Scottish Government Update of the 2001 Guidance on the Administration of Medicines in Schools

Scotland's Commissioner for Children and Young People's Administration of Medicines Working Group

February, 2014

Background

All children and young people may have a requirement to have medicines or healthcare procedures administered in school at some point in their lives. Medication may be required for the management of long-term conditions (such as asthma and diabetes), to deal with minor, short-term conditions (such as an infection) or in response to an emergency situation (such as an allergic reaction or epileptic episode).

The Scottish Government has committed to updating the existing guidance on the administration of medicines in schools, published in 2001 by the Scottish Executive. The 2001 guidance aimed to clarify the respective responsibilities of health boards, education authorities and schools on managing health care in schools, noting that NHS Boards have statutory responsibility for medical treatment and administration in schools. The guidance states that “pupils’ education should neither be interrupted nor curtailed by the need to take, or have medication administered in school.” Despite this, there is currently no legal duty requiring staff in education to administer medicines or health care procedures, and administration is undertaken on a voluntary basis.

Following SCCYP’s research (Annex 1) with pupils, parents, schools and local authorities, it became apparent that there were major inconsistencies in practice between authorities with respect to the administration of medicines in schools. Evidence highlights major issues across Scotland relating to confusion around policy and the law; inadequate levels of training or qualified staff; unsafe practices; lack of communication between the school and parents and young people; lack of respect, discretion and privacy and; failure to involve children and young people in healthcare planning.

In a 2012 Royal College of Nursing and UNISON UK-wide survey on supporting pupils with health needs in schools, support workers in schools raised concerns that there was a lack of adequate support and training for staff who administer medicines and health care procedures. Respondents reported that their confidence and competence was impaired by inadequate training, leaving them uncomfortable administering medicines or healthcare procedures in schools. Across Scotland there is some increasing pressure to address a perceived lack of training and inadequate pay and support for pupil support assistants.

Following the publication of this research, Scotland's Commissioner for Children and Young People established a Short-Life Working Group to discuss the main findings and to highlight specific changes that could improve the next iteration of the guidance on the administration of medicines in schools. This short briefing paper outlines the group’s recommendations and will serve to inform the Scottish Government group’s work on the guidance. The group formed by Scotland's Commissioner for Children and Young People will merge into the Scottish Government group.

Key concerns relating to the current version of the Administration of Medicines in Schools Guidance

1. The guidance should reflect the current Scottish policy and legislative framework

The policy and legislative context in relation to the administration of medicines and healthcare procedures in schools has changed significantly since the introduction of the 2001 guidance (See Annex 2). For example, the Education (Additional Support for Learning) (Scotland) Act 2004 and 2009 provides the legal framework for support to be provided to aid the education of children with additional support needs.

Most recently, the Equality Act 2010 includes a duty on schools to make “reasonable adjustments” for disabled pupils and prospective pupils if a disabled pupil would be at a substantial disadvantage in comparison with non-disabled pupils, unless an auxiliary aid or service is provided. In some schools, the requirement to make reasonable adjustments may be particularly challenging, for example in schools with open plan areas who may need to make changes to provide private spaces for children who need to take medication. It would be helpful for the group to consider how to support schools to make these changes and to what extent the need for administration of medicines while at school counts as an additional support need (which would make it mandatory).

Our research has also highlighted that there is some confusion over the interpretation of the age of legal capacity and the idea of consent. The UNCRC concept of the ‘evolving capacities of the child’ recognises that children acquire competencies at different ages and that this varies according to the circumstances. As enhanced competencies are acquired, there is a reduced need to direct and a greater capacity for the child or young person to take responsibility for decisions which affected them. The 2001 Guidance states that “By virtue of the Age of Legal Capacity (Scotland) Act 1991, a person under the age of 16 has legal capacity to consent to any surgical, medical or dental procedure if in the opinion of a health professional, that person is capable of understanding the nature of the treatment.” However, our research found that many local authorities did not refer to consent within their policies or forms. The guidance should be clear on proper practice in relation to consent to medical treatment and procedures with respect to involvement of parents and the age and stage of children and young people.

Additionally, the changes incorporated within the Children and Young People (Scotland) Bill, which was passed by the Scottish Parliament in February, and the Getting It Right For Every Child (GIRFEC) framework will have significant implications for the review of the guidance. The guidance should consider how the Named Person/Lead Professional and Child’s Plan, for example, will interact with the guidelines for schools. It should also highlight the relevant guidance relating to information sharing and in particular the importance of respecting and adhering to confidentiality. Reference could be made to the information from Health Rights Information Scotland and/or the Scottish Child Law Centre.

