CS1 School Protocol for Children with Diabetes Type 1

Background

There are about 29,000 children and young people with diabetes in the UK. About 26,500 of them have Type 1 diabetes (insulin dependent) and about 500 have Type 2 diabetes. There are a further 2,000 children and young people in the UK with diabetes whose diagnosis is not known [1].

- The current estimate of prevalence of Type 1 diabetes in children in the UK is one per 700–1,000.
- The peak age for diagnosis is between 10 and 14 years of age [2].
- Local authorities and primary care trusts (PCTs) can expect between 100 and 150 children with diabetes to live in their area. In July 2009 45% of schools from the whole county in which case study 1 (CS1) is situated responded to a request for information and reported 214 children with type 1 diabetes and 19 with type 2 diabetes.

The Juvenile Diabetes Research Foundation (JDRF) and Diabetes UK have worked together to develop a protocol for children with diabetes in school to encourage a partnership between the NHS, the Local Authority and parents. Prior to this there have been no guidelines in place for schools. The protocol was launched in February 2011 after two years of discussions between parents and CS1 County Council.

CS1 School’s protocol for children with diabetes

The CS1 protocol (appendix 5) is a set of guidelines ensure that school staff are supported and given the right equipment to support pupils with diabetes. The protocol outlines recommendations on how schools can provide medical care and emotional support to children who have diabetes. This includes an individual care plan for each child and providing a place for a child to test their blood glucose levels or have their insulin injection. Extra training for school staff prevents situations where children are prevented from going on day outings or residential trips and allowing children to eat snacks to regulate their blood glucose levels.

The protocol was developed in response to a group of parents making a request for more support for pupils with diabetes in CS1 schools. CS1 and the Local Involvement Network (LINks) has worked in partnership with CS1 Local Education Authority and Diabetes UK

(Regional Office), a Paediatric Diabetes Specialist Nurse from a local hospital and other interested parties to create a protocol/guidance document for implementation in CS1 schools. The problem in schools is a nationwide issue and it is hoped that this protocol will be used as guidance for other counties wanting to produce their own guidance. This document can be reproduced provided acknowledgement is made therein to the CS1 County Council.

Shortly before the Protocol was due to be published the parents from the working party were contacted by CS1 and LINks asking if they would be interested in being part of an CS1 and LINks Working Party to arrange a conference to launch the protocol to CS1's schools. CS1 and LINk won a bid on their own initiative for funding to host a conference to launch the Protocol and to roll it out across CS1 schools. The conference was in February 2011.

References

1.Royal College of Paediatrics and Child Health (2009). Growing up with diabetes: children and young people with diabetes in England
http://bit.ly/growing2009
2. NHS (2007). Making every young person with diabetes matter. Department of Health
http://bit.ly/young2007
http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2012.pdf

Supporting Pupils with Diabetes in Schools

August 2010 (updated December 2010)

SUPPORTING PUPILS WITH DIABETES IN SCHOOLS

INDE

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1.0 INTRODUCTION

The burden of diabetes in school age (5-16) children is high. There are at least 15,400 children in schools in England with diabetes. This has significant implications for schools and families, as more children require management for their diabetes during school hours.[1] Whilst some older children may be fully independent with their diabetes care, younger or disabled children may require support and assistance from school staff during the school day.

Education is a valuable part of children's and young people's lives. Appropriate diabetes care in the school and day care setting is necessary for the child's immediate safety, long term well being and optimal academic performance.[2] Diabetes should not alter a child's academic potential.[3]

It is therefore essential that all school staff have an awareness of this medical condition and the child's needs during the school day.

These guidelines have been produced with parents to ensure that school staff are supported and equipped to support children with diabetes. Where schools are insured through the Council and have followed these guidelines then they will be fully covered by the insurers.

2.0 INDIVIDUAL HEALTH CARE PLANS (IHCP)

All children in school with a medical need should have an individual health care plan as recommended by the DfES 2005 guidance Managing Medicines in Schools and Early Years Settings. An IHCP is a useful tool for the school to record important details about an individual pupil's medical needs, their triggers, signs and symptoms, medications and other treatments, as well as contact details and emergency numbers. It should also include permission from parents to share confidential information about their child's health and health needs.

