



**Scotland's Commissioner
for Children & Young People**

**The administration of medicines in schools
Report on FOI responses**

**Scotland's Commissioner for Children and Young People
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Acknowledgement

I would like to thank Scotland's local authorities for their responses which have provided useful insights into the policies and practices in the administration of medicines.

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Scotland's Commissioner for Children and Young People

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1. Introduction

This paper reports on responses to a Freedom of Information request carried out by Scotland's Commissioner for Children and Young People to explore how far current guidance on the administration of medicines in schools is being met and to gain an insight into current policies and practice.

2. Background

The practice around the administration of medicines in schools has been raised as a concern by young people, parents and practitioners working with children and young people. Whilst Health Boards have ultimate responsibility for the medical inspection, medical supervision and treatment of young people, educational establishments are responsible for the health, safety and welfare of pupils in their care. There is no legal duty that requires educational establishment staff to administer medicines in school. Many staff do this on a voluntary basis, whilst others have it written into their job descriptions.

In 2001, the then Scottish Executive issued guidance on the administration of medicines in schools, the aim of which was to "clarify the respective responsibilities of the health service and education authorities and schools on managing health care in schools". Since then, legislation¹ has placed duties on education authorities "requiring that pupils' education should neither be interrupted nor curtailed by the need to take, or have medication administered whilst in school". As such, "if parents or guardians ask that their children be given medication in school, it is essential that the NHS and education authorities work together to ensure appropriate arrangements are put in place wherever possible".² Most recently the Equality Act 2010 has been amended to include 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. This will take effect from September 2012.

3. Methodology

3.1 Freedom of Information Request

A Freedom of Information request was issued to Scotland's 32 local authorities by Scotland's Commissioner for Children and Young People. The request was as follows:

- Does your local authority have any local guidance and/or policy documents relating to the administration of medicines in schools and the management of health and care needs in schools; if it does, can you please supply me with information (or information recorded in documents) outlining and describing the local guidance and/or policy documents.

¹ Standards in Scotland's Schools etc Act 2000; Additional Support for Learning (Scotland) Act 2004 and as amended (2009)

² <http://www.scotland.gov.uk/Resource/Doc/158301/0042868.pdf>

- Does your local authority have any protocols and/or joint agreements with the corresponding Health Board regarding the administration of medicines in schools and the management of health and care needs in schools; and if it does can you please supply me with information (or information recorded in documents) outlining and describing the protocols and/or joint agreements.
- Contact details of person(s) in your local authority with responsibility for the administration of medicines in schools. If no person(s) in your local authority has responsibility for the administration of medicines in schools can you please indicate this in your response? These were collected and analysed using an Excel spreadsheet and qualitative content analysis.

3.2 Response Rate

Out of the 32 local authorities in Scotland, 26 responded within the timescale. A reminder was issued to the remainder and five outstanding responses were subsequently received. Only one council failed to provide the information requested.³

Type of response

The volume and quality of the information varied between local authorities, with some authorities providing comprehensive responses and others providing more limited information. The information also varied in currency. The policies for some authorities were up to date, but others were historic - in several cases (including one marked 'interim'), as much as 11 years old and often simply badging the 2001 Scottish Executive Guidance as their own. The scope of the guidance also varied, with some local authorities covering intimate care needs and complex medical needs within their policies and procedures and others focusing solely on short term and long term conditions.

4. Scottish Executive Guidance (2001)

The guidance document, *The Administration of Medicines in Schools* (Scottish Executive, 2001)⁴, refers to 'Health Care Needs' and draws a distinction between short term health care needs (when medication is needed for a short time e.g. to finish a course of antibiotics) and long term needs/conditions which require some sort of health care plan. Chapter 4 of the 2001 Guidance details the commonest long term conditions, including asthma, ADHD, diabetes, epilepsy, eczema, allergic reactions and cystic fibrosis. Intimate Care is referred to in Chapter 5 and readers are signposted to the SOEID publication *Helping Hands* for further guidance and advice on this.

Chapter 2 of the 2001 Guidance highlights the need for education authorities to

³ A response was provided but unrelated to the FOI request. Despite a further reminder, the information was not forthcoming. It was decided not to make an appeal to the Scottish Information Commissioner as any subsequent disclosure would probably be too late for the analysis.

⁴ Referred to hereafter as the 2001 Guidance.

develop a clear policy on “meeting the health care needs of pupils and the administration of medicines in schools within their area,” noting that this should be reflected in individual school policies and practices. The point is also made that in some cases, the necessary details may be contained in other plans and where this is the case, a separate health care plan will not be necessary (Chapter 3).