The guidance should clearly reflect these legislative changes and provide clarity over the age of legal capacity and issues relating to consent, confidentiality and information sharing. The Working Group should consider to what extent health needs and administration of medicines counts as an additional support need at school under the Additional Support For Learning legislation.

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2. The guidance should include explicit acknowledgment of children's rights and the United Nations Convention on the Rights of the Child (UNCRC)

The administration of medicines in schools is a children's rights issue. Since the publication of the previous guidance, there has been a growing awareness of children's rights across Scottish public policy, public services and society as a whole. Aspects of the UNCRC's main provisions in relation to children's rights in education have been transposed into Scots Education Law through sections 1 and 2 of the Standards in Scotland's Schools etc. Act, 2000. However, it is important to read the UNCRC as a whole and pay special attention to all relevant articles, particularly:

- The best interest principle (Article 3)
- The right to parental guidance; respect for the child's evolving capacities (Article 5)
- The child's right to participate in all decisions affecting the child (Article 12)
- The right to privacy (article 16)
- The rights of disabled children and young people (Article 23)
- The right to the highest attainable standard of health (Article 24)
- The right to a good-quality education (Article 28)
- The purposes of education (Article 29).

It will therefore be crucial to have more of a focus on children's rights in the guidance. The need to seek the views of the child should be clearer throughout the document, and at present it is not. For example, paragraph 11 refers to seeking agreement with regard to information sharing with parents but does not talk about seeking the views of the child or young person. Our research also revealed that only one local authority (Moray) specifically referred to the UNCRC within their policy, while involving children and young people in their care needs is referred to by 15 local authorities.

The guidance should be explicit that the rights and needs of children are of paramount concern. The aim should be to support all children to attend their chosen school, ensure that their school experience is positive and that they do not face any disadvantages due to their need for medication. Due to inadequate support at school, many children are not reaching their educational potential, face social isolation and in some cases may have their health compromised. All those at education authorities and health boards must be clear that they are expected to carry out duties relating to the administration of medicines in the best interests of the child and in line with all current policies and practice.

The guidance should be framed in terms of children's rights, which will ensure that the focus is on the rights and needs of children and young people.

3. The guidance should be subject to a clear review to ensure that the information it contains is still relevant

Given that the guidance has not been updated since 2001, there are a number of statements that require scrutiny to ensure that they are still relevant, for example, with respect to school trips and the storage of medicines. References to publications such as ‘Helping Hands’ should be updated, and consideration should be given to how these can be kept up to date as more relevant information and research is published. New initiatives such as the Children and Young People Acute Deterioration Management (CYPADM) forms should also be included as not all children with these forms are placed in special schools where there is a greater chance the staff will have had experience of them.

The new guidance should also reflect the ongoing cultural shift to focus more on self management and the shifting language of Additional Support Need terminology to empower children and young people to take ownership of their healthcare needs. It will be important to consider how this can be regulated and managed, for example by training teachers how to help children to self manage their conditions.
During the review, the Government Working Group should consider how to update the existing guidance and ensure that it remains current.

4. The Working Group and other stakeholders should discuss the scope of the guidance

Consideration should be given to the changing landscape in which schools will be delivering on the 2014 guidance. Children and young people are now much more able to manage increasingly complex medical problems within mainstream schooling due to medical advances. Additionally, different family structures (such as stepfamilies and looked after children) may provide a further layer of complexity in terms of parental consent and other issues that should be examined in order to ensure that there is clear guidance. Since the publication of the 2001 guidance there have been a number of significant changes in Scottish schools that should also be reflected, such as the increasing number of teaching assistants.

It would also be helpful for the Scottish Government to clearly establish the scope of the guidance—does it refer simply to the administration of medicines in schools or could it also encompass other healthcare procedures and supporting healthcare needs? The Working Group is concerned that restricting the scope of the guidance to medicines rather than healthcare procedures may mean that many children and young people’s needs are overlooked. There are a number of conditions where a child needs to be helped or supported but which do not necessarily include the direct administration of medicine, for in the care of a child with a heart condition, or in epilepsy.

The Government Working Group should consider how to develop ways to reflect the variety of increasingly complex healthcare needs in schools. It should also discuss the range of ongoing societal changes and how this may impact of the guidance, as well as considering the scope of the next iteration of the guidance.