The IHCP should describe the responsibilities of all parties. In the case of children with diabetes this is usually provided and written by the child's diabetes specialist nurse (PDSN/CDNS). The parents will tell you who this is and how to contact them. It is essential to involve the child, their parents and school nurse, and good practice to involve relevant school staff such as head teacher, nominated school staff, as well as the school Special Educational Needs (SEN) representative.

Everyone who is involved in the individual health care plan (IHCP) should keep a copy. An IHCP should be completed at the beginning of each school year, or when the child enrols. It should be updated at least yearly and whenever an

[1] Growing Up with Diabetes: children and young people with diabetes in England. Research Report by the Royal College of Paediatrics and Child Health. March 2009.

[2] Department of Health (2007). Making every young person with diabetes matter.

[3] International Society of Paediatric and Adolescent Diabetes (ISPAD 2000). Consensus Guidelines for the management of Type 1 Diabetes Mellitus in Children and Adolescents.

individual pupil’s medical needs change. Parents have the prime responsibility for their child’s health and should ensure their child is well enough to attend school. Parents are responsible for providing schools with up to date information about their child’s health.

3.0 PLANNING AN ADMISSION

Parents should arrange an **introductory meeting** with their chosen school’s head teacher before their child enrols or when the child first develops diabetes. (DfES / DH 2005).

This is best done in the term before they are due to start/transfer to allow adequate time for planning meetings and training of staff, and to ensure an IHCP is in place by the time the child starts.

- The parent should inform the school of their child’s needs at this initial meeting.
- The parent should provide the school with contact numbers for the child’s PDSN/CDNS.
- **The head teacher** should contact the school nurse and SEN representative at this stage.
- **The head teacher** should identify at least 2 suitable members of staff to take on a supportive role for the child.
- **The head teacher** should contact the PDSN and arrange training.

The training should involve the child (if appropriate), parent, head teacher, nominated members of staff, PDSN and school nurse. In some areas the initial diabetes training may be supplied by the school nurse under guidance of the Diabetic Specialist Nurse.

NOTIFICATION PROCESS

Stages	Process	Who
1	Parent notifies school. Arranges meeting with Head Teacher	• Parent
2	Prior to meeting Head Teacher informs School Nurse and SEN representative.	• Head Teacher
3	Introductory meeting. Parent identifies child's needs and provides PDSN/CDNS contact details.	• Parent • Head Teacher • School Nurse
4	Head teacher contacts PDSN/CDNS. Arranges training meeting.	• Head Teacher
5	Planning meeting. PDSN/CDNS discusses IHCP and identifies training needs, and dates for training.	• Parent • Head Teacher • PDSN/CDNS • School Nurse • Nominated staff
	PDSN/CDNS or school nurse and parents provides school with IHCP.	• PDSN/CDNS • School Nurse • Nominated staff
	Training. PDSN/CDNS or school nurse AND parents provides training to school staff until competent. This may occur in one meeting	PDSN/CDNS or School Nurse and Parents
6	SEN representative informs the LA of child's details and names of nominated staff. LA holds a register of details.	SEN representative: ECC

4.0 STAFF TRAINING

All school staff should have a general awareness and knowledge of diabetes and know what to do in an emergency (for example, a hypoglycaemic episode) when they have a pupil with diabetes in their school.

General awareness training can be provided to individual schools by the child's diabetic health care team (PDSN/CDNS) or the school nurse AND parents on request. It is the head teacher's responsibility to arrange training. The parents can provide contact details. Alternatively, head teachers can contact Head of SEN and Children with Additional Needs at the relevant County Council who hold a list of all Diabetic Specialist Nurses in their region.

The head teacher should nominate at least two members of staff who are willing and able to undertake further training to enable the school to meet the health care needs of the child. This ensures cover when one is absent.

In order that schools comply with the recommendations from the DH/DfES guidelines Managing Medicines in Schools and Early Years Settings 2005 and the Disability Discrimination Act, head teachers need to ensure they have sufficient members of support staff who are employed and trained to manage medicines as part of their duties.

Where this is not the case, head teachers must ensure that when staff contracts are reviewed or new posts created this role is incorporated in order that the school complies with their Disability Equality Duties (DDA 2005).

Training of school staff is done on an individual school basis by the child's PDSN/CDNS and/or school nurse and parents. Staff can be trained to take on a variety of skills including blood glucose monitoring and insulin administration.

The child's PDSN/CDNS and/or school nurse and parents will update school staff training and reassess their competence annually.

