. St Helens Schools – Subject to approval by individual Governing Bodies
	2. The protocol will be subject to regular review to ensure it is effective in meeting the key aims set out above.

## 3.0 Background

* 1. There are an increasing number of children and young people with complex medical conditions now accessing their education in a mainstream setting. This is a positive and welcome development reflecting advances in medical technology and the inclusion agenda that agencies have adopted over recent years. However, meeting needs of children in a mainstream school setting can present considerable challenges which will require agencies to work sensitively together to ensure the best outcome for the child can be achieved.
	2. The Department for Education recently revised its Statutory Guidance on Supporting Pupils with Medical Needs which came into force in September 2014. The guidance requires governing bodies to make arrangements to support pupils with medical needs acknowledging that this will require the input of a range of agencies and practitioners to ensure that safe and sustainable procedures are put in place, within a child centred approach.
	3. In order to ensure that local schools were supported to meet the requirements of the revised guidance and in seeking to respond in a co-ordinated manner to pupils with more complex conditions than had been met in the past, a Task and Finish Group was recently convened comprising Local Authority, Health and schools representatives.
	4. This protocol has been drawn up by the Task and Finish Group and aims to provide a

framework for informed decision making by governing bodies when seeking to respond to requests to support pupils with medical needs as these arise.

## 4.0 Legal Context

* 1. Section 11 of the Children and Families Act 2014 places a duty on Governing Bodies of maintained schools proprietors of academies and management committees of pupil referral units to make arrangements for supporting pupils at their schools with medical conditions. In meeting those duties they must have regard to the Statutory Guidance Supporting Pupils at School with Medical Conditions (April 2014).
	2. St Helens Clinical Commissioning Group is the accountable body and commissioner for the specialist paediatric nursing services that will provide the training, procedures and risk assessments for medical conditions under this protocol. The Clinical Commissioning Group also has a duty under Section 3 NHS Act 2006 to arrange for the provision of certain specified health services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility. This duty does not apply in relation to a service or facility if the Board has a duty to arrange for its provision.
	3. Local authorities have a duty under Section 10 of the Children Act to promote co- operation between relevant partners such as governing bodies of maintained schools, proprietors of academies, Clinical Commissioning Groups and NHS England with a view to improving the wellbeing of children including their physical and mental health.
	4. Headteachers shall ensure that there are effective procedures in place for supporting pupils with medical conditions and that there are sufficient trained numbers of staff to ensure safe delivery against individual pupil healthcare plans, including contingency and emergency arrangements.
	5. School staff may be asked to provide support to pupils with medical conditions, including the administering of medicines although they cannot be required to do so. Staff shall receive suitable and sufficient training in order to achieve the necessary level of competency before taking on responsibility to support pupils with medical conditions.
	6. Specialist paediatric nurse practitioners shall work with schools and the children’s joint commissioning team in support of arrangements to meet the needs of pupils in a school setting.
	7. Parents shall provide the school with sufficient and up to date information about their children’s needs. In some cases they may be the first to notify the school that their child has a medical condition. Parents should be involved in the development and review of their child’s individual health care plan and may also be involved in its drafting.
	8. Children should so far as they are able contribute to the development of the arrangements to meet their medical needs within a school setting. A longer term aim will be to develop their capacity to self administer medicines or treatment whenever practicable.

## 5.0 Clinical Accountability

* 1. Health professionals are legally accountable for any task they delegate even if they are not present when it is undertaken (Nursing and Midwifery Council, 2008).
	2. Schools will be provided with contact details of the Paediatric Clinical Nurse Specialist, who will offer advice and visit the school to solve any problems throughout the school year.
	3. Under Section 100 of the Children and Families Act 2014, Governing Bodies have a duty to make arrangements for supporting pupils at their schools with medical conditions.

## 6.0 Implementation

* 1. A standard operational procedure and risk assessment will be completed for all complex medical conditions to be undertaken in a school setting by appropriately trained staff. This process will be initiated by the relevant specialist paediatric nursing service for subsequent approval on a multi-agency basis by the Integrated Children’s Commissioning Team.
	2. The integrated children’s commissioning team, comprising of local authority and CCG officers will review any new or emerging conditions and refer these to a joint panel of senior CYPS\CCG and schools representatives in order to agree whether these can be supported under this protocol. Documentation will also be shared with the Council’s insurers for their approval.
	3. Once agreed through this route the procedure and risk assessment will form the basis of the support arrangements for pupils with those medical conditions. Agreed procedures have been developed for:
		+ Clean Intermittent Catheterisation
		+ Insulin Pumps
		+ Insulin Injections
	4. The headteacher will be the point of contact for parents or specialist nurse practitioners in considering whether a pupil with a medical condition can be supported in a school setting. For any new conditions, the request will be referred to the integrated children’s commissioning team located in Atlas House for their specialist advice and to co-ordinate the development of an operational procedure and risk assessment if these have not yet been agreed.
	5. For any requests for existing conditions (with agreed procedures and risk assessments in place) the headteacher will work with staff to identify whether there are any willing to be trained. Whilst the headteacher may, upon the request of staff, seek additional information from specialist nurse practitioners it is the headteacher’s role to liaise with their staff.
	6. Specialist nurse practitioners will provide school staff with relevant training in accordance with the agreed operational procedures and risk assessments.
	7. Human Resources will advise headteachers on the employment implications of taking on these additional duties including the evaluation of any revised job descriptions. In some cases this might involve an enhanced payment which will **not** be met by the school.
	8. Staff will only commence supporting a pupil with a medical condition when they have completed their training and are deemed to be competent by the specialist nurse practitioner. The written consent of parents will also be required and they should be involved as staff are identified and trained to support their child.
	9. On occasion it might not be possible to identify appropriate staff which will require the integrated children’s commissioning team, specialist nurse practitioners, the school and parents to work together to find an appropriate child centred solution. This could involve parents, carers or specialist nurse practitioners.

