**Appendix 2 (c)**

**EPILEPSY: PROCEDURES AND INDIVIDUAL HEALTHCARE PLAN TEMPLATE**

**PROCEDURES**

**Schools MUST ensure that the following points are implemented:**

1. School Handbook informs parents of their responsibility to ensure that all relevant information pertaining to their child’s health needs, including any changes to their condition or medication, is provided to the school.
2. All pupils with epilepsy have an Individual Healthcare Plan.
3. For pupils with epilepsy who have ***NOT*** *been prescribed emergency medication for use in school*:

|  |  |
| --- | --- |
| (i)  | parents provide a completed ‘Individual Healthcare Plan: Epilepsy’ excluding Section Three (see below) |[ ]

1. For pupils with epilepsy who **HAVE** been prescribed emergency medication for use in school:

|  |  |
| --- | --- |
| (i)  | parents provide a completed ‘*Individual Healthcare Plan: Epilepsy’* (see below) |[ ]
| (ii)  | parents supply the appropriate medication to the school in the original packaging/container in which it was dispensed including any patient information leaflet, and is clearly labelled with the pupil’s name in full and the dose to be given | [ ]   |

**Parent to confirm that** (*please tick*)**:**

|  |  |  |
| --- | --- | --- |
| (i)  | At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication being held in school exceeds the following October holiday period, I accept the school will securely hold the medication during the summer break for use at the start of the new term; or | [ ]   |
| (ii)  | At the end of the summer term (June), I will collect any prescribed long-term emergency medication from the school; or | [ ]   |
| (ii) | I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication that remains in school without my previous notification.NB: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies. | [ ]  |

1. For pupils requiring medication in school a copy of the prescription or prescription re-order form detailing the medication and dosage must be attached to the IHP.
2. Individual Healthcare Plans are reviewed at least annually and/or if there is a change of condition. **NB:** Care Inspectorate advice is that in Early Learning and Childcare settings it is good practice to review all agreed medical intervention at least every three months to check that the medication is still required, is in date and that the dose has not changed.
3. On completion of IHPs and following reviews, copies should be given to parents.
4. Emergency medication, if required, should be suitably accessible and stored securely as detailed below:

In **Early Learning and Childcare** settings:

Medication should be kept in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in the pupil’s classroom.

In **Primary Schools:**

Medication should be kept in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in the pupil’s classroom.

In **Secondary Schools:**

Medication should be kept in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in an easily accessible place.

In **Special Schools where registered nurses are not available:**

Medication should be kept in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in the pupil’s classroom.

In **Special Schools where registered nurses are available** in school at all times:

Medication should be kept in a zipped ‘poly pocket’ with the pupil at all times.

1. Epileptic seizures and emergency medication are recorded as follows:

|  |  |  |
| --- | --- | --- |
| (i)  | If a pupil has been observed having an epileptic seizure, this must be recorded on the *Record of Seizures Chart*. (see below) | [ ]  |
| (ii)  | The pupil’s *Record of Seizures Chart* should be kept in the medical folder.   | [ ]  |
| (iii)  | If any information has been recorded, the *Record of Seizures Chart* should be photocopied at the end of each term and given to the parents to take to the epilepsy clinic. | [ ]  |

**Schools MUST ensure that consideration is also given to:**

* **The School Curriculum**

Pupils with epilepsy who attend mainstream school will normally be able to access all areas of the curriculum. However, there are a few activities that should be carefully monitored and reasonable adjustments considered. Any special arrangements for the management and support of an individual pupil with epilepsy should be specified in the Individual Healthcare Plan.

* **General School Arrangements**

The class register should be clearly marked to indicate pupils with epilepsy so that when a supply teacher takes a class she/he is aware of any pupils with epilepsy in that class.

**Section One:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pupil’s name:** |       |  |  |
| **Date of birth:** |       |  |
| **CHI (if known):** |       |  |
| **Address:** |       |  |
| **School:** |       |  | Insert photograph of pupil |

|  |
| --- |
| This Individual Healthcare Plan should be completed by the pupil’s parent and, **where it involves the administration of emergency medication in school**, it must be approved by the relevant healthcare professional as detailed in this plan. (see Section Three)* If medication is required in school a copy of the prescription or the prescription re-order form detailing the medication and dosage must be attached to this plan.