STAFF INDEMNITY

County Councils fully indemnifies school staff that are insured through the county council's insurance scheme against claims for alleged negligence, providing they are:

1. Acting within their scope of duties;
2. Have followed documented procedures set out within this guidance;
3. Have received up to date training from an appropriately qualified health care professional;
4. Have been assessed as competent; and
5. Have maintained their competence by regular practice of the skill.

5.0 WHAT IS DIABETES?

Diabetes mellitus is a long term medical condition where the amount of glucose (sugar) in the blood is too high. This is because the pancreas does not make any or enough insulin, or because the insulin does not work properly or both. There are two main types of diabetes:

5.1 TYPE 1 DIABETES

Type 1 develops when the pancreas is unable to make insulin. It usually presents before the age of 40. The majority of children and young people have Type 1 diabetes.[4] Children with Type 1 diabetes will need to replace their missing insulin. This means they require insulin by multiple daily injections or an insulin pump for the rest of their lives. It is not related to diet or lifestyle and there is nothing the child or their parents could have done to prevent it.

5.2 TYPE 2 DIABETES

Type 2 diabetes is most common in adults, but the number of children with Type

2 diabetes is increasing, largely due to lifestyle issues and an increase in childhood obesity. It develops when the pancreas can still produce insulin but there is not enough or it does not work properly.

It often appears after the age of 40. This type is linked, to among other things, being overweight.

It can be managed with diet and exercise alone, but may require tablets or insulin.

[4] Growing Up with Diabetes: children and young people with diabetes in England. Research Report by the Royal College of Paediatrics and Child Health. March 2009.

6.0 TREATING DIABETES

Children with Type 1 diabetes manage their condition by the following:

- Regular monitoring of their blood glucose levels
- Insulin injections or use of an insulin pump
- Eating a healthy diet
- Physical activity

The aim of the treatment is to keep the blood glucose (sugar) levels within normal limits. People who do not have diabetes have blood glucose levels that are <7 mmols. Blood glucose levels need to be monitored several times a day. It is likely that a child will need to do this at least once whilst at school. Younger children may need help with this.

Poorly controlled diabetes increases the risk of developing long term complications such as damage to the eyes, kidneys, nerves, heart and blood vessels.

6.1 BLOOD GLUCOSE MONITORING

At school this may need to be done before a meal, anytime the child feels unwell and possibly before or after physical activity. Exact details will be discussed and documented in the child's Individual Health Care Plan (IHCP).

Blood glucose monitoring involves the pricking of a finger to obtain a tiny drop of blood using a special device called a lancet. A small amount of blood is placed on a test strip into a small electronic meter which displays the reading. The reading is displayed as a number in mmol/l. The target range for most children with diabetes is between 4-8 mmol, but children may have individual target; however this can be difficult to achieve particularly in the under 5s and during puberty. The test takes as little as a minute. **This testing is vital to the management of the condition and regulation of insulin and must be facilitated by a member of staff if the child is unable to do so themselves.**

The child should be asked if they wish to do this testing in private and a suitable place made available (not the toilet), though does not need to be out of the classroom.

The child should carry their own blood testing kit and should have it with them at all times. Some children will be able to do this independently whilst others, particularly primary school age, may need supervision or assistance from a member of staff. If it is not feasible for the child to carry their blood glucose meter with them, it should be stored in a safe place, obtainable at all times. It is important however to discuss the safe use and disposal of equipment in the classroom.

A sharps bin should be provided for safe disposal of sharps and locked away when not in use. Contact your school nurse for advice on the supply and collection of sharps bins.

- Refer to local sharps policy (School nurse should have local policy)
- Trained staff can refer to Procedure on Blood Glucose Monitoring in their individual training package.

The child's Individual Healthcare Plan (IHCP) will specify their individual blood glucose monitoring regime.

6.2 DIET

As with any child, a balanced and healthy diet is important (one that is low in fat, salt and sugar). A regular intake of starchy carbohydrates (bread, cereals, potatoes, pasta or rice) is important to provide an energy source. Fruit and vegetables should be encouraged and sugary drinks and very sweet foods avoided. Details should be contained within the IHCP, or advice sought from the diabetes nurse, particularly for children who adjust their insulin dose according to food intake or use insulin pumps who may be allowed some sugary foods.

Children with diabetes may choose to have school dinners or a packed lunch. Whichever they choose, the meal should contain:

- Starchy carbohydrate e.g. pasta, rice, potato, bread
- Fruit, vegetables, salad
- A drink that is water, or sugar free.