## 7.0 Monitoring and Review

* 1. This protocol shall be kept under regular review to ensure that it delivers it key aims, in particular ensuring that whenever reasonably practicable children and young people with medical conditions can have their needs met in a school setting.
	2. The integrated children’s commissioning team will have a key role in monitoring the numbers of children and young people with medical conditions who are supported in a school setting.

## 8.0 Authorisation

8.1 This protocol has been authorised by each of the participating agencies as set out below.

……………………………………… Signed on behalf of St Helens Council

Date.………………………………..

……………………………………...

Signed on behalf of St Helens Commissioning Clinical Group Date………………………………...

………………………………………

Signed on behalf of ………………………………………..

# Clean Intermittent Catheterisation (CIC) – Operational Procedure

### 1.0 Background

Children who have neurological problems such as spina bifida may well need specific interventions to enable them to achieve continence and maintain healthy bladders and kidneys. In this case, they may require a procedure called clean intermittent catheterisation (CIC) which enables the child’s bladder to be emptied. This involves inserting a soft silicone catheter into the child’s bladder via the urethra. This is a procedure that most children will learn to do for themselves but while they are learning, they will require help and support.

Normally a child will be identified as needing clean intermittent catheterisation within the first few months from birth and for St Helens children this is usually diagnosed by Alder Hey.

Alder Hey then inform the Paediatric Clinical Nurse Specialist who will train all identified family members before the child is discharged home in how to undertake the procedure, this is followed up by regular 3 monthly visits.

Once the parents have identified which establishment (nursery/school) they want their child to attend they will inform the Paediatric Clinical Nurse Specialist who will then begin the process of identification and training of appropriate staff members prior to the child starting at the establishment.

This procedure sets out how intermittent catheterisation can be delivered in a school or nursery setting and forms part of a broader set of CCG\LA procedures to support pupils with medical needs themselves informed by the DfE document Supporting Pupils at School with Medical Conditions (April 2014).

### Evidence Base

A number of national bodies have undertaken research and published guidance on support for children that require intermittent catheterisation, including the necessary requirements for this to undertaken by school staff who have received appropriate training. Key documents include:

* + - Including Me – Managing complex health needs in schools and early years settings (Council for Disabled Children).
		- Royal College of Nursing guidance
		- Managing Bowel and Bladder Problems in schools and early years settings – PromoCon
		- Continence at school – SEN Magazine
		- Enabling school staff to undertake clean intermittent catheterisation – Nursing Times (November 2010).

### 3.0 Procedure for Training

Training will be delivered by the Paediatric Clinical Nurse Specialist. Set out below is a flow diagram which identifies the key stages in developing the capacity for appropriately trained school nursery staff to undertake clean intermittent catheterisation.

Identified Establishment

Paediatric Clinical Nurse Specialist will contact establishment, arrange meeting involving parents, school staff and SENCO, explaining the nature of the condition, the training required and key competencies, and any equipment or environmental requirements.

First Training Session

Paediatric Clinical Nurse Specialist explains condition and reasons for procedure, provides demonstrations using training tools and works through the CIC guidance document.

Further Training Sessions

Paediatric Clinical Nurse Specialist will undertake a number of training sessions with identified staff member until satisfied that staff member is fully competent. This will include observing staff undertaking the procedure.

Procedure involves a soft silicone catheter tube being inserted in to the Urethra, once it reaches the bladder then urine will flow out of the tube until the bladder is empty, the

Training Completion

Paediatric Clinical Nurse Specialist will issue certificate of competency to trained staff. A catheterisation log is completed after each procedure and followed up by an annual review.

Certificate of c**ompetence is issued by the Paediatric Clinical** Specialist Nurse along with signed declaration from trained f member of staff and consent from parents

### Environment Requirements

Although the procedure does not require a room fitted out to clinical standards it should be undertaken in an appropriate location such as disabled toilets. There is a requirement for the school to provide the following:

* + 1. Gloves (non-latex disposable)
		2. Apron
		3. Pedal bin with yellow or orange waste bags to be disposed of as clinical waste.
		4. Pump soap
		5. Paper towels
		6. Adjustable bed if treatment for a girl

In support of the procedure, parents shall provide:

* + 1. Catheters
		2. Wipes
		3. Pads (if used)
		4. Nappy sacks
		5. Spare clothes
		6. Alcohol gel

### 5.0 Risks

Intermittent catheterisation is acknowledged as an intimate procedure which will require to be undertaken with due regard to safeguarding and the dignity of the young person. It is low risk if well managed and staff are trained and certified (by Paediatric Clinical Nurse Specialist) to undertake the procedure.

The catheter is made from a soft silicone material and there is no risk of puncturing the bladder from insertion of the catheter tube. Unlike an indwelling catheter, the intermittent catheter for children does not contain a guide wire and is designed to bend and curl if it hits an obstruction

A detailed risk assessment relating to infection control, pain, child refusing procedure, staff availability and safeguarding has been completed in support of this procedure (attached in Appendix A)

### 6.0 Staffing

The Paediatric Clinical Nurse Specialist will train any member of staff that has been identified to undertake this procedure. When undertaken in a school setting CIC has generally been undertaken by Teaching and Learning Assistants who have received appropriate training. Although the procedure itself only requires a single member of staff, additional staff members will be trained to provide cover for sickness and annual leave.