5. The guidance should address the voluntary nature of administering medicines by members of school staff

Working Group members have expressed particular concern some existing tensions between Health Board’s statutory responsibilities and the voluntary nature of the administration of medicines in schools. The current lack of legal duty requiring educational establishment staff to administer medicines in school and the consequent voluntary basis of staff involvement outlined within the guidance should therefore be thoroughly examined in order to address and discuss the following concerns:

- The impact of the lack of a legal duty and possible alternatives to this stance, such as a duty on local authorities to make arrangements for the administration of medicines;
- How to ensure that all children can attend school, regardless of their medical needs;
- How to meet the growing need for volunteers and ensure that there are enough willing volunteers in school with the adequate training and support;
- What happens when the volunteer is off sick, leaves or goes on maternity leave;
- Parents being unable to work or move too far from school as they are required to administer medicines themselves; and
- How to consistently include “administration of medicines” as part of job descriptions so that staff members are clear about what is expected of them and where the lines of accountability lie. This will help to reduce variation in practice across Scotland.

In the guidance, it will be paramount to set the right tone from the very beginning for all staff members in schools so that they know what their roles are. Parents should be confident that their child’s needs will be fully met by their chosen school.
6. The Scottish Government Working Group should consider how the guidance will be implemented in practice and how to reduce regional inconsistencies

Scotland's Commissioner for Children and Young People's Working Group on the administration of medicines in schools is concerned about how the current guidance is used in practice. Our research clearly shows that there is widespread variability over how the guidance is implemented, training levels, the duties of staff members, the involvement of children and young people, awareness of the guidance and how it interacts with local guidance on the administration of medicines. The Lancaster (2013) report states that “there is a need to raise awareness within schools about both national guidance and local policies relating to the administration of medicines in schools.”

There should be a clear accountability and monitoring framework to ensure that the new guidance is consistently implemented, including with reference to inspection. It would be helpful to highlight forms of redress should the organisations responsible not be able to provide for the child's needs. There should also be a more robust procedure within Education Scotland in terms of inspecting and reporting, for example to ensure that the health care procedures in the health care plan are agreed and adhered to.

*The guidance should be clear about what is expected of Local Authorities, schools and staff members, including Head Teachers, and the Scottish Government Working Group should consider ways to support the implementation of the guidance to ensure improved consistency across Scotland. The group should also consider the implementation of a monitoring and accountability framework.*

7. The guidance should further emphasise the need for better communication and planning

Lack of planning or poor planning has been identified by our Working Group members as significant barriers to good practice. Parents have highlighted to us the importance of clear and regular communication between themselves, the school and the child or young person. This includes providing regular opportunities to review and update healthcare plans and procedures. The confusion around reasonable adjustments for disability suggests the need for support and guidance for parents understanding their legal rights.

Our research revealed strong evidence that parents felt the need to be proactive in securing healthcare for their child at school. Many parents had to do extensive research to find out their rights and entitlements when this should be immediately clear from the outset. Plans on how to administer medicines in school, and any subsequent reviews, should include the relevant multisectoral professionals, including representatives from pharmacy. If parents are to be encouraged to ask the prescribing doctor about avoiding taking medication during school hours there should be a more proactive encouragement to include this in school handbooks and in guidance for parents.

*The guidance should further emphasise the value of effective communication between the school, parents or carers and child or young person.*

8. The guidance should place emphasis on high-quality training and staff numbers

Our research identified that lack of knowledge and understanding of health conditions and unsympathetic and uncaring attitudes amongst some staff were one of the major barriers to effective administration of medicines in schools. Enable's 2011 publication, *Bridging the Training Gap* states that “all school staff should recognise the possible physical, cognitive, emotional

and/or behavioural challenges faced by children and young people with learning disabilities and/or autism spectrum disorders and receive adequate training to fully support pupils to meet these challenges successfully in the learning environment.”

Our research also identified a lack of adequate training and staffing numbers in some schools, which must be addressed.4

The guidance should emphasise the value of whole-school training and clearly outline the role of local authorities and health boards in training staff to ensure that they can deliver on their responsibilities. Awareness raising and training should be included in pre-service teacher education programmes, as well as in-service teacher development. Staff should be clear about what their role and responsibility is in the event of an emergency and who to contact as a source of advice and support post-training, especially where there is a particularly complex procedure.

The guidance should outline what local authorities and schools are expected to deliver in terms of whole-school training and awareness-raising and support to teaching staff, in particular how they will ensure that support staff and student teachers receive adequate, high-quality training.

9. **The guidance should clearly link to other policy areas and highlight best practice**

When developing the guidance it will be important to ensure links are made to other policy areas, such as the development of guidance for children too ill to attend school, and to ensure ongoing joint working between health, education and social work. It will also be helpful to hear how the results of the Scottish Government analysis of needs for children with exceptional healthcare needs may affect the updating of this guidance.

