# SWANBOURNE HOUSE

THE Stowe GROUP

## 13a First Aid Policy

Includes policies for general healthcare, first aid, storage and administration of prescribed and non-prescription medication, and supporting pupils with specific chronical medical conditions

Applicable to Boarding and Early Years Foundation Stage

| | |
|---|---|
| Date | August 2022 |
| Review Date | August 2023 |
| Custodian | School Nurse / Assistant Head Pastoral |

# To be read in conjunction with:

- 14d – Educational Visits Policy
- 11 – Health and Safety

## References:


A. Keeping Children Safe in Education, September 2022.
B. Working Together to Safeguard Children, July 2018.
C. Dept of Health – Guidance on the use of Adrenaline auto-injectors in schools, dated 15 Sept 2017.
D. Dept of Health – Guidance on the use of Emergency Salbutamol Inhalers in Schools, dated March 2015.
E. Information Sharing – advice for practitioners providing safeguarding services to children, dated March 2015.
F. Health and Safety - Reporting of Injuries, Diseases & Dangerous Occurrences Regulations, 2013.
G. DfE, Guidance on First Aid for Schools.
H. DfE, Boarding Schools National Minimum Standards, dated April 2015.
I. DfE, Supporting Pupils at School with Medical Conditions, dated December 2015.
J. Public Health England – Guidance on infection control in schools and other child care settings, dated March 2017.
K. Nursing and Midwifery Council, The Code, Professional Standards of Practice and Behaviour for Nurses and Midwives, published January 2015.
L. NICE, Anaphylaxis Guidelines CG134, reviewed August 2014.
M. HSE, L74 – First Aid at Work (Third Edition), dated 2013.
N. HSE, OCE 23 – Cleaning up Body Fluids, dated 2011.
O. DfE Understanding and Dealing with Issues Relating to Parental Responsibility dated January 2016.
P. DfE Statutory framework for the Early Years Foundation Stage, updated September 2021

## Amendments

| Amendment | Date | Description |
|---|---|---|
| 1 | Nov 15 | Annual Review and Update |
| 2 | Nov 16 | Annual Review and Update |
| 3 | Mar 17 | Further review following ISI document update |
| 4 | Sep 17 | Annual Review and update on Anaphylaxis and Asthma |
| 5 | Oct 18 | Annual review and update |
| 6 | Sept 19 | Removal of reference to Home Farm Day Nursery |
| 7 | Jan 20 | Fraser guidelines included |
| 8 | August 2022 | Updated by new school nurse / KMK |
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| 12 | | |
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| 15 | | |

**Current First Aiders (13)**

Teresa Keay
Nicky Strange (PFA)
Jane Smith (PFA)
Lucinda Geliot
Katy Brown
Meghan Myers (PFA)
Amy Blane
Andrew Kirk
Sam Gunning
Rebecca Walters
Susan Caddick
Matt Heaven
Marlese Levermore (PFA)

## 1. Mission and Vision

a. To unlock and develop the confidence and individual talents of each child.
b. To nurture every pupil, enabling them to be resilient and build self-worth, through the widest variety of opportunities.
c. To provide our pupils with an engaging, collaborative and progressive teaching and learning community based on mutual respect, an understanding of individual needs and the willingness to rise to challenge.
d. To ensure both day and boarding pupils are well prepared within the context of a character and values education for their next school and adult lives in a fast-moving and challenging globalised world.

## 2. Policy Introduction

Swanbourne House School First Aid Policy applies to all staff and pupils both day and boarding, including the Early Years Foundation Stage. The procedures described comply with the Independent Schools Standards Regulations (The Education (Independent Schools Standards) (England) Regulations 2015, amended in March 2018) also known as the Registration Standards or ISSRs; the National Minimum Standards for Boarding Schools (made under section 87 of the Children Act 1989[NMS] and the Stutory Framework for the Early Years Foundation Stage [EYFS]. These regulations are laid down by the DfE.

### Aims

This policy aims to ensure that the school has adequate, safe and effective first aid provision to ensure every student, member of staff and visitor to be well looked after in the event of any illness, accident or injury. First Aid will be carried out in a timely and competent manor no matter how major or minor the incident. For the purpose of this policy, first aid is defined as the help that is given to an injured person until professional medical treatment is available.

## 2.1 Delegated Responsibilities

a. **Head**. The Governors delegate day-to-day responsibility and oversight through the Head for ensuring the school has adequate and appropriate first aid policies, equipment, facilities and trained personnel.

b. **School Doctor**. Our school doctor is Dr Beth Peel and is, based at the 3W's practice is employed to oversee the health of all full time boarders in school, to ensure that the correct medical, first aid and clinical procedures are applied..

- Advising on relevant policies and procedures
- Providing support and advice to the nursing staff
- Conducting regular meetings with nursing staff and supporting their CPD
- Acting as the GP for all full boarders who will be registered with her Practice
- Provide general health care to pupils. Staff and pupils registered with another practice should seek further advice from their own GP
- Conduct additional visits if there are significant numbers of sick children
- Provide additional advice if there are significant numbers of sick children

c. **School Nurse.** The School Nurse is a Registered Nurse on part 1 of the register, based in the school surgery on the ground floor of the Main House and oversees medical routines for the whole School as set out in this policy and has the delegated responsibility for drafting/reviewing related documentation. The School Nurse is line managed jointly be the School Medical Officer and the Assistant Head (Pastoral).

(1) The School Nurse holds a current NMC registration and keeps professionally updated. Revalidation is checked at annual appraisal.
(2) Nursing staff are responsible for ensuring that members of staff have the appropriate and necessary first aid training (delivered by HSE recommended bodies) and that staff have sufficient understanding and confidence to deliver the required first aid at the point of need.
(3) Early Years Foundation Stage (EYFS) requirement for this setting is at least one person with a current paediatric first aid certificate is on the premises at all times when the children are present. This also applies to outings and trips. Staff who are paediatric first aid trained are collated on the expanded SCR.

In the School in September 2022, 13 members of staff are first aid trained and they receive update training every three years. Staff who are first aid trained are listed on the expanded SCR and the Assistant Head Pastoral also has an updated list.

(4) Personal, Social and Health Education (PSHE) provides age appropriate advice and guidance on healthy eating, making healthy lifestyle choices, alcohol, illegal substance and solvent abuse, smoking, sex education, sexually transmitted diseases, and protecting oneself from abuse. The School Nurse has input into the Relationship and Sex Education (RSE) aspect of PSHE and provides puberty/RSE talks to the girls and boys. The school surgery has an open door policy in that any child, including boarders in boarding time (NMS 7.1 - 7.3), can come and discuss any concerns or queries they may have relating to their physical and mental health, and emotional wellbeing at any time. For boarders during their induction, they are assigned a shadow to support during the early period of boarding. Houseparents' review boarders progress with parents after the first week.

d. **Staff, Visitors and Pupils**. All staff, visitors and pupils while on school premises are expected to take reasonable care of their own and others' Health, Safety and Welfare.

e. **First Aiders**. The School Nurse and Admin Support are jointly responsible for ensuring that an adequate number of qualified and appropriately trained First Aiders are available across the site. A First Aider is an individual who has completed a course of training in first aid at work that has been approved by the Health and Safety Executive. Under the updated regulations, the School will follow the advice and apply 'best practice' by holding regular refresher training for staff. This will be delivered by an approved trainer, with training records in place as evidence. From October 2009 the training requirements in accordance with the Health and Safety (First Aid) Regulations 1981 are:

- ***First Aid at Work (FAW)***delivered by an approved first aid training provider/organisation. The training consists of 3 days training with continuous assessments to achieve the three year qualification.