In accordance with school safeguarding procedures a second member of staff should be present in a chaperone role, although that member of staff need not necessarily be trained.

When undertaken in a medical setting the RCN guidance sets out that clean intermittent catheterisation would usually be carried out by either unregistered health staff or non-health qualified staff who have completed the training set out in this procedure.

It should also be acknowledged that whilst any member of school staff may be asked to support pupils with medical conditions they cannot be compelled to do so. Even when willing staff have been identified and trained, the written consent of parents to the proposed arrangements will also be required.

### 7.0 Clinical Accountability

Health professionals are legally accountable for any task they delegate even if they are not present when it is undertaken (Nursing and Midwifery Council, 2008).

Schools will be provided with contact details of the Paediatric Clinical Nurse Specialist, who will offer advice and visit the school to solve any problems throughout the school year.

Under Section 100 of the Children and Families Act 2014, Governing Bodies have a duty to make arrangements for supporting pupils at their schools with medical conditions.

### Supporting Documentation

The training provided to staff by the Paediatric Clinical Nurse Specialist will also be underpinned by the the following documentation:

* + - Guidance on Clean Intermittent Catheterisation for Carers in Schools (September 2012)
		- School Intimate Care Policy (Model Policy drawn up by Bridgewater Healthcare Trust)
		- Individual Care Plan
		- Parents signed authorisation
		- Training Log
		- Catheterisation Record Sheet

### 9.0 Monitoring and Review

The Paediatric Clinical Nurse Specialist will review arrangements put in place at a school or nursery on at least a six monthly basis.

This procedure will also be subject to at least annual review by the Local Authority and Clinical Commissioning Group as part of the wider arrangements for supporting pupils with complex medical needs.

Appendix A

# Concise Risk Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **G. Risk Type**Based on Impact (B) above, what is the potential hazardous or adverse outcome?Using the ***Example Matrix*** as a guide, place a brief description in the boxes below, and tick or cross the appropriate boxes for consequence and likelihood. | **Consequence** |  | **Likelihood** |  | Use the Risk Matrix below to calculate the level of risk i.e. Low, High, Extreme etc. |
| 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic | 1 Rarely | 2 Possible | 3 Likely | 4 Highly Likely | 5 Almost certain |
| **Break down in infection control** |  |  | **X** |  |  | **X** |  |  |  |  | **LOW** |
| Child describes pain when catheter is passed |  |  | **X** |  |  | **X** |  |  |  |  | **LOW** |
| 1. **Child refuses catheter**
 |  |  | **X** |  |  | **X** |  |  |  |  | **LOW** |
| 1. **No staff available to do catheter**
 |  |  |  | **X** |  |  | **X** |  |  |  | **HIGH** |
| 1. **Safeguarding**
 |  |  |  | **X** |  | **X** |  |  |  |  | **MODERATE** |
|  |  |  |  |  |  |  |  |  |  |  |  |

**GAUGE THE OVERALL RISK TO THE AIMS AND OBJECTIVES OF THE ORGANISATION**

|  |  |
| --- | --- |
| **H. Current** (pre-action) | **Impact rating (0) x Likelihood rating (0) = Risk rating (0)** |
| **I. Target** (post-action) | **Impact rating (0) x Likelihood rating (0) = Risk rating (0)** |
| **J. Risk Matrix** | **1 Rare** | **2 Unlikely** | **3 Possible** | **4 Likely** | **5 Almost Certain** |
| **5 Catastrophic** | 5 Moderate | **10 High** | ***15 Extreme*** | ***20 Extreme*** | ***25 Extreme*** |
| **4 Major** | 4 Moderate | **8 High** | **12 High** | ***16 Extreme*** | ***20 Extreme*** |
| **3 Moderate** | *3 Low* | 6Moderate | **9 High** | **12 High** | ***15 Extreme*** |
| **2 Minor** | *2 Low* | 4Moderate | 6 Moderate | **8 High** | 10 High |
| **1 Insignificant** | *1 Low* | *2 Low* | *3 Low* | 4 Moderate | 5 Moderate |

|  |  |
| --- | --- |
| **Service/Speciality** | Paediatric Continence – catheter in schools |
| **Date** | 19/08/14 |
| **Assessor** | Sheena Kennedy |
| 1. **Description of Hazard/Task:** *(What is going to go wrong?)*
	1. Break down in infection control
	2. Child describes pain when catheter is passed
	3. Child refuses the catheter
	4. No staff available to do catheter
	5. Safeguarding
 | 1. **Description of most likely Impact/Consequence:** *(What would be the effect should this Hazard (A) occur?)*
	1. Potentially child may develop urine infection
	2. Delay in Catheterisation
	3. Bladder cannot be emptied, may lead to leaking
	4. As above
	5. Accusation of or actual abuse
 |
| * 1. **Current Control Measures** *(What is preventing the Hazard (A) from actually occurring now or limit the Impact (B)?)*
		1. Strict infection control measures in competency pack.

School provide pedal bin, gloves, aprons and soap, alcohol gel.* + 1. Catheter would stop, child would be given option to start again, if refusal, parent to be called. Staff to document
		2. Parent to be called, child to be asked why and investigated.
		3. Two members of staff minimum to be trained in school, parents to be called only as exception to rule.
		4. Staff trained, certificates issued, parent authorisation granted, Care plan issued, staff are DBS checked.
 | * 1. **Gaps in Control** *(What Controls should be in place but are not currently evident?)*
		1. Stock of equipment in schools, if UTI child will need to commence antibiotics, potential absent from school.