Some children will need to eat approximately the same amount of carbohydrate at lunch times to keep blood glucose levels under control. Others will be required to count the carbohydrate content of each meal and snack. Further information on this can be obtained from the child’s parents or Diabetes Specialist Nurse.

It is important to know the times the child needs to eat and organise this accordingly, e.g. they may need first sitting of lunch. In larger schools it may be useful to supply the child with a dinner pass that allows them to jump the queue.

School Dinners

Younger children on school dinners should be supervised by a member of staff to ensure they choose the right things, and that they eat all of their dinner. The head teacher is responsible for selecting members of staff for this duty and ensuring it is carried out. Where schools have a pre-planned rolling menu, parents should be able to select the choices with their child beforehand and give this to the head teacher. The head teacher should ensure that all staff involved with school dinners know which children have diabetes and provide them with a copy of the child's pre-planned menu choices. The insulin dose may vary according to what the child has eaten and their blood glucose reading. This should be documented in the child's ICHP.

Packed Lunch

Younger children with a packed lunch should also be supervised to ensure they eat all of their lunch and that they don't swap items with other pupils. Parents are responsible for providing the packed lunch. The insulin dose may vary according to what the child has eaten and their blood glucose reading. This should be documented in the child's IHCP.

If the child has their normal insulin injection and does not eat all of their lunch, please contact the parents for advice.

Older children are usually more knowledgeable about their choices and may alter their insulin dose depending on what they have eaten. School staff should encourage them to make healthy choices, and still contact the parents for advice if they have concerns.

Snacks

Some pupils with Type 1 diabetes need to eat at regular intervals. Missing a meal or snack could lead to a low blood glucose level requiring emergency treatment. **Whilst the child will normally do this at school break times, there may be occasions when a snack will need to be taken during lessons.** This may be particularly important before P.E. or during times of stress e.g. exams.

If a child with diabetes asks to eat during a lesson this should be accommodated. Under no circumstance should a child be refused or told off for this request. It may be useful for the teacher to explain the nature of diabetes to the class to enable the other pupils to be supportive and understanding. This of course should only be done with the child's/parents consent. The Juvenile Diabetes research Foundation (JDRF) can provide teachers with class activity plans to help with this. Visit www.jdrf.org.uk

The child's IHCP will state dietary routine whilst at school.

6.3 INSULIN THERAPY

Most children have Type 1 diabetes. This means that it is highly likely pupils will require one or more insulin injections during the school day. Insulin can only be given as an injection or via a pump device.

Some children are prescribed a fixed dose of insulin, but other pupils may need to adjust their insulin dose according to their blood glucose readings, food intake and activity. **Insulin is absolutely vital to their everyday life. Without it, they would die.** Some pupils use a pen-like device to inject insulin several times a day, but some may receive continuous insulin through a small pump.

Insulin pens

Insulin pens are very popular with young people as they are discreet and easy to use. The insulin pen should be kept at room temperature but any spare insulin should be kept in the fridge. When opened it should be dated and discarded after

1 month. The head teacher should nominate a member of staff to liaise with the child (older) and their parents to check stocks and dates weekly. **Parents should ensure enough insulin is available at school and on school trips at all times.**

Insulin should not be kept in direct sunlight or near a radiator as it is destroyed by extreme heat. Older children will probably be able to independently administer their insulin. However, smaller children may need supervision or an adult to do this for them. Always refer to the child’s Individual Healthcare Plan regarding their insulin requirements.

- Trained school staff can refer to the procedure on How to inject insulin using an insulin pen, contained in their individual training package.

Insulin Pumps

Insulin pumps are usually worn all the time but can be disconnected for periods of PE and bathing etc. They are about the size of a mobile phone and can be discretely worn e.g. attached to a belt or in a pouch. They continually deliver insulin into the layer of tissue just beneath the skin (subcutaneous tissue). Many insulin pumps can calculate how much insulin needs to be delivered when programmed with the child's blood glucose level and food intake.

Some children may be able to manage their pump independently, but others may require supervision or assistance.

Always refer to the child's Individual Health Care Plan for the child's insulin therapy requirements at school.

- Trained staff can refer to Procedure for Insulin Pumps, contained in their individual training package.

Medication for Type 2 Diabetes

Although Type 2 Diabetes is mainly treated with lifestyle changes (e.g. healthy diet, losing weight and increased exercise) tablets or insulin may be required to achieve normal blood glucose levels.