Once completed, the parent is responsible for taking a copy of this Individual Healthcare Plan to all relevant hospital appointments for updating.Please read the Privacy Notice available at:<https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000> |

**Section Two:**

|  |  |
| --- | --- |
| **Parent Contact 1** | **Parent Contact 2** |
| **Name:** |       | **Name:** |       |
| **Relationship to pupil:** |       | **Relationship to pupil:** |       |
| **Address:** |       | **Address:** |       |
| 🕾 **Home:**  |       | 🕾 **Home:**  |       |
| 🕾 **Work:** |       | 🕾 **Work:** |       |
| 🕾 **Mobile:** |       | 🕾 **Mobile:** |       |
|  |
| **Hospital/Clinic Contact(s)** | **General Practitioner(s)** |
| **Name:** |       | **Name:** |       |
| **Job title:** |       | **Address:** |       |
| **Address:** |       |  |       |
| 🕾: |       | 🕾: |       |

|  |
| --- |
| **Section Three:** |
| *To be completed for a pupil* ***who is prescribed Emergency Medication (MIDAZOLAM) for use in school****.* |
| **Description of seizure(s) requiring emergency management:** |
|       |

* **Emergency Medication Guideline (MIDAZOLAM):**

|  |  |  |
| --- | --- | --- |
| If this pupil has a seizure as described above which lasts longer than  |       | minutes, |
| or a cluster of |       | seizures within |       | minutes; |
| give |       | ml ( |       | mg) of Midazolam (buccally/intra-nasally). |

* **CALL emergency services if:**

|  |  |  |
| --- | --- | --- |
| The seizure does not stop |       | minutes after the administration of Midazolam. |

 **OR**

|  |
| --- |
| If another seizure occurs within 6 hours. |

* **When the seizure has stopped or you call emergency services, contact parent.**

|  |  |
| --- | --- |
| **Name of prescribing clinician:** |       |
| **Job Title:**  |       |
| 🕾: |       |
| **Signature:** | **Date:** |       |

*(****OR*** *a signed emergency medication guideline from the prescribing clinician is sufficient to cover the NHS signature requirements of this form. The issued guideline from the clinician should be stapled to the IHP.)*

**Section Four:**

To *be completed for a pupil with epileptic seizures* ***not prescribed emergency medication for use in school****.*

|  |
| --- |
| **Description of seizures:** |
|       |

This pupil has the following types of epileptic seizures with associated symptoms (tick as necessary):

[ ]  **Generalised tonic clonic seizures:**

 [ ]  May go stiff

 [ ]  Would fall if standing

 [ ]  Is unresponsive

 [ ]  Eyes may deviate

 [ ]  Colour may change

 [ ]  All limbs may begin to jerk/shake/twitch

[ ]  **Absence seizures:** brief loss of awareness

[ ]  **Atonic seizures:** ‘drop attack’, pupil falls straight down but recovers quickly

[ ]  **Focal seizures with or without altered awareness:** may

 [ ]  Look blank or pale

 [ ]  Lick or smack lips

 [ ]  Pluck at clothes

 [ ]  Other: Please describe the pupil’s signs of their focal seizure, e.g. hears strange noises, experiences hallucinations or odd smells, twitches/jerks one area of the body. **Please specify:**

|  |
| --- |
|       |

**Details of Emergency Care:**

[ ]  Follow instructions on Symptom and Action Flowchart for a Generalised Tonic Clonic
 Seizure (see below)

**OR**

[ ]  Follow instructions on Symptom and Action Flowchart for Absence, Atonic and Focal Epileptic Seizures with or without altered awareness (see below)