4. a third member of staff may be needed if more than one child in school needed catheters |
| * 1. **Assurance** *(How are we checking that the Controls (C.a.) continue to work?)*
		1. Certificate of competency presented to staff once nurse specialist and parent is happy
		2. Parent to report if it is happening at home to nurse specialist , staff to advise parent
		3. Review by Nurse Specialist every school year minimum, and ad-hoc when requested by school or parent.
		4. School to report to nurse specialist if staff member is on long term sick or left the place of work.
		5. As 1 to 4 above
 | **D.b. Gaps in Assurance** *(What Assurance should be in place but is not currently evident?)*The views and wishes of the child to be incorporated within the development of arrangements for delivery of CICC. |
|  |

|  |
| --- |
| **E**. This action will most likely treat the risk by (circle or highlight): - |
| Reducing the impact or likelihood | Avoiding doing the task altogether | Transfer the task to another organisation | Accepting/Tolerating the current impact and likelihood |
| * 1. **Actions** *(What needs to be done1 to put Controls (C.b.) or Assurance (D.b.) in place?)*
		1. Training in infection control and process and competencies of catheterisation
 | **F.b. Lead** M**anager**Paediatric Clinical Nurse Specialist | **F.c. Projected completion date**Governing Body, staff, parents will need to consent to CIC delivery arrangements at school site. |

1 Actions must be both Reasonable and Practicable at the same time.

# Insulin Injections – Operational Procedure

## 1.0 Background

There are roughly 29,000 children with type 1 diabetes in the UK, around 40% of whom are in the primary school age-group and the number is increasing, particularly in the under fives. Numbers of children likely to require this support locally will be low and usually less than 10.

The management of diabetes in childhood has undergone changes with intensification of insulin regimes, increasing use of insulin pumps, closer monitoring of blood glucose levels and carbohydrate intake levels in order to adjust each rapid-acting insulin dose or pump bolus.

Mixed insulins which can cover the school day without the requirement for an insulin dose at lunchtime have now largely been removed from production as children and toddlers in particular do very well with multiple-dose insulin (MDI) regimes or insulin pumps.

With increasing numbers of children being diagnosed with type 1 diabetes at younger ages and intensification of insulin regimes, more children require support with their diabetes at school.

Within St Helens, once a child has been assessed and determined that insulin injections are required then the paediatric specialist nurse will contact the school to make arrangements for training.

This procedure sets out how insulin injections can be delivered in a school or nursery setting in order to support a child with Type 1 Diabetes and forms part of a broader set of CCG\LA procedures to support pupils with medical needs themselves informed by the DfE document Supporting Pupils at School with Medical Conditions (April 2014).

## Evidence base

A number of bodies have undertaken research and published guidance on support for children that use insulin injections which includes the necessary requirements for this to be undertaken by school staff that have received appropriate training. Key documents include:

* + - Diabetes in Primary schools: overcoming barriers to good care – Dr Julie Edge (Consultant in Paediatric and Adolescent Diabetes)
		- Supporting children and young people with diabetes – Royal College of Nursing
		- Diabetes in Schools – Diabetes UK ( [www.diabetes.org.uk/guide-to-diabetes/schools](http://www.diabetes.org.uk/guide-to-diabetes/schools) )
		- Talking T1 – JDRF ( [www.jdrf.org.uk/life-with-type-1-diabetes/school-resources](http://www.jdrf.org.uk/life-with-type-1-diabetes/school-resources) )

## Procedure for Training

Training will be delivered by the Paediatric Clinical Nurse Specialist and is usually given to a minimum of 3 identified members of staff, this allows for cover for staff absences. The training is conducted by the Children’s & Young People’s Diabetes (C&YPD) Clinical Nurse

specialist from the hospital where the child attends to have their diabetes managed. The training is supported by training documentation, an individual care plan with step by step instruction for each child and supervision by members of the hospital diabetes team for the first week and longer if necessary. Training is given to school staff at two levels (the procedure is the same for both levels, but when ‘supervising’ the member of staff will only be confirming checks and dosage levels):

* + 1. Staff to administer the insulin injection.
		2. Staff to supervise a child that can self-administer their insulin injection.

## Procedure

The procedure is broken down into a number of steps which are:

* + - * Take a glucose monitoring reading (Staff receive additional training if they need to perform this)
			* Prepare the insulin pen for injection
			* Inject insulin dose using the pen device

**Take glucose monitoring reading**

Glucose is monitored by use of a lancet pen with a pre- loaded needle from home.

The trained member of staff uses the lancet pen to pin prick the child’s finger so that the glucose in the blood can be measured. The reading is displayed automatically on the equipment.

**Prepare the Insulin Pen**

The Insulin pen comes pre-loaded from the child’s home. An auto-cover needle (i.e. safe) needs to be attached. Parents will inform the school of the type of insulin and correct dosage amount.

A visual check to ensure the right insulin is loaded is completed and the dosage amount set on the pen. 2 staff members check dosage

**Inject insulin dose**

Once the pen has been prepared it is pressed on to a suitable part of the child (usually the arm) and then the top of the pen depressed to administer the dosage.

The needle is then removed and disposed of in the sharps bin Once completed the pen is returned to the child’s medicine bag.