If medicines need to be taken during school time, the school should facilitate this. Your school will have an existing policy on medicines in schools which should be followed.

- Refer to school's Medication Policy or DfES guidance 2005.

Always refer to the child's Individual Health Care Plan for medication requirements.

6.4 EXERCISE AND PHYSICAL ACTIVITY

Exercise and physical activity have benefits for everyone, including children with diabetes. People with diabetes are more at risk of heart disease, so it is essential that children with diabetes are included in exercise at school. Having diabetes should not stop them from taking part in PE or even being selected to represent the school or other sporting clubs.

However, because exercise uses up muscle fuel (carbohydrate) it can lower blood glucose levels, and therefore there is an increased risk of a hypoglycaemic episode occurring in children with diabetes. With proper planning however, this can usually be avoided.

All school staff involved in supervising exercise should:

- Be aware of children with diabetes in their care and the effects of exercise on their blood glucose levels.
- Make sure the child has taken a blood glucose reading (younger children may need help with this) just prior to the activity to check that it is safe to take part. This is particularly important for swimming.
- Carry hypoglycaemia treatment with them and know where the emergency kit box is located. In larger schools it is a good idea to keep one in the PE Department
- Allow the child to take a bag with them if it contains emergency supplies e.g. drinks and snacks.
- Be able to recognise and treat a hypoglycaemic episode.
- If planned exercise is prolonged (i.e. 45 minutes) the child may need an additional drink and snack before and/or during exercise. (See Individual Health Care Plan).
- Note that older children may alter their insulin around exercise so always check with them first as they may not need to eat a snack.
- Be aware of those children using an insulin pump. Inform the child of the nature of the exercise and duration so that they can decide if they need to disconnect their pump. (Younger children may need help with this).
- Check that the child has reconnected their pump at the end of the activity. (Younger children may need help with this)
- Encourage the child to check their blood glucose reading at the end of the activity if required. (Younger children may need help with this).

- Contact the parents for advice if the blood glucose is outside an acceptable range according to their IHCP. If below 4mmol follow the hypoglycaemia protocol.

PE TEACHERS – REFER TO IHCP

7.0 DIABETIC EMERGENCIES

A child’s blood glucose may vary during the school day. It may be too low **(hypoglycaemia or hypo) or too high (hyperglycaemia or hyper).** Both of these situations can make the child ill and render them unable to safely look after themselves. It is during these times that a child is most likely to need adult support.

All school staff should have an awareness of diabetes and be able to offer practical assistance to the child during an emergency.

All staff should know where the emergency kit box is kept.

7.1 EMERGENCY KIT BOX

An emergency kit box should be kept in school for each child with diabetes. It should be labeled with the child’s name and class and emergency contact numbers. In larger schools it is a good idea to have several strategically placed.

It is suggested the kit box should contain snacks, a sugary drink and dextrose tablets. However, the exact contents, as well as details relating to emergency action school staff need to take in the event of a hypo/diabetic emergency, will be stated in the child’s Individual Health Care Plan.

The parents are responsible for supplying the school with the kit box and for keeping it stocked.

The head teacher should make all staff aware of where it is kept and should inform the parents once supplies have been taken from it.

The head teacher should ensure all school staff read this policy and that all new or temporary staff are made aware of children in their class with Diabetes.

General awareness training for staff can be arranged by contacting the child's PDSN/CDNS and/or speak to school nurse.

7.2 HYPOGLYCAEMIA (HYPO) – BLOOD GLUCOSE LESS THAN 4 MMOL

This occurs when **blood glucose levels fall too low (less than 4mmol/l).**

Hypos are most likely to happen before meals, if snacks are missed, during physical activity, after physical activity or when the child has diarrhoea or vomiting.

Teachers of PE in particular should be made aware of the signs.

Hypos can occur if the pupil has taken too much of their diabetes medication, delayed or missed a meal or snack, taken part in strenuous or unplanned physical activity, or if the child has been drinking alcohol. Hypos occur suddenly and cannot be predicted. Most children will have warning signs; however some children will not and may be completely unaware of their deteriorating state. **Any child with diabetes who is feeling unwell should always check their blood glucose levels**.