- ***Emergency First Aid at Work*** (EFAW) delivered over a minimum of 6 hours contact time. The continual assessment throughout the training session will lead the successful candidates to hold a three year certificate.

**First Aiders are responsible for:**

- Responding to first aid situations, including emergencies, common illnesses and injuries
- For emergencies and accidents, calling the School Nurse in surgery to attend
- If serious, to call for an ambulance
- Informing the Bursar/Grounds and Maintenance Teams if an ambulance has been called so that guides can be deployed
- Ensuring first aid boxes are restocked after use
- Documenting any first aid care that they give
- Carrying out first aid treatment within the training they have received
- Maintaining their training, proficiency and competencies

f. **Appointed Person**. There may be occasion when a FAW First Aider is not available or when a risk assessment determines that one is not required. In these circumstances a group organiser is required to appoint a responsible person, responsible for calling an ambulance should an accident occur. An appointed person is an individual who has undertaken first aid training. Appointed persons are responsible for:

- Responding to first aid situations, including emergencies and common illnesses and injuries
- Calling the Emergency Services and/or Surgery getting further first aid assistance
- Informing the Grounds and Maintenance Teams/Management if an ambulance has been called so that guides can be put out.
- Ensuring first aid box are restocked after use
- Documenting any first aid care given
- Maintaining own training and competencies

g. **Other Staff Training**. Staff training should be conducted at least annually and include:

- Awareness of Asthma, Allergies and Epilepsy
- How to recognise the symptoms and the requirement to raise the alarm quickly if an attack occurs
- Ensuring staff are competent and confident to support pupils with these ailments and able to fulfil the requirements of the individual care plan
- Basic first aid training is given to some staff as part of their induction programme

## 3. Collective Responsibility

The Governing Body, Senior Leadership Team and all staff are collectively responsible for safety and this responsibility includes arrangements for first aid, based on an assessment of the risks presented by the various activities undertaken, either on or off site. Specifically, the School has a duty to provide staff, visitors and pupils with the following information:

- The number and locations of first aid boxes/kits
- Arrangements for dealing with first aid incidents
- Arrangements for dealing with emergencies
- Arrangements for offsite activities and trips

### 3.1 Risk Assessment. A series of risk assessments are undertaken by staff which identifies:

- The potential hazards
- People who may need assistance (pupils, staff members or the public)
- First aid provision, training levels, staff numbers, equipment
- The remoteness/location of the activity and the problems this may incur
- Access to the emergency services
- The risk assessments are updated annually or as required

## 3.2 Practical Arrangements at the Point of Need

a. Accident. In the event of an accident or serious medical emergency the School Nurse can be immediately contacted either by telephone (Ext 216) or using one of the School's walkie-talkie radios on Channel 7. All staff should be prepared to contact the emergency services if required and appropriate. If the Nurse can not be contacted then the Main Reception will be contacted.

b. **Immediate Capability**. School Nurse, Boarding parents' and first aid trained staff (some paediatric).

c. **Surgery**. The school surgery is equipped with essential first aid facilities and equipment; including children's own epipens, spare inhalers (other spare reliever inhalers are kept in the PE office & Main reception), a fully stocked first aid cabinet and a three-bed sick bay.

- The surgery is staffed by the School Nurse or appropriately trained first aider during term-time from 8.30am – 4.30pm daily. The School Nurse is also available at Saturday afternoon sports fixtures, as per the fixture schedule.
- Outside these times, first aid cover is provided for boarders by the Boarding and Assistant House parents.
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## 4. First Aid Kits

First Aid boxes are stocked with the minimum contents as outlined by the HSE, this is covered in the list below. The boxes will only contain equipment that staff have been trained to use, and relate to the activity taking place. Items may be added according to the first aid needs, where a risk assessment has been completed. No medication should be held in a first aid box and only trained staff should administer emergency medicine. This training can be delivered by the surgery staff. Kits are checked termly by the nurse, replenished as required and that all stock is checked as sterile, where appropriate, and in date.

a. If a kit is used the School Nurse is to be informed so that rapid replenishment can take place.

b. First Aid Kits are to be taken for all off site activities, including away matches, all sporting events, school trips and any other activities. These first aid kits are held in the surgery to ensure the correct content and will be allocated to each trip using information provided by the lead adult taking the trip.

**4.1 First Aid Kit Locations.** First Aid kits are conspicuous and coloured green with a white cross. A number are distributed throughout the School at strategic locations:

Main House

- Main House Reception

- Main House Kitchens x 2
- Cloister Classroom Corridor
- Walker Building
- Fremantle building (Science labs x 2, DT Room, Downstairs corridor)
- Swimming pool
- Studio
- Maintenance Workshop
- Changing rooms - additional kits are also held in the changing rooms office for easy deployment to the Astro courts and pitches as necessary
- Cricket Pavilion
- 1x on each boarding floor

Manor House

- Food prep room
- Stable Block corridor
- Coach House corridor
- Manor House ground floor corridor
- Manor House first floor corridor

**4.2 Defibrillator Location**. The defibrillator is located in a box on the wall in the Cloisters outside the Bridget More Hall. The School Nurse is responsible for checking the equipment; expiry date, battery monitoring and appropriate signage around the site. Anybody can use the defibrillator, no training is needed. The 999 staff will instruct on how to use it over the telephone.

**4.3 First Aid Box Contents**. The School Nurse is responsible for replenishing the first aid boxes. Boxes are checked once a term. Where contents have been used a record should be kept stating which elements need replacing. Boxes will contain:

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| 1 | First Aid Guidance sheet |
| 1 | Clinical waste bag |
| 2 | Eye dressings |
| 6 | Medium dressings |
| 2 | Large dressings |
| 30 | Plasters |
| 20 | Antiseptic wipes |
| 4 | Triangular bandages |
| 4 | Eye wash |
| 1 | Foil blanket |
| 1 | Resuscitation Aid |
| 2 | Pairs protective gloves |

Contents of First Aid box 1 (off site trips/ Sports)

| | |
|---|---|
| 1 | First Aid Guidance sheet |
| 1 | Pack of vomit bags/ 1 Clinical waste bag |
| 2 | Eye dressings |
| 4 | Medium dressings |

| | |
|---|---|
| 2 | Large dressings |
| 30 | Plasters |
| 20 | Antiseptic wipes |
| 2 | Triangular bandages |
| 2 | Foil blanket, |
| 1 | Resuscitation Aid |
| 4 | Pairs protective gloves |
| 4 | Disposable ice-pack |
| 2 | crepe bandages |
| 1 | Roll of Micropore tape |
| 2 | packs of gauze swabs |

## 5. Signs and Information

The School has a responsibility under HSE legislation to ensure that pupils, employees and visitors are aware of the location of first aid boxes and First Aiders. First aid boxes and signage should be green and white complying with the Health and Safety at Work (Signs and Signals) Regulations 1996. Each department must display a HSE approved sign stating the location and name of the nearest first aider. This should be displayed in a prominent place to ensure maximum visibility. Additionally all first aid boxes should be clearly labelled and easily accessed, if the location of the box is not clearly visible then an additional sign, for example on the cupboard door, is required.