5. Local Authority Policies and Procedures

5.1. Health Care Plans

Most of the local authorities provide some form of ‘health care plan’ as the means of helping schools to identify the supports needed for children who require the administration of medicines - the format in the 2001 Guidance is generally followed, i.e. plans are reserved for long term needs/conditions and short term health care needs do not require plans.

The FOI information showed the following:

- **27 of the local authorities referred to a ‘health care plan’, with only four not doing so. (East Ayrshire, Glasgow, North Lanarkshire, Orkney)**

The terminology used to describe these ‘health care plans’ as revealed in the FOI information varied substantially. This ranged from ‘individual health care plans’ to ‘individual pupil protocols’.

“The main purpose of an individual school health care plan for a pupil with health care needs is to identify the level and type of support that is needed at school.” (Aberdeen City)

“In order to identify the necessary safety measures that are needed at school to support pupils with special medical needs and to ensure that they and others are not put at risk, an individual health care plan (IHP) should be completed for each child.” (East Lothian)

“A School Health Care Plan is required for all pupils who require emergency medication or who have a complex, chronic condition that requires more in-depth planning and support.” (City of Edinburgh)

“The level of support that is required at school can be ascertained by the completion of an Individual Pupil Protocol. A written agreement will clarify for parents, pupil and staff the help that the school can provide and receive.” (Moray)

“The involvement of both NHS Borders and Scottish Borders Council reinforces the close liaison and support necessary for schools to deliver this important service and allows them to develop Individual Health Care Plans (IHCPs) appropriate to pupil needs.” (Scottish Borders)

These examples show that most authorities – in line with the 2001 Guidance - saw the issuing of a health care plan as a useful mechanism to identify the levels and types of support required for the child or young person.

All 31 local authorities provided templates, apart from four. North Lanarkshire’s

guidance included various appendices: a Parental Request Form (personal details, medication, GP information, parental approval); letter from the headteacher; records of dosage and record of issue for paracetamol. There is also specific guidance on separate long term conditions. Orkney Council provided a school/parent agreement and a sample record card of dosage.

5.2 Scope of the Policies

In terms of scope, most policies covered both short term and long term medical conditions and made this distinction, with actual health care plans generally covering long term conditions only. Scottish Borders Council's policy also included guidance on what documentation should be in an Individualised Health Care Plan (IHCP). This covers general documentation and condition specific documentation. Many of the policies contained detailed information on each long term condition. The length of the policies varied considerably, from the very short (Orkney) to the very detailed (Scottish Borders, Argyll & Bute and West Dunbartonshire Councils).

Some policies provided detail on how to deal with 'intimate care needs' and 'complex health care needs', whilst others referred to this but merely signposted to where further information was available (e.g. with reference to the 'Helping Hands' publication). The terms 'intimate care needs' and 'complex needs' were not always used to refer to the same thing.

The FOI information showed that:

- **17 local authorities referred to intimate care needs. Of these, 10 signposted to the *Helping Hands* publication (Dumfries & Galloway included this publication within their policy)**
- **2 local authorities provided more detailed guidance around children with more complex needs (i.e. not long term conditions). Angus Council, for example, had a protocol specifically for the feeding of a child with a gastrostomy tube**
- **12 Local authorities did not refer to intimate care needs in their policies or plans.**

5.3 Self Administration of Medication

The 2001 Guidance notes that "it is good practice to allow pupils who can be trusted to do so to manage their own medication from a relatively early age and schools should encourage this". Furthermore, "appropriate facilities should be provided to allow pupils to do this in private".⁵

The FOI information indicated that:

- **23 of the 31 local authorities referred to self-administration of medication within their policies and 8 did not.**

⁵ The administration of medicines in schools (para 67)
<http://www.scotland.gov.uk/Resource/Doc/158301/0042868.pdf>

We see that self-administration is generally supported across local authorities, but that detail on how or where that should take place is not always elaborated upon. The examples below show how local authorities approached this issue.

“A parent/carer or pupil over the age of 16 is required to provide written information about self administered medication, self administered health programmes and self administered tests which may be required during the school day.” (no reference to private facilities) (City of Edinburgh)

“It is good practice to allow pupils who can be trusted to do so to manage their own medication from a relatively early age and schools should encourage this. Appropriate facilities should be provided to allow pupils to do this in private.” (Shetland)

“It is good practice to allow pupils who can be trusted to do so to manage their own medication from a relatively early age and schools should encourage this. Where supervision is required, staff may undertake such duties on a voluntary basis.” (no reference to private facilities) (Moray)

“If a parent considers their child to be responsible enough to carry and administer their own medication, they should be encouraged to do so from a relatively early age.” (Midlothian)

A number of local authorities (e.g. Edinburgh and West Dunbartonshire) commented on the importance that is now placed on children being able to self-administer, although few specifically referenced the need for appropriate facilities.