A hypo should be treated quickly. If untreated, the child may become unconscious. Never leave a pupil alone during a hypo or send them off to get food alone. They should be supervised by an adult and someone sent to get the emergency kit box if the child does not have their own emergency supplies. Parents may need to be contacted if the episode is severe or the child remains unwell after treatment.

Most children will know if they are hypo and will be able to take action or tell you what to do. They will normally require a sugary drink (not diet) or glucose tablets and sometimes a snack from their school bag or emergency box. Follow the child's Individual Health Care Plan for specific treatment details.

If unconscious place the child in the recovery position on their side, dial

999 and contact the parents. Do NOT give them anything by mouth. When the paramedics arrive tell them the child has diabetes.

The child's Individual Health Care Plan will list the individual warning signs.

Warning signs may include:

Feeling hungry
Sweating Drowsy

Glazed eyes, blurred vision

Pale

Shaky or trembling

Headache

Lack of concentration, vagueness

Mood changes e.g. angry or aggressive, anxious or irritable

Rapid heartbeat

Tingling lips

HYPOs

- Refer to procedure for Hypoglycaemia. See child’s IHCP.
- Trained staff can refer to procedure for Emergency Glucagon Injection p-contained in their individual training package.

7.3 HYPERGLYCAEMIA (HYPER) (BLOOD GLUCOSE MORE THAN 14 MMOL) AND KETOACIDOSIS

This occurs when blood glucose levels rise and stay high. Symptoms of hyperglycaemia do not appear suddenly but build up over time. School staff need to be aware that whilst children can become unwell, they may show no symptoms. A hyper may be caused by too little or no insulin, too much carbohydrate, stress, infection or fever. Extra insulin will be required.

Warning signs may include:

Thirst

Frequent urination

Tiredness

Dry skin Nausea
Blurred vision

Prolonged hyperglycaemia can lead to a very serious condition called Diabetic Ketoacidosis (DKA). It can take anything from a few hours to a few days to develop and is life threatening.

Warning signs:
Abdominal pain
Vomiting

Deep and rapid breathing (over- breathing)

Breath smells of acetone (like nail polish remover)

If a pupil displays symptoms of ketoacidosis, contact the parents immediately. If they are unavailable, call 999. When the paramedics arrive tell them the child has diabetes.

The child's Individual Health Care Plan will list warning signs.

HYPERs

- Refer to procedure on Hyperglycaemia. See child's IHCP.

Staff training in diabetic emergencies is available from the child's PDSN/CDNS

and/or school nurse.

8.0 SCHOOL TRIPS

Pupils with diabetes must not be excluded from day or residential trips on the grounds of their condition. They are protected by DDA (Disability and Discrimination Act) and the DED (Disability Equality Duty). However good planning is essential. For residential trips **parents should be informed at least**

7 days prior to the event and there should be a review of the risk assessment and the child's individual health care plan with the appropriate diabetes nurse.

Day Trips/Overnight stays

Going on a day trip should not cause any real problems however staff should be aware that the routine is likely to be different from the normal school routine and to expect the possibility of hypos and hypers occurring. As with residential trips, planning ahead is important to avoid any real problems.

The child's teacher should meet with the parents **at least 72 hours prior to the trip to discuss arrangements and the child's needs.** There should be a review of the existing risk assessment tool to determine if any additional safety measures need to be taken. Teachers should choose the medical option when using this tool.

All school staff on the trip should be aware of the child with diabetes and take with them a copy of the child's Individual Health Care Plan as well as an emergency kit box for treating a hypoglycaemic episode. Parents should ensure their child has all of their diabetic equipment and insulin with them and that they are happy with the arrangements.

Overnight stays will need more planning. It is useful to have copies of the itinerary and sample food menus available at the first planning meeting.

Involving the child's Paediatric Diabetic Specialist Nurse (PDSN) and/or school nurse is advisable. Higher staffing levels may be required to supervise the child with diabetes more closely.

If the child is unwell or loses equipment on the trip take them to the nearest

Accident and Emergency Department.

Check that travel insurance is suited.

For information and advice about traveling abroad contact:
Diabetes UK - 020 7424 1000

www.diabetes.org.uk

9.0 OTHER CONSIDERATIONS

General Sickness

If a child is unwell their blood glucose level may rise, even with a cold.

Having high blood glucose levels may make the child thirsty and need to pass urine more frequently. If school staff notice this, they should contact the parents for advice as the child may need extra insulin.