**Agreement to Individual Healthcare Plan**

**Parent:**

* I have read the [Privacy Notice](https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000).
* I request that the school contacts the healthcare professional(s) named on this form if required, and for those professionals to advise the school in any relevant matters in connection with my child’s healthcare as they relate to this form.
* I accept responsibility for keeping the school informed of anything that might be relevant in relation to the implementation of this care.
* I accept responsibility for ensuring that there are supplies of any relevant in-date medication, materials or equipment for my child’s needs in the original packaging/container in which it was dispensed including any patient information leaflet, clearly labelled with my child’s name in full and the dose to be given.
* At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication being held in school exceeds the following October holiday period, I acknowledge there is the option for the school to securely hold the medication during the summer break for use at the start of the new term. I confirm that Section 4 of this form has been completed to highlight my intentions.
* I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication that remains in school without my previous notification.

## NB: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies.

I wish my child to have the care/medication detailed in this plan and I accept that the emergency services will be summoned, where appropriate.

|  |  |
| --- | --- |
| **Name of parent:** |       |
| **Signature:**  |  | **Date:** |       |

**Pupil aged 12 years or over (if appropriate):**

* I agree to the requested healthcare arrangements as detailed in this plan.
* I have read and understood the [Privacy Notice](https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000).

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:**  |  | **Date:** |       |

**Section Five:**

**The Head Teacher/designated person:**

* I agree to the procedures detailed in this plan being administered in school.
* The healthcare/medication will be administered by staff who have knowledge and understanding of the appropriate healthcare and interventions.
* In the event of an emergency, the emergency services will be summoned and the school will follow advice received from the health professionals.

|  |  |
| --- | --- |
| **Name of Head Teacher/designated person:** |       |
| **Job Title:** |       |
| **Signature:** |  | **Date:** |       |

**Staff administering the healthcare to the pupil:**

* I have read this pupil’s Individual Healthcare Plan.
* I have knowledge of and understand the healthcare and medication requirements detailed in this plan.
* I agree to administer the healthcare and medication to this pupil as detailed in this Plan.

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Member** | **Job Title** | **Date** | **Signature** |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
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|       |       |       |  |
|       |       |       |  |
|       |       |       |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pupil’s name:** |       | **Date of birth:** |       | **School:** |        |

|  |  |
| --- | --- |
| **Review agreement of parent and pupil aged 12 years or over (if appropriate)** | **Review agreement of Head Teacher/school** |
| * I can confirm that the existing Individual Healthcare Plan continues to reflect the current needs of my child/this pupil, and propose that a further review is undertaken in line with the next review date which I have detailed below\*.
* I will inform the school if my child’s/this pupil’s needs change prior to the next review date, and will arrange with the school for a replacement Individual Healthcare Plan to be completed.
* I request that the school contacts the named healthcare professional(s) and for those professionals to advise the school in any relevant matters in connection with this Individual Healthcare Plan.
* I accept responsibility for keeping the school informed of anything that might be relevant in relation to the implementation of this care.
* I accept responsibility for ensuring that there are supplies of any relevant in-date medication, materials or equipment for my child’s needs in the original packaging/container in which it was dispensed including any patient information leaflet, clearly labelled with my child’s name in full and the dose to be given.
* At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication being held in school exceeds the following October holiday period, I acknowledge there is the option for the school to securely hold the medication during the summer break for use at the start of the new term. I confirm that Section 4 of this form has been completed to highlight my intentions.
* I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication that remains in school without my previous notification.
* I wish my child/this pupil to have the care/medication detailed in this plan and I accept that the emergency services will be summoned, where appropriate.
 | * I agree to the procedures detailed in this plan being administered in school.
* The medication will be administered by staff who have the knowledge and understanding of the appropriate healthcare and interventions.
* In the event of an emergency, the emergency services will be summoned and the school will follow advice received from the health professionals.
 |
| **Date review undertaken** | **Method****(F) Face to Face****(P) Post****(T) Telephone** | **Name of parent reviewing (BLOCK LETTERS)** | **Parent signature****(if review conducted face to face or by post)** | **Pupil’s signature (if appropriate)** | **\*Next proposed review date** | **Name of staff member (BLOCK LETTERS)** | **Staff member’s signature** |
| / / |  |  |  |  | / / |  |  |
| / / |  |  |  |  | / / |  |  |
| / / |  |  |  |  | / / |  |  |
| / / |  |  |  |  | / / |  |  |