## 6. Arrangements for Pupil's Health and those with Particular Medical Conditions

Parents are requested to complete a health questionnaire prior to starting the school. This documents general medical information, immunisations, allergies and a signed consent form allowing a first aider to administer first aid to their child as necessary. It also gives permission for the first aider to give basic over the counter medications, and any prescribed medications the child may be given. Consent forms together with individual Health Care Cards for each pupil are kept locked in the School Surgery and the information updated on Isams.

- See **Annex A** procedure in the event of illness
- See **Annex B** for Health Records and Supporting Children with Medical Conditions Policy
- See **Annex C** for the Storage and Administration of Controlled Drugs Policy
- See **Annex D** for the Early Years Administration of Medication Policy
- See **Annex E** for the Administration of Medication Policy
- See **Annex F** for the Asthma Policy
- See **Annex G** for the Diabetes Policy
- See **Annex H** for the Epilepsy Policy
- See **Annex I** for the Anaphylaxis Policy (Allergies)
- See **Annex J** for Hygiene Procedures for dealing with Spillage of Body Fluids.

### 6.1 In School Term Time

- If a pupil complains of illness, the teacher should conduct an initial assessment and apply common sense. Only if necessary, should the pupil be sent to the Surgery with a note to see the School Nurse or first aider on duty

- First Aiders will deal with minor injuries within their personal competency, referring the injured person for primary care provision if necessary. More serious injuries should be referred to the Surgery.
- The Surgery is open during term time only
- No member of staff or volunteer should administer first aid unless he or she has received HSE approved training, and that training is in date

## 6.2 Out Of School

- The trip co-ordinator is to check the nominal role of pupils with the Surgery prior to departure for any known pupil conditions that require regular or emergency medication. A list will be given to the trip leader from the surgery with information of children who have medical conditions, allergies, or medication to take.
- In particular, accompanying adults should check that any asthma sufferers have their inhalers with them and any diabetic pupils have the relevant medication.
- It is also important that any medication (**adrenaline devices**) are carried by the member of staff, this requirement should form part of the offsite risk assessment.
- Where possible the pupil should also carry a spare and, where the need is identified, staff must have received training from the School Nurse to administer the required medication.
- The trip co-ordinator should carry a mobile phone
- A risk assessment must be carried out prior to departure and cleared with the member of staff responsible for offsite activities - emergency procedures must be covered as part of this risk assessment
- If a serious injury occurs during an offsite visit or away Sports fixture, the offsite activities major incident plan should be put into action. The attending member of staff should immediately inform the School (School Nurse) of the situation, and if there is any doubt of the injury, whether they have been seen by a first aider or not, if the symptoms indicate a potential implication to the injured party, they must attend the nearest Accident and Emergency Department for clarification. If members of staff have any doubts, they must take the pupil(s) to A&E without delay keeping the Surgery and Bursar informed.
- If there are any children who take prescribed controlled drugs then the trip leader must come to the surgery and read and understand the controlled drugs policy.

## 6.3 Emergency Situations.

An emergency situation is determined by the adult who is first on scene. The incident can be downgraded or conversely escalated once an initial assessment has been made. The procedure outlined below should be followed:

- An emergency situation is identified
- Is a qualified First Aider immediately available able to deal with the incident within their competency and training?
- Make an early determination if an ambulance is required as our rural location can cause delays (if an ambulance is called, inform the Admin office of the exact location of the emergency so that guides can be put out appropriately)
- During term time only, the Surgery is notified and the on duty member of staff will attend the scene (School staff may have to relieve surgery staff if there are inpatients – to be co-ordinated through the admin office)
- See **Annex K** for a more detailed aide memoire

a. The School Nurse on arrival will take control of the incident and will decide on the best way to proceed. If an ambulance hasn't been called and the nurse considers the situation warrants, the nurse will initiate the callout. The Head or Deputy Head is to be advised of all ambulance callouts so that guides can be appropriately positioned to ensure the ambulance crew attend the injured person in the quickest possible time. The Deputy Head also will start a log for the incident and act as a central point of contact.

b. Arrangements are to be made to ensure that pupils are accompanied in the ambulance by a member of staff if parents are unable to be contacted or are unable to get to school before the ambulance is ready to leave.

## 6.4 Competencies and Protocols.

At all times, First Aiders must operate within their own scope of competencies and should not attempt any skills with which they are not trained or confident. All staff who administers first aid must be within the 3 year qualification period. First Aiders must identify themselves to the patient and verbally explain that they are able to treat them. From April 2013, **it has been necessary for First Aiders to request consent from the injured party before treating them. Where the casualty is unconscious First Aiders will use implied consent to treat a casualty.** This requirement will be outlined in the First Aiders' training.

## 7. Calling an Ambulance

If an ambulance is called, it is the attending member of staff or first aider's responsibility to ensure that this is actioned without delay, and that the Maintenance Team and the surgery staff have been called/informed so that they can also take action/attend the location. From the internal School phone system you must dial 999 and state:

Ambulance required at

**Swanbourne House School**, Swanbourne, Milton Keynes, **MK17 0HZ**

Telephone number: **01296 720264**

- Exact location within the site of the person needing help
- Caller's own name, and contact details
- Name of the person needing help and their age
- A brief description of the person's symptoms (and any known medical condition)
- Inform ambulance control of the best entrance and state that the crew will be met at this entrance and taken to the pupil
- Don't hang up until the information has been repeated back to you
- *If you are making a call from a mobile phone – be aware that you will be asked for your mobile phone number*

**Grid References - Ordinance Survey Sheet 165 Aylesbury and Leighton Buzzard Area**

Entrance to Main Drive - **SP 802272** (51° 56' 14" N 000° 50' 12" W)

Main House - **SP 799271** (51° 52' 12" N 000° 50' 20" W)

Manor House - **SP 801273** (51° 56' 14" N 000° 50' 12" W)

Entrance to Back Drive - **SP 803270** (51° 56' 12" N 000° 50' 9" W)

Bottom Pitches - **SP 802265** (51° 55' 56" N 000° 50' 16" W)

Once an ambulance has been called, the Office / Deputy Head / Director of Operations ***must*** be informed with clear directions for the location of scene of the incident.

- See **Annex L** for the Taking Children to Hospital in a Car

## 7.1 Guidance – When to Call an Ambulance

An ambulance is to be called in the following circumstances:

- a significant head or neck injury
- fitting, unconsciousness, or concussion
- difficulty in breathing and/or chest pain
- a severe allergic reaction
- a severe loss of blood
- severe burns or scalds
- serious break or fracture

## 8. Documentation

It is imperative that accurate documentation of any first aid treatment is recorded. The school Nurse will keep an up to date spreadsheet of all first aid given. All incidents/accident/near misses are logged on Smartlog. Documentation forms are kept in surgery along with accident forms if needed. Any documentation is copied and kept in Patients medical notes. First Aiders must ensure that the following information is recorded for any incident:

- Name of casualty
- Time and date
- Presenting complaint/injury
- Treatment given/offered
- Any observations taken about the incident/area
- Any follow up advice (sent to Medical Centre)/referral to outside agency

## 9. Health and Safety

**9.1 Introduction.** A number of risks are inherent to all those involved in dispensing first aid. All staff must take precautions to avoid infection and must follow basic universal hygiene procedures. Single-use disposable gloves are provided within first aid boxes. Additionally first aiders should ensure that they have access to hand washing facilities both before and after attending to the first aid situation.