**Monitoring**

At regular intervals throughout the day, normally every 2 hours, the child’s blood sugar levels need to be monitored, this is achieved by measuring the glucose levels with the monitoring kit supplied by the child’s parents.

## Environmental Requirements

Normally the procedure is carried out in any private room and the school would provide:

* + - Gloves
		- Yellow sharps bin & pedal bin with yellow or orange waste bags which the council collects and disposes off.
		- Pump soap
		- Paper towels Parents provide:
		- Lancer pen with new needle installed each day by the parents
		- Insulin dosage amounts
		- Insulin pen preloaded with insulin and auto cover needle
		- Medicine bag for glucose monitoring equipment, insulin pen, etc.

## 5.0 Risks

Administering insulin injections is acknowledged as an intimate procedure which will require to be undertaken with due regard to safeguarding and the dignity of the young person. It is low risk if well managed and staff are trained and certified (by Paediatric Clinical Nurse Specialist) to undertake the procedure.

Provided the guidelines are followed and only staff trained to undertake the procedure and certified as competent carry out the procedure then the risk is minimal.

A detailed risk assessment relating to infection control, pain, child refusing procedure, staff availability and safeguarding has been completed in support of this procedure (attached in Appendix A)

## 6.0 Staffing

The C&YPD Clinical Nurse Specialist will train any member of staff that has been identified to undertake this procedure. When undertaken in a school setting training on use of insulin injections has generally been undertaken by teaching and learning assistants who have received appropriate training. Although the procedure itself only requires a single member of staff, additional staff members will be trained to provide cover for sickness and annual leave. School staff are also taught to recognise early signs in child’s behaviour which may relate to either low or high blood sugars. Blood sugars should be tested every 2 to 3 hours.

When undertaken in a medical setting the RCN guidance sets out that clean intermittent catheterisation would usually be carried out by either unregistered health staff or non-health qualified staff who have completed the training set out in this procedure.

It should also be acknowledged that whilst any member of school staff may be asked to support pupils with medical conditions they cannot be compelled to do so. Even when willing staff have been identified and trained, the written consent of parents to the proposed arrangements will also be required.

## 7.0 Clinical Accountability

Health professionals are legally accountable for any task they delegate even if they are not present when it is undertaken (Nursing and Midwifery Council, 2008).

Schools will be provided with contact details of the Paediatric Clinical Nurse Specialist, who will offer advice and visit the school to solve any problems throughout the school year.

Under Section 100 of the Children and Families Act 2014, Governing Bodies have a duty to make arrangements for supporting pupils at their schools with medical conditions.

## Supporting Documentation

All trained staff are supported by the C&YPD Clinical Nurse Specialist and also the following documentation:

* + - Guidance on insulin pens in a school setting
		- Blood glucose training
		- Auto cover needles
		- School Intimate Care Policy
		- Individual Care Plan
		- Parents signed authorisation
		- Training Log
		- Individualised school trip care plans

## 9.0 Monitoring and Review

The Paediatric Clinical Nurse Specialist will review arrangements put in place at a school or nursery on at least a six monthly basis.

This procedure will also be subject to at least annual review by the Local Authority and Clinical Commissioning Group as part of the wider arrangements for supporting pupils with complex medical needs.

Appendix A

# Concise Risk Assessment – Insulin Injection

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk** | **Consequence** |  | **Likelihood** |  | Use the Risk Matrix below to calculate the level of risk i.e. Low, High, Extreme etc. |
| 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic | 1 Rarely | 2 Possible | 3 Likely | 4 Highly Likely | 5 Almost certain |
| **No trained school staff available to administer or supervise the administration of the injection** | **1** |  |  |  |  | **1** |  |  |  |  | **low** |
| **Incorrect dose administered to child (including no insulin injected)** |  |  | **3** |  |  | **1** |  |  |  |  | **low** |
| **Sharps injury** |  | **2** |  |  |  | **1** |  |  |  |  | **low** |
| **Unsafe storage** |  | **2** |  |  |  | **1** |  |  |  |  | **low** |
| **Safeguarding staff / maintaining child’s dignity** |  | **2** |  |  |  | **1** |  |  |  |  | **low** |

**GAUGE THE OVERALL RISK TO THE AIMS AND OBJECTIVES OF THE ORGANISATION**

|  |  |
| --- | --- |
| **H. Current** (pre-action) | **Impact rating (0) x Likelihood rating (0) = Risk rating (0)** |
| **I. Target** (post-action) | **Impact rating (0) x Likelihood rating (0) = Risk rating (0)** |
| **J. Risk Matrix** | **1 Rare** | **2 Unlikely** | **3 Possible** | **4 Likely** | **5 Almost Certain** |
| **5 Catastrophic** | 5 Moderate | **10 High** | ***15 Extreme*** | ***20 Extreme*** | ***25 Extreme*** |
| **4 Major** | 4 Moderate | **8 High** | **12 High** | ***16 Extreme*** | ***20 Extreme*** |
| **3 Moderate** | *3 Low* | 6Moderate | **9 High** | **12 High** | ***15 Extreme*** |
| **2 Minor** | *2 Low* | 4Moderate | 6 Moderate | **8 High** | 10 High |
| **1 Insignificant** | *1 Low* | *2 Low* | *3 Low* | 4 Moderate | 5 Moderate |
| **Service/Speciality** | Children & Young People’s Diabetes Service – Insulin injections in schools |
| **Date** | 1.9.2014 |