**N.B. On completion of the above, copies should be given to parent.**

**Section Seven: Record of Seizures Appendix 2 (c)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pupil’s name:** |       | **Date of birth:** |       | **School:** |       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date: |       |       |       |       |       |       |
| Recorded by: |       |       |       |       |       |       |
| Description of seizure |       |       |       |       |       |       |
| Length of and number of seizures: |       |       |       |       |       |       |

**If emergency medication is prescribed for use in school:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Time of initial dose: |       |       |       |       |       |       |
| Outcome: |       |       |       |       |       |       |
| Time of second dose (if any): |       |       |       |       |       |       |
| Outcome: |       |       |       |       |       |       |
| Signature of giver: |  |  |  |  |  |  |
| Signature of witness: |  |  |  |  |  |  |

**Section Eight:**

**Symptom and Action Flowchart for a Generalised Tonic Clonic Epileptic Seizure**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pupil’s name:** |       |  | Insert photograph of pupil |
| **Date of birth:** |       |
|  |
| **Signature of parent:** |
| **Date:** |       |
| NONOYESNOYESNOYESNOYESYESYESNOAfter a further 5 minutes (or as directed in emergency medication guideline) has the pupil stopped jerking or is relaxing?Give medication as per Individual Health Care Plan.* After a seizure the pupil will probably feel sleepy.
* Allow child to rest in a quiet area.
* Inform parent.
* Fill in the epilepsy record chart.
* Dial 999 for ambulance, state that the pupil is having an epileptic seizure.
* Follow instructions given by ambulance control staff.
* Stay with pupil.
* Reassure pupil.
* Contact parent.

Does the seizure last longer than 5 minutes or longer than the time specified in the pupil’s Individual Healthcare Plan?DO NOT try to move the pupil.DO NOT try to stop the pupil jerking.DO NOT put anything in pupil’s mouth.1. Note time.
2. Move furniture/objects pupil could bang against.
3. Place something soft under pupil’s head.
4. If possible put pupil on his/her side.

When pupil stops jerking/relaxes, place on their side and cover them from waist down in case of incontinence, to minimise embarrassment.Are you unsure or worried?Is the pupil responding to stimuli?Does the pupil have any injury that may require treatment?**Symptoms:** may go stiff, would fall if standing, is unresponsive, eyes may deviate, colour may change, all limbs may begin to jerk/shake/twitch.Is emergency medication prescribed for use in school? |

**Section Eight:**

**Symptom and Action Flowchart for Focal Epileptic Seizure**

**With or Without Altered Awareness**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pupil’s name:** |       |  | Insert photograph of pupil |
| **Date of birth:** |       |
|  |
| **Signature of parent:** |
| **Date:** |       |
| YESYESNONONOYESNOYESNOYES* After a seizure the pupil may feel sleepy.
* Allow pupil to rest in a quiet area.
* Inform parents.
* Fill in epilepsy record chart
* Dial 999 for ambulance stating that pupil is having an epileptic seizure.
* Follow instructions given by ambulance control staff.
* Stay with pupil.
* Reassure pupil.
* Contact parent.

Give medication as per Individual Healthcare Plan.Is the pupil beginning to respond to verbal stimuli?Does the pupil have any injury that may require treatment?Note time.Speak calmly.Guide the child gently to sit if standing.DO NOT speak abruptly to the pupil.DO NOT handle the pupil abruptly.Reorient pupil to:* place
* time
* task

Are you unsure or worried?Is emergency medication prescribed for use in school?Does the seizure last longer than 10 minutes or longer than the time specified in pupil’s Individual Healthcare Plan?**Symptoms:*** **Focal seizure with or without altered awareness:** e.g. may look blank, pale, lip licking/smacking, plucking at clothes, strange smell etc.
 |