**9.2 Blood Borne Virus**. The School has a duty of care to all employees to protect them against risks involved from their work activity. It is important that the School first aid risk

assessment contains control measures to protect staff from blood borne virus. When dealing with a casualty the first aiders must wear protective gloves (provided in the first aid kits). This will give increased protection against direct contact with bodily fluids/ blood. As an additional precaution any open wounds should also be covered.

If the first aider is at all concerned about cross infection after dealing with a casualty then they should seek advice from the Surgery staff. Such incidents must be reported to the Bursar as a near miss incident.

**9.3 COSHH**. The School operates under the guidance of the Control of Substances Hazardous to Health Regulations (2013) and must ensure that the correct procedures are maintained. All staff will work within Universal Safety Precautions while administering first aid, for the protection of themselves and the pupil, as outlined above. All clinical waste will be disposed of through the correct routes; this includes items used out in the field by first aiders and soiled equipment used by the Surgery. Yellow bio-hazard bags are available in all first aid boxes. 'Sharps' boxes are available for the disposal of sharp medical equipment (needles) used by Surgery.

## 10. Accidents

**10.1 Introduction**. Under the direction of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (1995) amended 2012, certain types of accidents must be reported to the HSE. The employer must keep a record of any reportable injury, disease or dangerous occurrence. This must include:

- Date
- Time
- Personal details of person affected
- Location of accident
- Nature of event
- Treatment required

**10.2 Reporting.** All accidents, no matter how small, must be reported, documented and given to the School Nurse, by the First Aider attending the incident or the member of staff who is in charge of the activity (including Sports) or the Houseparent if the incident occurs in House time. This also applies for near miss events that must be monitored as part of the School's Health and Safety Management System.

a. **Pupils**. Details of an accident will be entered in the child's medical records, parents contacted and an accident form completed if necessary.

b.**Staff**. Injuries to staff and visitors should also be reported to the School Nurse.

The following incidents will be reported to the HSE if an **employee** is injured, wherever they are working:

- fractures, other than to fingers, thumbs and toes;
- amputations;

- any injury likely to lead to permanent loss of sight or reduction in sight;
- any crush injury to the head or torso causing damage to the brain or internal organs;
- serious burns (including scalding), which: cover more than 10% of the body; or
- cause significant damage to the eyes, respiratory system or other vital organs;
- any scalping requiring hospital treatment;
- any loss of consciousness caused by head injury
- any other injury arising from working in an enclosed space which: leads to hypothermia or heat-induced illness; or requires resuscitation or admittance to hospital for more than 24 hours

**10.3 Physical Violence**. Some acts of non-consensual physical violence to a person at work, which result in death, a specified injury or a person being incapacitated for over seven days, are reportable. In the case of an over-seven-day injury, the incapacity must arise from a physical injury, not a psychological reaction to the act of violence. Examples of reportable injuries from violence include an incident where a teacher sustains a specified injury because a pupil, colleague or member of the public assaults them while on school premises. This is reportable, because it arises out of or in connection with work

**10.4 Reportable Occupational Disease**. Employers must report occupational diseases when they receive a written diagnosis from a doctor that their employee has a reportable disease linked to occupational exposure. These include:

- carpal tunnel syndrome;
- severe cramp of the hand or forearm;
- occupational dermatitis, e.g. from work involving strong acids or alkalis, including domestic bleach hand-arm vibration syndrome;
- occupational asthma, e.g. from wood dust and soldering using rosin flux;
- tendonitis or tenosynovitis of the hand or forearm;
- any occupational cancer;
- any disease attributed to an occupational exposure to a biological agent

**10.5 Stress**. Work-related stress and stress-related illnesses (including post-traumatic stress disorder) are not reportable under RIDDOR. To be reportable, an injury must have resulted from an 'accident' arising out of or in connection with work. In relation to RIDDOR, an accident is a discrete, identifiable, unintended incident which causes physical injury. Stress-related conditions usually result from a prolonged period of pressure, often from many factors, not just one distinct event.

**10.6 Incidents to Pupils and Other People who are not at Work**. Injuries to pupils and visitors who are involved in an accident at school or on an activity organised by the school are only reportable under RIDDOR if the accident results in:

- The death of the person, and arose out of or in connection with a work activity;
- An injury that arose out of or in connection with a work activity **and** the person is taken directly from the scene of the accident to hospital for treatment (examinations and diagnostic tests do not constitute treatment).

The lists of specified injuries and diseases described in Section 8.2 **only apply to employees.** If a pupil is injured in an incident remains at school, is taken home or is simply absent from school for a number of days, the incident is **not reportable**.

The responsible person at the school should consider whether the incident was caused by:

- A failure in the way a work activity was organised (e.g. inadequate supervision of a field trip)
- The way equipment or substances were used (e.g. lifts, machinery, experiments, etc.);
- The condition of the premises (e.g. poorly maintained or slippery floors).

**10.7 Accidents to Pupils during Sports Activities.** Not all sports injuries to pupils are reportable under RIDDOR, as organised sports activities can lead to sports injuries that are not connected with how schools manage the risks from the activity. The essential test is whether the accident was caused by the condition, design or maintenance of the premises or equipment, or because of inadequate arrangements for supervision of an activity. If an accident that results in an injury arises because of the normal rough and tumble of a game, the accident and resulting injury would not be reportable. Examples of reportable incidents include where:

- The condition of the premises or sports equipment was a factor in the incident, e.g. where a pupil slips and fractures an arm because a member of staff had polished the sports hall floor and left it too slippery for sports; or
- There was inadequate supervision to prevent an incident, or failings in the organisation and management of an event.

**10.8 Accident Grading System**. Swanbourne House uses the following grading system for accidents:

a. Grade 1. A minor injury/accident requiring little or no intervention e.g. falls (not including head injuries) with no obvious injury or small graze.

b. Grade 2. A minor injury/accident requiring some intervention e.g. cleaning of small wound, application of ice pack for a nose bleed.

c. Grade 3. A minor injury/accident requiring intervention, monitoring and observation e.g. minor head injury, sprain, significant wound. An accident form should be completed so that the Head is aware should parents wish to discuss it after the event.

d. Grade 4. Acute accident/injury where there is thought to be a significant injury e.g. significant swelling, restricted movement, suspected fracture, mild concussion. (Parents/boarding parents informed and advised to take to A&E). **Accident form to be completed.**

e. Grade 5. Major accident/injury e.g. severe blood loss, unconscious, severe head/neck injury, severe bone injury where child cannot mobilise, cardiac arrest. Ambulance and parent called immediately. **Accident form to be completed.**

## 10.9 Responsibility/Monitoring and Review

- It is the responsibility of the attending First Aider, member of staff in charge of the activity when the injury occurred (trips, sporting events) Houseparents' or Assistant Houseparents (if the accident happens in the Boarding house) to ensure that the correct information is provided to the School Nurse so that the appropriate documentation is completed

- Accident statistics are considered termly at the Health and Safety meeting to identify trends and gaps in procedure.

## Annex A - Procedure in the Event of Illness

**1. Procedure.** If a child is unwell during lessons then a member of staff will assess the situation and decide the next course of action, applying common sense.

a. **Lower School**. The class teacher will assess the situation and then call the named first aider or School Nurse if required.

b. **Middle and Upper School**. If a child is unwell during lessons, then a member of staff will assess the situation and decide the best course of action. The child must be accompanied to the surgery by a member of staff if they:

- Have sustained a head injury
- Are breathless and asthmatic
- Have an epileptic episode
- Signs of allergy/anaphylaxis
- Suffer from diabetes
- Have acute severe pain
- Have vomited
- Are unduly distressed.