|  |  |
| --- | --- |
| **Assessor** | Helen Thornton, Children & Young People’s Diabetes Clinical Nurse Specialist |
| 1. **Description of Hazard/Task:** *(What is going to go wrong?)*
	1. No school staff available to administer or supervise administration of insulin at meal time.
	2. Incorrect dose administered or insulin not injected
	3. Sharp injury occurs
	4. Safeguarding; child sometimes has to inject exposing their legs or stomach
 | 1. **Description of most likely Impact/Consequence:** *(What would be the effect should this Hazard (A) occur?)*
	1. Child’s blood sugar would raise making them feel unwell if they ate without receiving insulin.
	2. Child’s blood sugar could go too high or too low. Both require monitoring and treatment. Too high requires an insulin correction dose and too low requires rapid acting glucose to be administerd followed by a carbohydrate snack and always a re-test of the child’s blood sugar level.
	3. Staff may encounter a sharp injury.
	4. Child’s dignity may be compromised. Two staff members always to be present during supervision or administration of injections.
 |
| * 1. **Current Control Measures** *(What is preventing the Hazard (A) from actually occurring now or limit the Impact (B)?)*
		1. A team of school staff ‘around the child’ (minimum of three) are trained to administer or supervise the administration of insulin, to allow for sickness or study leave.
		2. All insulin doses are written in the child’s diabetes diary on a daily basis by the parent. If a correction dose is required when the child’s blood sugar is high, the parent or member of the hospital diabetes team are available to give advice of the new dose to be administered.
		3. Majority of children use autocover safety needles where the risk of an injury is impossible. The few children who prefer not to use an autocover safety needle, usually a Novofine needle, are provided with a needle remover device to prevent / minimise a needle sharp injury. Schools are provided with sharp bins.
		4. A written care plan is provided to the staff undertaking the training which states the injection must take place in a private environment and 2 staff members to be present.
 | * 1. **Gaps in Control** *(What Controls should be in place but are not currently evident?)*
		1. In an emergency situation, if the trained school staff not available, the Children’s Diabetes team should be contacted to arrange alternative support / cover.
		2. Staff have access to contacting either the parent of the child for advice or the C&YPD Clinical nurse Specialist for advice.
		3. No child is known to be of high risk for blood bourne diseases. All staff to follow Local Authority guidelines for a needle stick injury.

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| --- | --- |
| * 1. **Assurance** *(How are we checking that the Controls (C.a.) continue to work?)*
		1. School staff receive competency based training with a written care plan and instructions for device for each child. Staff are observed until deemed competent by a registered children’s nurse from the Children’s Diabetes team (only 3 nurses). Annual updates given to school staff as part of the child’s transition to the next school year.
		2. Parent to report if it is happening at school to nurse specialist , staff to advise parent & organise re-training.
 | **D.b. Gaps in Assurance** *(What Assurance should be in place but is not currently evident?)* |
| **E**. This action will most likely treat the risk by (circle or highlight): - |
| Reducing the impact or likelihood | Avoiding doing the task altogether | Transfer the task to another organisation | Accepting/Tolerating the current impact and likelihood |
| **F.a. Actions** *(What needs to be done1 to put Controls (C.b.) or Assurance (D.b.) in place?)*School staff to be trained, deemed competent and present. | **F.b. Lead Manager**Hospital C&YPD team accountable for ensuring staff trained in schools | **F.c. Projected completion date**On-going, annually |

1 Actions must be both Reasonable and Practicable at the same time.

# Insulin Pump – Operational Procedure

## 1.0 Background

There are roughly 29,000 children with type 1 diabetes in the UK, around 40% of whom are in the primary school age-group and the number is increasing, particularly in the under fives. Numbers of children likely to require this support locally will be low and usually less than 10.

The management of diabetes in childhood has undergone changes with intensification of insulin regimes, increasing use of insulin pumps, closer monitoring of blood glucose levels and carbohydrate intake levels in order to adjust each rapid-acting insulin dose or pump bolus.

Mixed insulins which can cover the school day without the requirement for an insulin dose at lunchtime have now largely been removed from production as children and toddlers in particular do very well with multiple-dose insulin (MDI) regimes or insulin pumps.

With increasing numbers of children being diagnosed with type 1 diabetes at younger ages and intensification of insulin regimes, more children require support with their diabetes at school.

Within St Helens, once a child has been assessed and determined that an insulin pump is required then the paediatric specialist nurse will contact the school to make arrangements for training.

This procedure sets out how an Insulin Pump can be operated in a school or nursery setting in order to support a child with Type 1 Diabetes and forms part of a broader set of CCG\LA procedures to support pupils with medical needs themselves informed by the DfE document Supporting Pupils at School with Medical Conditions (April 2014).

## Evidence base

A number of bodies have undertaken research and published guidance on support for children that use insulin pumps which includes the necessary requirements for this to be undertaken by school staff that have received appropriate training. Key documents include:

* + - Diabetes in Primary schools: overcoming barriers to good care – Dr Julie Edge (Consultant in Paediatric and Adolescent Diabetes)
		- Supporting children and young people with diabetes – Royal College of Nursing
		- Diabetes in Schools – Diabetes UK ( [www.diabetes.org.uk/guide-to-diabetes/schools](http://www.diabetes.org.uk/guide-to-diabetes/schools) )
		- Talking T1 – JDRF ( [www.jdrf.org.uk/life-with-type-1-diabetes/school-resources](http://www.jdrf.org.uk/life-with-type-1-diabetes/school-resources) )

## Procedure for Training

Training will be delivered by the Paediatric Clinical Nurse Specialist and is usually given to a minimum of 3 identified members of staff, this allows for cover for staff absences. The training is conducted by the

Children’s & Young People’s Diabetes (C&YPD) Clinical Nurse Specialist and is backed up by training documentation, individual care plans for each child containing step by step instructions and supervision for the first week and longer if necessary.