Research has highlighted numerous areas of good practice and the guidance could include case studies and reference to relevant resources to promote best practice. For example, NHS Borders have undertaken some work to advance the 2001 guidance and have expanded it to be applicable to multi-agencies.

The guidance should be cognisant of ongoing policy work, links should be made to relevant areas and joint working should be encouraged. It would also be helpful for the new guidance to include case studies of best practice.

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4 ibid
Annex 1: Research undertaken by Scotland’s Commissioner for Children and Young People

- **The administration of medicines in schools report on FOI responses**, October 2012, outlines the result of a scoping exercise of the 32 local authorities in Scotland. Local authorities were asked about local guidance and/or policy documents relating to the administration of medicines in schools and protocols and/or joint agreements with the corresponding Health Board. The report concluded that there was some good practice with respect to the administration of medicines in some local authorities, but that there was a great deal of variation, particularly in relation to children's rights.

- Scotland's Commissioner for Children and Young People held a focus group with children and young people with asthma, looking at how asthma is managed at school, how this could be improved and highlighting areas of good practice. We also interviewed a parent of three children, all of whom required a range of healthcare procedures at school and involving the administration of medicines and held a focus group with nurses providing support to children with long-term health conditions and their families. These nurses identified a number of barriers to the effective administration of medicines and health care procedures in schools and identified best practice.

- ‘No barriers to medication at school’ (Stone, K., Doyle, S), August 2013, outlines the views of parents and carers on the administration of medicines and health care procedures in schools. The survey gathered views on current practice, the extent to which needs were being met and if children's views were being taken into account.

- **Findings from a survey of schools** (Lancaster, B), across 9 local authorities, 2013, survey sought information on policies and procedures, training and development, health care plans, joint working and meeting pupils’ needs. The survey found that a quarter of respondents were unaware of the 2001 Scottish Executive guidance and 8% were unaware of their local authority's policy relating to the administration of medicines in schools. Three schools reported that they had no volunteers to help administer medicine to care for pupils with intimate care needs, conditions that may require emergency treatment or other medical, long-term conditions. Although most schools reported having some volunteers, the information reported for each individual group of pupils highlights gaps in the availability of volunteers. The survey also found differences between schools in the proportion of teachers and support staff who received training.

- Scotland's Commissioner for Children and Young People established a working group to take forward the research on the administration of medicines and healthcare procedures in schools, with a remit of: considering the findings from the research; reflecting on personal insights and experience; considering recent policy and practice developments around the administration of medicines in schools and the implications of these; and making formal recommendations to the Scottish Government.
Annex 2: Current policy and legislative background relating to the administration of medicines in school

- **Standards in Scotland’s Schools etc. Act 2000**—Section 15 established the presumption to mainstream or, to educate, CYP with ASNs in mainstream schools. The Act places a duty on education authorities to “secure that the education is directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential.” The Act also recognised that the needs of some children and young people were better met in specialist provision.

- **Education (Disability Strategies and Pupils’ Educational Records) (Scotland) Act 2002**—This requires responsible bodies to prepare and implement accessibility strategies for pupils and prospective pupils with disabilities. The Act aims to improve access to the curriculum, to the physical environment of schools, and to information and communication with disabled pupils.

- **Education (Additional Support for Learning) (Scotland) Act 2004 amended by the Education (Additional Support for Learning) (Scotland) Act 2009** This legislation provides the legal framework for support to be provided to aid the education of children with additional support needs and establishes:
  - The concept of additional support needs, which replaces special educational needs.
  - Coordinated Support Plans (CSPs) for children with significant and complex needs.
  - The establishment of the Additional Support Needs Tribunals for Scotland (ASNTS) to hear cases involving children and young people facing barriers to learning
  - From March 2011, the ASNTS has been able to consider appeals (claims) made by the parent or the child (where he/she has capacity) against the responsible body that has discriminated against the person because of a disability.

- **Getting It Right For Every Child (GIRFEC), 2008**—a multi-agency approach to identifying and meeting the needs of all children, by putting the child at the centre of all decision-making, support and intervention. The Curriculum for Excellence also aims to enable all children and young people to become successful learners, confident individuals, responsible citizens and effective contributors.

- **Equality Act 2010**—Established a legal duty on schools and education authorities to provide reasonable adjustments for disabled pupils. From September 2012, the reasonable adjustments duty extends to **auxiliary aids and services for disabled students.** The duty is “to take such steps as it is **reasonable** to have to take to avoid a **substantial disadvantage**” to a disabled pupil caused by a provision, criterion or practice applied by/ on behalf of a school or by the absence of an auxiliary aid or service.

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