The School Nurse will provide first aid as required and decide when and if the child can return back to class, and whether to contact the parents. Children with vomiting and/or diarrhoea should remain off school for 48 hours after the last episode.

**2. Sick Bay.** Sick Bay is located on the ground floor of the Main House in Surgery and comprises two beds. There are reading books and the area is suitably designed to ensure privacy while still ensuring close supervision and the need for infection control. During the weekdays the School Nurse or Boarding House Assistants are available to care for pupils. (NMS 7)

**3. Overnight Care.** If a child becomes unwell overnight the Boardingparents will make a decision whether to move the child to the sick bay in boarding or to seek further professional advice. There is a sick bay situated in boarding and consists of a separate bathroom and a three bedded room. If boys and girls are sick the boardingparents will identify a separate bedroom to be used if isolation is needed from the rest of the boarders, this could be on the boys or girls floor dependant on who sick If so a member of staff will sleep in the adjacent room. (NMS 7)

Boarders will be assessed the following morning by the School Nurse and if necessary arrangements will be made for them to see a doctor or to be reviewed by the School Doctor on a Monday.

## Annex B - Health Records & Supporting Children with Medical Conditions

1. All children (day and boarders) have their own individual health record clearly labelled with their full name and separate folders with NHS notes for Boarders registered with the 3Ws practice.

2. Any child with any diagnosed illness/condition/allergy e.g. Asthma, Epilepsy, Diabetes, Cystic Fibrosis will need an Individual Health Care Plan (IHCP). These are formulated with pupils & parents and discussed with consent of parents and child with appropriate staff. Close liaison with academic, boarding staff and sports staff with regards to the medical management of needs and support for the child. Consent is gained from the parent to put the pupil's name on the medical needs mini list which is kept on the staff notice board. Extra training for staff may be required depending on the individual child's need. The School Nurse will liaise with other professionals and healthcare staff in the community to ensure we can provide a safe environment where the child can participate in all school activities as much as possible.

3. Dietary needs are set out for the catering staff to minimise the risk to pupils of consuming the wrong foods where a food allergy is known to be present. We are a nut free school. These lists are updated regularly.

4. All records contain relevant health and welfare information provided by parents and consent for first aid treatment in school and on trips. These records include any significant known drug reactions, major allergies and notable medical conditions, and this information is available to staff likely to administer medication or treatment. All records for the Middle and Upper school are held in a locked filling cabinet in surgery. Lower School hold their own health records which are transferred to the Middle School when the pupil moves up.

5. Records include identification of the persons with parental responsibility for the boarder, contact details for parents and any other emergency contact arrangements, and any court orders affecting parental responsibility or the care of the pupil.

6. Regular meetings take place between the School Nurse and the Houseparent's to discuss any children that have been identified as requiring individual support in the way of individual welfare plans or IHCP's protecting confidentially where necessary. The School Nurse will also liaise with teachers in Lower, Middle and Upper School about any day pupils requiring any medical intervention or support.

7. Confidentiality of personal information about pupils is protected as the School Nurse adheres to the NMC Code of Professional Conduct, as follows:

- That any School Nurse and Doctor has an obligation to his/her patient, regardless of age, to confidentiality unless there is considered occasions where not sharing this information with others e.g. academic staff, child protection representative in the school, may put the child at risk of harm.
- Where information is to be shared it is good practice, although not essential, to gain a child's consent.

# Annex C - The Storage and Administration of Controlled Drugs (NMS 7.1 and 7.6)

**1.** All medications are to be securely stored, to ensure no child or unauthorised person has access to them. **All medications are to be fully accounted for.**

**2. Procedures.**

a. All Controlled Drugs (CDs) are to be signed in and out of Surgery in the Controlled Drugs Register book, e.g. when being dispensed daily, taken home for holidays, returned from holidays via parents, or when repeat prescriptions being brought in from Pharmacy. (Controlled drugs register book kept locked in medical cupboard.)

b. For CDs to be kept double locked (in the blue secure box which is locked in medicine cupboard). Surgery also locked if no adult is present. Keys to be kept in the locked key cabinet on the wall.

c. Each child must have their own page in the controlled drugs register book. There is an index page at the front of the book with each child's name, medication and the page number of the book where the records are documented. On the individual page the date, time, name, dose, signatures and balance must be documented.

d. Also document in the child's medical notes that they have had their medication.

**Each time medication is given it is to be dispensed and signed for by a qualified nurse or appropriately trained member staff.**

e. Full signatures and full names to be kept as a record to allow for easy traceability at a later date should the need arise. Details of signatures are on the inside page of the controlled drugs register book.

f. For once monthly rechecking of CDs held in Surgery to be carried out by the Registered School Nurse and the Boarding houseparents.

g. Records to be stored until the children involved are 25 years old.

h. For any loss of medication to be reported using a formal report and for School Nurse, GP, Head Teacher, Parents and Head of Boarding to be contacted ASAP.

# Annex D - Early Years Administration of Medication

**1. Statement of intent.** Swanbourne House is committed to ensuring that there is an effective management system to support children with medical needs, including the safe administering of medication.

**2. Procedures.**

**A. PRESCRIBED MEDICINES**

(1) Parents are asked to inform the child's class teacher of the need for medication.

(2) The class teacher will take medication to a Paediatric First Aider for safe storage.

(3) The Paediatric First Aider will establish with the parents the correct dosage and timings of medication which will either be written on the label or made note of when passed to the Paediatric First Aider. The following will also be established:

(a) That only medications are accepted with the child's own name on it and not that of another person, including another child or family member.

(b) That prescribed medication has a pharmacy or dispensing dentist label on it stating child's name and dosage.

(c) Whether there have been any allergic reactions to the medication or if this is the first time this medication has been prescribed; this information will be passed to the Paediatric First Aider.

(4) To give permission for Paracetamol [Calpol], and the time of last dose, in the case of not being able to contact parents in an emergency during the course of prescribed medication.

(5) The parent must sign and date the 'administration of medicine form'.

(6) All medication to be administered by the School Nurse or a paediatric first aider who will give medication only if satisfied that all criteria are correct. If there is any doubt, the member of staff will not give the medication but will seek immediate advice from Surgery team.

(7) The Paediatric First Aider will document dosage, time and child.

(8) If any doubt arises, the School Nurse is to be contacted.

B. EMERGENCY PARACETAMOL PROCEDURE.

(1) The reason for giving medication to be established

(2) Paracetamol may be given for a temperature over 37.5°C or over.

(3) Check with the parent by telephone or in person, that the giving of medication is acceptable if permission has not already been given

(4) Check with the parent the last time of medication (e.g. paracetamol must not be taken more frequently than every four hours and the maximum dose in 24 hours must not be exceeded for that age group). Ibuprofen (Junior Nurofen) is contra-indicated in children with asthma and therefore should not be given.

(5) Check with parents whether they have previously had the medication and, if so, were there any problems.

(6) Check expiry or use by date on medication.

(7) All medication should be given under supervision of appropriate adult, and in the first case our Paediatric First Aider.

(8) Details of treatment given to be recorded; giving dose, reason, date and time in the child's treatment folder as soon as it has been administered

(9) All over the counter medicines must be kept securely locked and out of reach of children; over the counter medicines used are: Calpol, Paracetamol Suspension, Ibuprofen for children, Arnicare cream, Anthisan cream.

(10) Parents (including of EYFS children) will be informed of time and dose of medication given on collection or via telephone/email.