The procedure is broken down into a number of steps which are:

* + 1. Take a glucose monitoring reading
		2. Prepare insulin pump
		3. Pump will administer insulin dosage
		4. Check pump when finished and return to pouch

Take glucose monitoring reading

Glucose is monitored by use of a lancer pen with a preloaded needle.

The trained member of staff uses the lancer pen to pin prick the child’s finger so that the glucose in the blood can be measured. The reading is displayed automatically on the blood glucose equipment.

Prepare the Insulin Pump

To prepare the Insulin pump first it is removed from the child’s protective pouch, then enter the glucose reading obtained and then enter the carbohydrate level of the child’s food (this will be provided by parents on a daily basis or the Local Authority catering department if on school dinners).

The pump will now calculate the correct dosage to be administered.

Pump administers insulin

Once the glucose and carbohydrate values have been entered the pump will calculate the insulin dosage required and at the press of a button will begin to administer the dosage during which time the trained member of staff waits for the pump to finish.

Dosage finished

Once the insulin pump has completed the dosage an alarm will sound and the trained member of staff can then return the pump to the child’s protective pouch.

## Environment Requirements

Normally the procedure is carried out in any private room and the school would provide:

* + - Gloves
		- Pedal bin with yellow or orange waste bags which the council collects and disposes off.
		- Pump soap
		- Paper towels
		- Parents provide:
		- Lancer pen with new needle installed each day
		- Carbohydrate value of child’s food
		- Insulin pump preloaded with insulin
		- Medicine bag for glucose monitoring equipment etc.

## 5.0 Risks

Operation and support of an Insulin Pump is acknowledged as an intimate procedure which will require to be undertaken with due regard to safeguarding and the dignity of the young person. It is low risk if well managed and staff are trained and certified (by Paediatric Clinical Nurse Specialist) to undertake the procedure.

Provided the guidelines are followed and only staff trained to undertake the procedure and certified as competent carry out the procedure then the risk is minimal.

The insulin pump is pre-programmed with maximum and minimum parameters to ensure that potentially life threatening doses cannot be administered by mistake.

A detailed risk assessment relating to xxx dose administration, hypoglycaemic episodes, staff availability and safeguarding has been completed in support of this procedure (attached in Appendix A)

## 6.0 Staffing

The C&YPD Clinical Nurse Specialist will train any member of staff that has been identified to undertake this procedure. When undertaken in a school setting training on use of insulin pumps has generally been undertaken by teaching and learning assistants who have received appropriate training. Although the procedure itself only requires a single member of staff, additional staff members will be trained to provide cover for sickness and annual leave. School staff are also taught to recognise early signs in child’s behaviour which may relate to either low or high blood sugars. Blood sugars should be tested every 2 to 3 hours.

When undertaken in a medical setting the RCN guidance sets out that clean intermittent catheterisation would usually be carried out by either unregistered health staff or non-health qualified staff who have completed the training set out in this procedure.

It should also be acknowledged that whilst any member of school staff may be asked to support pupils with medical conditions they cannot be compelled to do so. Even when willing staff have been identified and trained, the written consent of parents to the proposed arrangements will also be required.

## 7.0 Clinical Accountability

Health professionals are legally accountable for any task they delegate even if they are not present when it is undertaken (Nursing and Midwifery Council, 2008).

Schools will be provided with contact details of the Paediatric Clinical Nurse Specialist, who will offer advice and visit the school to solve any problems throughout the school year.

Under Section 100 of the Children and Families Act 2014, Governing Bodies have a duty to make arrangements for supporting pupils at their schools with medical conditions.

## Supporting Documentation

All trained staff are supported by the C&YPD Clinical Nurse Specialist and also the following documentation:

* + - Guidance on insulin pumps in a school setting
		- Blood glucose training
		- School Intimate Care Policy
		- Individual Care Plan
		- Parents signed authorisation
		- Training Log
		- Individualised school trip care plans

## 9.0 Monitoring and Review

The Paediatric Clinical Nurse Specialist will review arrangements put in place at a school or nursery on at least a six monthly basis.

This procedure will also be subject to at least annual review by the Local Authority and Clinical Commissioning Group as part of the wider arrangements for supporting pupils with complex medical needs.

**Appendix A**

# Concise Risk Assessment – Insulin pump

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk** | **Consequence** |  | **Likelihood** |  | Use the Risk Matrix below to calculate the level of risk i.e. Low, High, Extreme etc. |
| 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic | 1 Rarely | 2 Possible | 3 Likely | 4 Highly Likely | 5 Almost certain |
| No trained school staff available to administer or supervise the administration of the insulin via pump | 1 |  |  |  |  | 1 |  |  |  |  | low |
| Incorrect information entered into pump resulting in Incorrect dose administered to child |  |  | 3 |  |  | 1 |  |  |  |  | low |
| Interruption of insulin delivery either by occlusion or the administration set coming out of the child’s body. |  |  | 3 |  |  | 1 |  |  |  |  | Low |
| If the child has a severe hypoglycaemic episode, the pump will continue to deliver insulin |  |  |  | 4 |  | 1 |  |  |  |  | likely |
| Safeguarding staff / maintaining child’s dignity |  | 2 |  |  |  | 1 |  |  |  |  | low |