5.4 Non Prescription Medication

Most local authorities were clear that non-prescription medication should only be given with conditions attached to use. Others stated that this should never happen.

The FOI information illustrated that:

- **In 23 cases, conditions were attached to use**
- **In 5 cases, non prescription medicine was never allowed**
- **5 local authorities did not refer to this.**

The examples below reflect this divergence.

“Children under 12 should never be given aspirin, unless prescribed by a doctor. It is recognised that some pupils require taking non-prescription medication....in these cases, parents will be asked to authorise and supply appropriate painkillers in their original containers, labelled etc.” (Angus)

*“On the advice of a number of authoritative bodies, Scottish Borders Council Education and Lifelong Learning department has made the decision that **there can be no administration of any prescribed medication (this includes paracetamol)**”. (their bold) (Scottish Borders)*

“Non prescription medicines will not be administered in schools.” (Highland)

5.5 Alternative Arrangements

The information received was generally vague around what would happen if the school could not comply with a request.

Although this is not referred to in the 2001 Guidance, some of the local authorities were very specific about what would happen if the school felt unable to meet the needs of children and their parents (or expectations seemed unreasonable). Others did not refer to this. The FOI information showed that alternative arrangements were clearly referenced in 14 local authorities in either the policies or the accompanying forms/templates and not referred to in 17 authorities. Some local authorities noted that they may not be able to accede to all requests but gave no indication as to what would then happen if that were the case, although they were clear that procedures would be put in place, should they be able to.

Where no voluntary provision was available, advice was sought elsewhere. This varied from seeking advice from the GP, health board personnel or the head of educational services, as illustrated below.

“Where no voluntary provision for the administration of medicines is available, the headteacher, or in his/her absence, the delegated person, shall organise measures in conjunction with appropriate health board personnel.”
(Moray)

“The headteacher can seek advice from the school nurse/.. doctor if concern about meeting needs/parents’ expectations appear unreasonable and if appropriate.”
(Aberdeenshire)

“Schools may not be able to accede to all requests from parent, but where the request can reasonably be met, headteachers must ensure relevant procedures are put in place to safeguard the interests of both pupils and staff.”
(Midlothian)

“The authority does not place a requirement for staff to accede to all requests for assistance made by parents, but sets out procedures where the request can be reasonably met.”
(Perth and Kinross)

“In instances of doubt or difficulty, the headteacher should consult with the parent, who may need to clarify the difficulty with the GP and, if necessary the appropriate head of educational services, to identify the best course of action.”
(Angus)

5.6 Religious / Cultural Views

Respect for the cultural and religious views of the child is an important aspect of the United Nations Convention on the Rights of the Child (article 30), yet only seven of the 31 local authorities referred to religious and/or cultural views in any way, for example:

“Parents’ cultural and religious views should always be respected.”
(Dundee)

“Parents/carers’ cultural views should always be respected.” (Falkirk)

Only one local authority referred directly to the views of children in their policy.

“Parents’ and pupils cultural and religious views should be respected.”

(Renfrewshire)

Clackmannanshire Council was more expansive about how religious views should be reflected in considerations around medical treatment:

“Problems may arise when emergency treatment is required for a child show family hold strict religious views which preclude certain drugs or blood transfusion. Where parents approach a head teacher seeking the admission of their child to the school and inform the head teacher that they hold particular convictions on medical treatment, it is suggested that they should be told (and that this should be confirmed in writing) that whilst their convictions are respected, the head teacher is not prepared to accept any restrictions on his/ her authority as the person acting in loco parentis to the pupils.”

(Clackmannanshire)

5.7 Reference to Children’s Rights

There is no explicit reference to children’s rights in the 2001 Guidance. Out of the 31 local authorities reviewed, only one (Moray) specifically referred to the United Nations Convention on the Rights of the Child within their policy. This laid out two key principles of the UNCRC: article 3 (the best interests of the child) and article 12, which refers to listening to the views of the child in issues affecting them, in accordance with the child’s age and maturity. The 2001 Guidance also states that the child will need to contribute to a detailed health care plan if he/she “is sufficiently mature and capable of understanding”, (para 44).

The FOI information illustrated that:

➤ **Involving children and young people in their care needs is referred to by 15 local authorities, 13 of which are in regard to their health care plans. The other two direct references are around consent and confidentiality.**

5.8 Age of Legal Capacity

The UNCRC concept of the ‘evolving capacities of the child’ is an important one. This 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 affect them. Children’s capacities differ according to the nature of the rights to be exercised and this should be considered when addressing consenting to medical treatment.