## Annex E – Administration of Medication Policy

1. **Aim.** To ensure the correct child receives the correct dosage of medication at the correct time.

2. **Prescription Only Medication (POM).** These are medications prescribed by a GP, Dentist, or other NHS medical professional) Where a course is prescribed, this should be followed through to the end of the course, unless otherwise instructed. (E.g. Antibiotics/ Steroid inhalers).

A. PROCESS.

(1) Establish with School Nurse or Boarding parents the correct dosage and timings as well also reason for medication.

(2) Complete 'administration of medicines in school' form which parents sign.

(3) POM should be in the container as dispensed by the pharmacist or dental practice.

(4) Do not accept or give medications with another person's name on it e.g. brothers or sisters.

(5) Check storage instruction as may need to be stored in a fridge.

(6) Ask the child their name even if you know the child well. Recheck dosage and child's name and expiry date.

(7) **Give the medication only if you are satisfied that all the criteria are correct (i.e. person, time and dosage) if in any doubt do not give – but seek immediate advice from a member of surgery. Check that the pupil has not already been administered the dose by another member of staff earlier, or that parents have not already given 'medicine' at home, for day pupils.**

(8) Document dosage/time and sign medication form. Once course is completed this form will go into the child's record.

3. **Administration of Over the Counter Medication (OTC) or Homely remedies**. To ensure correct medication is given to a child safely and correctly for specific symptoms or illness. Often these medications are for 'ad hoc' symptom relief and do not require ongoing treatment. There is a protocol for each OTC in surgery displayed on the inside door of the drugs cupboard.

a. **Process**.

(1) Get a clear history from the child and ideally the parent to establish the health need and if medication is required.
(2) Check that the child does not have any contra-indications e.g. asthma, renal failure, not to take ibuprofen. (**These details are noted on the pupil's folder**).

(3) Check if the child has any allergies.
(4) Check medical records to see history and to check for any medication given recently.
(5) Ensure the correct dose is given at the correct time and that not more than the allowed dose is given over a 24 hour period.
(6) Document dosage and time and signature in child's records.
(7) School Nurse to review notes and pupils who require OTC medication for more than 2 days.
(8) Contact parents and/or arrange medical review as required.

4. **Storage and disposal of Medication.** All medications at the Manor House are locked in a cupboard or stored in the locked fridge.

5. At Swanbourne House School, pupils are deemed NOT competent to hold and administer their own medication. However, there are exceptions to this, e.g. Ventolin inhalers for asthmatics, insulin for diabetics and epipens for allergy sufferers. In these cases, pupils are assessed as to their ability to assess when they require medication and when to seek help from a member of staff if they are not responding to their medication.

6. Any member of boarding staff who has given medication following this policy (e.g. night time) hands over details when the Nurse comes on duty. There is a book in surgery for documenting out of hours patients. All mediction given will be logged on Isams and the School Nurse informed.

7. All medication which is out of date, no longer required, or not collected by parents after an agreed time, is disposed of via Lloyds pharmacy in Winslow, or the dispensary at Swan Practice, Buckingham. Sharps Bins are given to the GP surgery to dispose of. All Stock is checked termly, replenished and disposed of as necessary.

8. Controlled Drugs that are given back to the pupil's parent/guardian need to be signed out of the controlled drugs register book by whoever is collecting them with a date and time and also signed by a witness such as the School Nurse.

# **Annex F – Asthma Policy** (Reference D refers)

1. **What is Asthma?** On average 3 children in any one class suffer from asthma; 1.1m children in the UK are currently receiving treatment for asthma. Asthma is a condition that affects the airways – the small tubes that carry air in and out of the lungs.

2. When a person with asthma comes into contact with something that irritates their airways (an asthma trigger), the muscles around the walls of the airways tighten so that the airways become narrower and the lining of the airways becomes inflamed and starts to swell. Sometimes sticky mucus or phlegm builds up which can further narrow the airways.

3. All these reactions cause the airways to become narrower and irritated - making it difficult to breath and leading to symptoms of asthma.

4. From 1st October 2014 the Human Medicines (Amendment) (No.2) Regulations 2014 allowed schools to purchase salbutamol inhalers without prescription for use in emergencies. Salbutamol is a relatively safe medicine, particularly if inhaled, but medicines can have some adverse effects and those of inhaled salbutamol are well known, tend to be mild and temporary and are not likely to cause serious harm.

   a. *Asthma Medicines.* The school recognises that pupils diagnosed with asthma need immediate access to reliever inhaler at all times. All children with this diagnosis should have an inhaler in their sports bag and a spare one in surgery for emergencies.

   b. **The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.**

   c. **The emergency inhaler can be used if the pupil's prescribed inhaler is not available (for example because it's broken or empty).**

**A child may be prescribed an inhaler for their asthma which contains an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhaler is not accessible – it will still help to relieve their asthma and could save their life.**

   d. **The Emergency Kit**. An emergency asthma inhaler kit should contain:

- A salbutamol metered dose inhaler
- At least two plastic spacers compatible with the inhaler
- Instructions on using the inhaler and spacer
- Instructions on cleaning and storing the inhaler
- Manufacturer's information

- A checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded
- A note on the arrangements for replacing the inhaler and spacers
- A list of children permitted to use the emergency inhaler as detailed in their individual healthcare plan
- A record of administration of the emergency inhaler

e. **Staff Responsibilities**. The School Nurse is the named member of staff responsible for overseeing the asthma protocol and use of emergency inhalers, her responsibilities include:

- Delivering staff training
- Checking on a monthly basis that the emergency inhalers and spacers are present and in working order, and have sufficient number of doses available
- Ensuring replacement inhalers are procured when expiry dates approach
- Ensuring replacement spacers are available following use
- Ensuring the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or that replacements are available if necessary
- Ensuring the emergency inhalers are stored at the appropriate temperature and in accordance with manufacturers guidelines – usually <30°C
- Ensuring the emergency inhaler is kept separate from a child's own inhaler and clearly labelled to avoid confusion
- Ensuring correct disposal of used emergency inhalers and spacers
- Maintaining an up to date, easy to access asthma register of children that provides the ability for a quick check by staff of children with asthma, that parental consent for the use of the emergency inhaler has been given and a photo of each child (parental consents should be updated regularly – ideally annually)

f. **Staff Training**. All staff should be trained to:

- Recognise the symptoms of an asthma attack, and how to distinguish them from other conditions with similar symptoms
- Recognising an asthma attack
- Recognising when emergency action is required
- Be aware of the school's asthma policy
- Be aware of children on the asthma register
- Know how to access the inhaler
- Making appropriate records of asthma attacks

g. **Emergency Inhaler Kit Locations**. Emergency inhaler kits are located as follows:

- Main Reception
- Pavilion
- Surgery
- Manor House

- Changing rooms

**5.** **Asthma Triggers.** A trigger is anything that irritates the airways and causes asthma symptoms. Everybody's asthma is different and everyone will have different triggers, most have several. It is important that children with asthma get to know their own triggers and try and stay away or take precautions.

a. **Common Triggers**:

- viral infections
- house dust mites
- pollen
- cigarette smoke
- furry animals
- feathered animals
- pollution
- laughter
- excitement
- stress
- exercise
- grass

**B.** **COMMON SIGNS OF AN ASTHMA ATTACK.**

- Persistent coughing
- Shortness of breath
- A wheezing sound coming from the chest (when at rest)
- Tightness in chest
- Difficulty in speaking in full sentences. Some children will go very quiet
- Sometimes young children will express feeling tight in the chest as tummy ache
- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