**GAUGE THE OVERALL RISK TO THE AIMS AND OBJECTIVES OF THE ORGANISATION**

|  |  |
| --- | --- |
| **H. Current** (pre-action) | **Impact rating (0) x Likelihood rating (0) = Risk rating (0)** |
| **I. Target** (post-action) | **Impact rating (1) x Likelihood rating (1) = Risk rating (L)** |
| J. Risk Matrix | 1 Rare | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost Certain |
| 5 Catastrophic | 5 Moderate | 10 High | ***15 Extreme*** | ***20 Extreme*** | ***25 Extreme*** |
| 4 Major | 4 Moderate | 8 High | 12 High | ***16 Extreme*** | ***20 Extreme*** |
| 3 Moderate | *3 Low* | 6 Moderate | 9 High | 12 High | ***15 Extreme*** |
| 2 Minor | 2 Low | 4 Moderate | 6 Moderate | 8 High | 10 High |
| 1 Insignificant | *1 Low* | *2 Low* | *3 Low* | 4 Moderate | 5 Moderate |

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| --- | --- |
| **Service/Speciality** | Children & Young People’s Diabetes Service – Insulin pump usage in schools |
| **Date** | 1.9.2014 |
| **Assessor** | Helen Thornton, Children & Young People’s Diabetes Clinical Nurse Specialist |
| 1. **Description of Hazard/Task:** *(What is going to go wrong?)*
	1. No school staff available to administer or supervise administration of insulin at meal or snack time.
	2. Incorrect information entered into pump resulting in incorrect dose administered.
	3. Interruption of insulin delivery either by occlusion or set coming out
	4. In a severe hypoglycaemic episode pump will continue to deliver insulin
	5. Safeguarding-child sometimes has to exposing their legs or stomach or upper hip area to enable inspection of insulin set site.
 | 1. **Description of most likely Impact/Consequence:** *(What would be the effect should this Hazard (A) occur?)*
	1. Child’s blood sugar would raise making them feel unwell if they ate without receiving insulin. This would then have a direct impact on their ability to take part in education & school activities.
	2. Child’s blood sugar could go too high or too low. Both require monitoring and treatment. Too high requires a correction dose and too low requires rapid acting glucose followed by a retest of blood sugar.
	3. Childs blood sugar would become too high and the child would feel unwell.
	4. Child would remain unconscious
	5. Child’s dignity may be compromised. Staff could be accused of abuse.
 |

* 1. **Current Control Measures** *(What is preventing the Hazard (A) from actually occurring now or limit the Impact (B)?)*
		1. A team of school staff ‘around the child’ (minimum of three) are trained to administer or supervise the administration of insulin, to allow for sickness or study leave.
		2. Two trained staff members oversee the inputting of numbers into the pump to reduce risk of wrong numbers being entered into the pump. The pump itself has many safety measures to prevent user error including providing a warning to the staff member if the blood glucose entered is outside of a normal specified range with written prompts on how to proceed in this situation. The pump is programmed with a maximum dose so that an overdose of insulin cannot be administered. The pump knows when the last insulin dose was given and takes this into account when calculating doses therefore prevents too much insulin being administered too close together.
		3. Staff are trained to monitor for high blood sugar and to check for occluded set or the very unlikely event that the set has come out of the

child’s body. In the event of a high sugar that is

not resolving or the set has come out the parent will be called to attend school to change set / administer an insulin injection

* + 1. Staff are trained how to suspend the pump or disconnect set from body in the event of a severe hypoglycaemic episode and place child in recovery position & ring for an ambulance

5. Staff trained and 2 staff members should always be present. Parental permission granted. Staff are DBS checked and a care plan is issued

* 1. **Gaps in Control** *(What Controls should be in place but are not currently evident?)*
		1. In an emergency situation, if the trained school staff not available, the Children’s Diabetes team should be contacted to arrange alternative support / cover. Parents should only be asked to cover in exceptional circumstances.
		2. Staff have received training and have access to contacting either the parent of the child for advice or the Children & Young Peoples diabetes nurses for telephone advice if any concerns
		3. There is a written plan in place staff are not expected to change sets.
		4. Staff in school undertake training
		5. Safeguards in place

|  |  |
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| * 1. **Assurance** *(How are we checking that the Controls (C.a.) continue to work?)*
		1. School staff receive competency based training with a written care plan and instructions for device for each child. Opportunity is given for staff to be observed until deemed competent by a registered children’s nurse from the Children’s Diabetes team (only 3 nurses). Annual updates given to school staff as part of the child’s transition to the next school year.
		2. Parent to report if any issues at school to nurse specialist and update training can be provided as required to school staff.
		3. Review by Nurse Specialist every school year minimum, and ad-hoc when requested by school or parent.
		4. School to report to nurse specialist if staff member is on long term sick or left the place of work.
		5. All control measures in place
 | **D.b. Gaps in Assurance** *(What Assurance should be in place but is not currently evident?)* |
| **E**. This action will most likely treat the risk by (circle or highlight): - |
| Reducing the impact or likelihood | Avoiding doing the task altogether | Transfer the task to another organisation | Accepting/Tolerating the current impact and likelihood |
| * 1. **Actions** *(What needs to be done to put Controls (C.b.) or Assurance (D.b.) in place?)*
		1. Record of training of designated school staff in diabetes and the use by staff of insulin pump therapy or supervision of i to be maintained and updated on a regular basis.
 | **F.b. Lead Manager**Hospital Children’s & Young People’s Diabetes team | **F.c. Projected completion date** |