Vomiting

If a child with diabetes vomits at school, monitor the child's blood glucose level and contact the parents for advice. Look out for signs of a hypo or hyper and treat accordingly.

10 HELP AND ADVICE

School staff can obtain further help and advice from the following:

1. **Diabetes UK**

   Phone - 020 74241000,
   www.diabetes.org.uk

   Email - info@diabetes.org.uk

2. **Juvenile Diabetes Research Foundation (JDRF)**

   Phone- 0870 240 1640 - to order a free cross-curricular resource and management tool kit.

   www.jdrf.org.uk

3. **Department for Education (DfE) formally DCSF,**

   www.teachernet.gov.uk

4. www.medicalconditionsatschool.org.uk
5. Your school nursing team
6. The child's PDSN/CDNS
7. The child's parents
8. Head of SEN and Children with Additional Needs based at the relevant County Council

11 REFERENCES AND FURTHER READING

1. Growing up with Diabetes: children and young people with diabetes in England. Research Report by the Royal College of Paediatrics and Child Health. March 2009
2. Department of Health (2007). Making every young person with diabetes matter.
3. International Society of Pediatric and Adolescent Diabetes (ISPAD 2000). Consensus Guidelines for the management of Type 1 Diabetes Mellitus in Children and Adolescents.

Other documents used in compiling these guidelines:

- DfES/DH (2005). Managing Medicines in Schools and Early Years Settings.
- Medical Conditions at School. A policy resource pack.
- Children with diabetes at school. What all staff need to know. Diabetes UK.
- Briefing. Making all children matter: Support for children with diabetes in schools. Diabetes UK. November 2008.
- Diabetes in Schools. NUT Health & Safety Briefing.
- Supporting Children with Type 1 diabetes in school and early years settings. A collaborative approach by the Children's Diabetes Team in Leeds and Education Leeds. September 2007.
- Norfolk County Council Pupils with Diabetes in West Norfolk Schools General Guidelines for staff.
- Supporting the administration of Insulin in Schools. Pupils with diabetes in Schools. General guidelines for staff. Nottinghamshire County Council.

- Policy for the management of diabetes in schools. Standard Circular HIS 9. May 2008. Fife Council Education Service.

12 LEGISLATION

Under Section 175 duties of the LA and Governing Bodies of the Education Act (2002) it states that;

1. A local authority shall make arrangements for ensuring that the functions conferred on them in their capacity as a local education authority are exercised with a view to safeguarding and promoting the welfare of children.
2. The Governing body of a maintained school shall make arrangements for ensuring that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children who are pupils at the school.

Disability Discrimination Act (DDA) 1995

Whilst a pupil with diabetes may not consider themselves to be disabled, in many cases they will meet the statutory definition of disability.

SENDA 2001

The Special Educational Needs and Disability Act affords protection to pupils.

It is unlawful for schools to treat disabled pupils less favourably than their non-disabled peers for a reason that relates to the person’s disability (the reasonable adjustments duty). If a disabled pupil is, or is likely to be, at a substantial disadvantage, schools are legally obliged to take all reasonable steps to prevent that disadvantage, by implementing reasonable adjustments e.g. a child with diabetes cannot be excluded from a school trip or sports event for a reason that directly relates to their medical condition.

Disability Equality Duties (DDA 2005) & Equality Act 2010

Requires schools to:

- Promote equality of opportunity between disabled persons and other persons;
- Promote positive attitudes towards disabled persons;
- Take steps to take account of disabled person’s disabilities even where that involves treating disabled people more favourably than their non- disabled peers.

Schools have to show they comply in everything they do - right from the planning stage onwards.

Health and Safety at Work Act 1974 (HASAWA)

Schools have an obligation to protect pupils against risks to their health and safety e.g. where a pupil suffers as a result of being denied treatment (this could include denying a snack to prevent/relieve hypo).

Refer to the school’s Health and Safety Policy.

National Guidance NUT - (Health and Safety Briefing on Diabetes) Encourages the uninterrupted education in schools and support of children with diabetes; Advocates the implementation of policies with individual Health Care Plans. However, it states that there is no legal or contractual duty on teaching staff to administer diabetes medicines and that this is nevertheless voluntary. This briefing is available from NUT by phoning 0207 380 4775 or NUT website at www.teachers.org.uk.

DfES - Managing Medicines in Schools and Early Years Settings

Available from DfES by phoning 0845 6022260
http://publications.teachernet.gov.uk.