**6.** **What to do in the event of an asthma attack?**

- Keep calm, reassure the child and send for the School Nurse
- Encourage the child or young person to sit up and slightly forward – do not hug or lie them down
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- If there is no immediate improvement, continue to give two puffs at a time every two minutes, up to a maximum of ten puffs
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
- If the child does not feel better or you are worried at ANYTIME before you reach 10 puffs, **call 999 for an ambulance**

- If an ambulance doesn't arrive in 10 minutes give another 10 puffs in the same way

**a. How to use an inhaler (best used via spacer)**

- Remove cap and shake inhaler
- Breathe out gently
- Put mouthpiece in mouth and as you begin to breathe in, which should be tidal/normal breathing, press canister down and continue to inhale steadily and deeply
- For a second dose wait for approximately 30 seconds before repeating previous steps

**b. How to use an inhaler with small spacer.**

- Remove caps from inhaler and spacer. Shake inhaler and insert into back of spacer
- Breathe out gently.
- Place mouthpiece of spacer in mouth
- Press inhaler canister once to release a dose of the medicine
- Take a deep, slow breath in. If you hear a whistling sound, you are breathing in too quickly
- Hold breath for about 10 seconds or as long as is comfortable
- Remove spacer and breathe out
- To take another dose, wait 30 seconds then repeat steps 1-6
- Ensure tight clothing is loosened
- **Reassure the child**

**6.** Surgery can be accessed by all staff in an emergency. All inhalers are kept in the class room by the teachers. All school staff will let pupils take their own medicine when they need to.

a. All inhalers and medications should be signed in and out of the medication book to enable tracking of all medication held in surgery.

b. All inhalers should be clearly labelled and the expiry dates checked every half term.

c. All Aero chambers and Spacers should be clearly labelled and stored with the inhalers. If issued to pupils, aero chambers and spacers should only be used by the named person and washed regularly.

d. Reliever inhaler is usually **blue**, taken at the first sign of attack. All first aid kits include a reliever inhaler and small aero chamber (spacer).

e. Preventer inhaler is usually **brown**, sometimes white or purple. These are taken in the morning and evening.

**7. Record Keeping.** The school keeps records of all pupils with asthma and the medicines they take. When the child joins the school or moves up to the Middle and Upper School a medical questionnaire is sent out to parents. If the child is noted to have asthma then more information is asked for, initially by telephone call, followed up by a request for a copy of "My Asthma Plan" or a IHCP to be completed.

**8.** Asthma care plans are requested for those pupils who have mild asthma. In addition a "My Asthma plan" is completed for those pupils that have moderate to severe asthma, that are on a preventer and possibly been hospitalised before due to asthma. Care plans need to be reviewed on a yearly basis by the school nurse and parent/carers. A central asthma register is kept and is available to all staff on the central notice board in the staff room, in all emergency inhaler kits and in surgery.

**9.** **Exercise and Activity - PE and Games.** The school ensures that the whole school environment, including the physical, social, sporting and educational environment, is favourable to pupils with asthma. Taking part in sports, games and activities is an essential part of school life for all pupils. All staff know which children in their class have asthma and all PE teachers at the school are aware of which pupils have asthma from the schools asthma register. For games teachers to be aware of pupils that have asthma, that are going on an "away" school match and to ensure that those pupils have their inhaler and spacer with them. Pupils are encouraged to participate fully in all PE lessons. PE teachers will remind pupils whose asthma is triggered by exercise or cold in the winter months to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. All pupils need to take their inhaler down to the lesson site with them and are encouraged to use them if need be. All PE, games coaches and classroom teachers are aware of what to do in an asthma attack and received training from a school nurse, who has asthma training. Classroom teachers follow the same principles as described above for games and activities involving physical activity.

**10.** **Additional Roles and Responsibilities.** The school will work in partnership with all interested parties including the schools governing body, all school staff, school nurse, parents/carer's, employers of school staff, doctors and nurse and pupils to ensure that the policy is planned, implemented and maintained successfully.

**A.** **ALL SCHOOL STAFF HAVE A RESPONSIBILITY TO:**

- Understand the school's asthma policy
- Know which pupils they come into contact with have asthma
- Know what to do in an asthma attack
- Allow pupils immediate access to their reliever inhaler
- Know where the emergency asthma inhaler kits are located
- Inform School Nurse and parents/carer's if child has an asthma attack
- Inform school nurse and parent/carer's if pupils are taking more reliever inhaler than they normally would
- Ensure that pupils have their asthma medication with them if they are going out of school on a school trip
- Ensure pupils that have been unwell catch up on missed school work
- Be aware that pupils may be tired due to night time symptoms
- Keeps an eye out for pupils with asthma experiencing bullying
- Liaise with school nurse, parents/carer's, SENCO and head of department if pupil is falling behind because of their asthma
- To notify school nurse if they require further training

**B.** **PE TEACHERS.** PE teachers have a responsibility to:

- Understand asthma and the impact it can have on pupils. Pupils with asthma should not be forced to take part in activity if they feel unwell. They should also not be excluded from activities that they wish to take part in if their asthma is well controlled
- Ensure pupils have their reliever inhaler with them during activity or exercise and are able to take it when needed
- If a pupil has asthma symptoms while exercising, allow them to stop, take their reliever inhaler and as soon as they feel better to return to their activity (most pupils with asthma should wait at least 5 minutes). If symptoms are getting worse or there is no relief from the inhaler then to send someone to fetch school nurse. Do not send the asthmatic pupil
- Remind pupils with asthma whose symptoms are triggered by exercise to use their inhaler before getting changed (10-15 minutes before activity)
- Ensure pupils with asthma always warm up and down thoroughly
- Ensure when going on away matches that the pupil has their inhaler with them and the 1st aid match kit is taken as it contains a spacer if needed

**C.** **SCHOOL NURSE.** School Nurse has a responsibility to:

- To work with the teachers in planning and implementing pupil education on asthma in PHSE and group sessions as needed
- Organise health promotion within the school to raise awareness of asthma in schools
- To review medical questionnaire on all new pupils and flag up those with diagnosed asthma and asthma symptoms
- To work with parents/carers to complete the school asthma cards and ensure that all pupils have a personal asthma action plan
- Liaise with parents to ensure continuity of care between school and home with regards to asthma management, recognising triggers and use of inhalers
- To ensure that all pupils with asthma have their medical notes clearly labelled with a blue dot label to indicate that they suffer with asthma
- Ensure that pupils know how to use their asthma inhaler (and Spacer) effectively
- To ensure the boarders with asthma are regularly monitored with regards to asthma medication and peak flows and all full and weekly boarder have a 6 monthly review with the Doctor or School Nurse regarding their asthma
- Communicate with school staff if a pupil in their care has severe asthma symptoms (with consent of the child and parent/carer's)
- Offer the parents and child a copy of their personal "My Asthma Plan"

**D.** **PUPILS.** Pupils have a responsibility to:

- Treat other pupils with and without asthma fairly
- Let any pupil having an asthma attack have their reliever inhaler (usually blue) and ensure a member of staff is called
- Tell their parents/carers, teachers, PE teachers and school nurse when they are not feeling very well
- Treat asthma medicines with respect and not let their friend use them
- Keep a reliever inhaler (usually blue) with them at all times
- If borrowed the spare inhaler from surgery to return at home time
- To know how to take their own asthma medicines
- To know to come to surgery immediately if reliever medication is not helping