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.” (para 50)

under 'confidentiality').

Of all the information received, this area showed the greatest range of responses. The FOI information showed the following:

- **11 of the 31 responses from local authorities referred to the Age of Legal Capacity (Scotland) Act (1991).**

More specifically and when looking at consent and defining an age,

- **12 local authorities did not refer to consent within their policies or forms (eg Orkney, Glasgow)**
- **2 local authorities referred to consent but did not specify an age**
- **2 local authorities noted that only young people of 12 and over can consent**
- **4 local authorities noted that only young people over the age of 16 can consent to medical treatment**
- **11 local authorities noted that any child or young person can consent if a medical professional deems that the child is capable of understanding the implications of the treatment.**

It is worth looking at the detail within the documents to highlight the variety of approaches taken across the local authorities.

"No pupil under 16 should be given medication without his or her parent's written consent. A pupil aged 16 or over will have full capacity to consent or refuse consent) to medical treatment and will have the right to medical confidentiality." (Aberdeenshire)

"Consent to medical treatment as indicated in the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995, states that due regard shall be given to children's views subject to their age and maturity. (This applies to all children, but those over 12 are generally presumed to have sufficient age and maturity)... The 1991 Act clearly states that the decision about the child's maturity lies with the doctor and that under Scots Law, young persons under the age of 16 are able to consent to their own medical examination or treatment 'if a doctor thinks they understand the nature and possible consequences of the treatment of examination'." (Dumfries and Galloway)

"It would generally be assumed by a qualified medical practitioner that at age 12, the child is capable of consenting." (Falkirk)

"By virtue of the Age of Legal Capacity (Scotland) Act 1991, a person under the age of 16 has a 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." (Inverclyde)

"No pupil under 16 should be given medication without his or her parent's written consent." (West Lothian)

Renfrewshire noted that parents have a legal duty of care and that “it is preferable to work with them, but if children do not wish their parents to be involved or informed, there is no legal requirement to do so”. Two local authorities (Midlothian & Dundee) suggested that it was good practice to inform parents, even when consent was not a legal requirement.

These responses reflect a considerable amount of confusion around the age of legal capacity and the idea of consent.

5.9 Training

A key part of the 2001 Guidance focuses on the delivery of training. Para 49 states that a health care plan may reveal the need for some school staff to have further information about health care procedures or specific training in administering a particular type of medication or in dealing with emergencies. The point is made that school staff should **never** administer medication without appropriate training from health professionals.

“If school staff volunteer to assist a pupil with healthcare needs, the employer should arrange appropriate training in conjunction with the NHS board, who will be able to advise on future training needs.”

(Para 49)

It is further noted that volunteers will require more detailed training and that specific training (eg on specific conditions) may be required.

The FOI information on training showed the following:

- **26 of the 31 local authorities indicated that training is generally delivered by health professionals**
- **2 local authorities did not specify who provided the training, 2 did not answer and one responded ‘other’ but did not provide further information.**

Moreover with regard to the type of training and frequency:

- **Training was noted as ‘compulsory’ for 29 local authorities, with 2 failing to answering the question**
- **15 local authorities provided general and specific training, with 14 providing only specific training**
- **16 local authorities referred to the need for continuous training and highlighted how often this should take place. 13 local authorities did not mention the frequency of training.**

On the whole therefore, considerable importance was placed around training, although continuous training was mentioned in only half of the responses. No reference was made to general training for all school staff in the 2001 guidance, but many local authorities differentiated between general and specific training.

6. Some Conclusions

The FOI and content analysis illustrates that (on paper) there is some good practice across Scotland with regard to the administration of medicines in schools. There is however, a great deal of variation. This is particularly apparent in the area of involving children in decisions affecting them and around consent. Overall, the policies appear to have a limited focus on the rights of children and young people, yet there is an increasing emphasis on minimising the effect of disability on children's lives and their opportunities for participation more broadly as well as a better awareness of children's rights.

All local authorities indicated that the administration of medicines in schools is done on a voluntary basis and stress that there is a legal duty to do so, but on the information received, there appears to be a much more facilitative approach from some local authorities than others, perhaps best reflected in the attitudes towards training.

Many of the policies and procedures rely heavily on the 2001 Guidance and in some cases this forms most of the policy. There have been a number of significant changes to policy and legislation since 2001, as well as current thinking on self administration. It is suggested that it may be appropriate to review this guidance to reflect this.

References

Scottish Executive (2001), *The Administration of Medicines in Schools*

SOEID (1999), *Helping Hands*



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