- To know their own asthma triggers and to avoid them or prevent an asthma attack, by using their reliever inhaler

**E.** **PARENTS/CARERS.** Parent/carers have a responsibility to:

- Inform the School Nurse on the child's admission to the school, (via a medical questionnaire) that the child has asthma
- Sign the medical questionnaire form to allow the emergency inhaler to be used if needed
- Inform the school nurse if a new diagnosis of asthma is made or the child has asthma symptoms
- Ensure the school has an up to date asthma card for their child
- Read, sign and return their child's personal asthma action plan
- Tell the school of any changes to the child's asthma medication
- Tell the school of any change in the child's asthma symptoms
- Ensure the child's asthma medication and spacer is labelled with their name
- Provide the school with a spare named reliever inhaler within its expiry date
- Keep the child at home if they are not well enough to attend school
- Ensure the child catches up with any school work they have missed
- Ensure their child has regular asthma reviews with their doctor or nurse every 6-12 months

# Annex G – Diabetes Policy

1. Children with Type 1 diabetes have the added complication of injecting, blood testing and managing hypos, which can make them feel different from their friends and classmates. Handling conversations about their diabetes should always be done sensitively. It's also important to remember that children with Type 1 diabetes are not all the same; the way one child manages their diabetes will be different to another. Every child with diabetes must have an Individual Health Care Plan (IHCP) developed by the child (where appropriate), their parent, a Paediatric Diabetes Specialist Nurse (PDSN) and appropriate School staff. This plan will detail the child's individual care needs.

2. **What is Type 1 diabetes?** Type 1 diabetes develops when the body cannot make insulin to manage the levels of glucose in the blood properly, allowing too much glucose to build up. Type 1 diabetes usually develops before 40 years old, and is the most common type of diabetes found in children and young people

3. **Injecting at School.** Pupils who need to inject at school will need to bring in their insulin and injecting equipment. In most cases the equipment will be an insulin 'pen' device rather than a syringe. Some children may want a private area where they can take their injections, others may be happy to inject in public. Both situations should be allowed. Children might need help with injecting, especially if they're younger, newly diagnosed or have learning difficulties. Their parent, carer or PDSN will be able to explain the help they need, demonstrate how the equipment is used and tell you how the pen and insulin should be stored.

    a. Multiple Daily Injections (MDI). MDI can control blood glucose levels better than twice daily injections. Most children are now started on MDI from diagnosis. Children taking MDI will need an injection with each meal as well as one at bedtime and/ or in the morning. This means they'll need to have an injection at lunchtime, and perhaps at other times of the school day too.

    b. Two injections a day. Children who take two injections a day usually take them at breakfast and evening meal time, and so won't usually need to inject during the school day. This is less common nowadays.

    c. Insulin pumps at school. Children who use an insulin pump will need to give extra insulin via the pump when they eat or if their blood glucose levels are high. This is done by pressing a combination of buttons. Again, children might need help with this. Their parent, carer or PDSN can teach school staff how to give insulin via the pump and how to look after the pump at school.

4. **Eating.** No food is off limits to a child with Type 1 diabetes, but food and drink choices can affect a child's diabetes management.

    a. **Food**. Children with diabetes should follow the same diet that's recommended for all children – one that's low in fat (for older children), salt and sugar and includes five portions of fruit and veg a day. Too many sweets and chocolates are not good for anyone, so they should be a treat rather than a regular snack. Diabetic foods are not

recommended because they still affect blood glucose levels, can have a laxative effect and are expensive.

b. **Snacks**. Children who take insulin twice a day and younger children (no matter how they take insulin) may need snacks between meals. Snacks may need to be eaten during lessons and the choice of snack will depend on the individual child, but could be:

- a portion of fruit
- an individual mini pack of dried fruit
- a cereal bar
- a small roll or sandwich
- biscuits

c. **Older Children**. Older children who take insulin with meals or who are on a pump may not need snacks between meals. The child's parent, carer or PDSN will advise on whether snacks are needed and when, and the best type of snack to be taken.

## 5. Highs and Lows.

a. **Hypoglycaemia (hypo).** Hypoglycaemia happens when blood glucose levels fall too low (below 4mmol/l). Most children and families will call it a 'hypo'. You need to be aware that children with diabetes are likely to have hypos from time to time and they can come on very quickly. Sometimes there's no obvious cause, but usually it's because the child:

- has had too much insulin
- has not had enough carbohydrate food
- has been more active than usual

(1) How to recognise a hypo. Most children will have warning signs of a hypo. These warning signs can include:

- feeling shaky
- sweating
- hunger
- tiredness
- blurred vision
- lack of concentration
- headaches
- feeling tearful, stroppy or moody
- going pale

Symptoms can be different for each child and the child's parent or carer can tell you what their child's specific warning signs are. They will also be listed in the child's IHCP.

(2) Treating a hypo.

Hypos must be treated quickly. Left untreated, the blood glucose level will continue to fall and the child could become unconscious or have a seizure. Some children will know when they are going hypo and can treat it themselves, but others, especially if they're younger, newly diagnosed or have learning difficulties, might need help. A child should not be left alone during a hypo or be made to go and get the treatment themselves. Recovery treatment must be brought to the child. In the event of a child having a hypo, here's what to do:

i. If a child's blood glucose levels are too high or too low while at school, they might start to feel unwell. Some children with diabetes may have more frequent absences because of their condition. Things to be aware of and look out for:

- Check the child's blood glucose level (when possible)
- If too low-
  - Immediately give them something sugary to eat or drink, like 3x jelly babies, 4x fruit pastilles, 200mls orange juice. [15-20 grams of sugary foods/drinks]
- Check the blood glucose level again in another 20–30 minutes to make sure that they have returned to normal.
- Some children will need a snack after treating a hypo, such as a piece of fruit, biscuits, cereal bar, small sandwich or the next meal if it's due*. The child's parent, carer or PDSN will tell you if they need a follow-on snack.
- Once a hypo has been treated and the blood glucose has returned to a normal level there is no reason why the child can't continue with whatever they were doing. However, it can take up to 45 minutes for a child to fully recover.
- Children should have easy access to their hypo treatments and should be allowed to eat or drink whenever they need to, to prevent or treat a hypo.

Ii. **Unconsciousness**. In the unlikely event of a child losing consciousness, **do not give them anything by mouth**. Place them in the recovery position (lying on their side with the head tilted back). Call an ambulance, tell them the child has Type 1 diabetes and then contact their parent or carer.

- All parents have an emergency injection of glucagon [a hormone that raises blood glucose levels], which can be given if a child becomes unconscious, and in some cases this will be available in school.

b. **Hyperglycaemia (hyper).** Hyperglycaemia happens when blood glucose levels rise too high. Most children and families will call it a 'hyper'. All children are likely to have high blood glucose levels sometimes and they might happen because the child:

- has missed an insulin dose or hasn't taken enough insulin

- has had a lot of sugary or starchy food
- has over-treated a hypo
- is stressed
- is unwell
- has a problem with their pump

Children on pumps will need to treat high blood glucose levels more quickly.

**6. School Life.**

a. **Physical Activity**. Diabetes should not stop children from enjoying any kind of physical activity, or being selected to represent your school in sports teams. But children with diabetes will need to plan for physical activity, which includes checking their blood glucose levels carefully and making sure they drink enough fluids. All forms of activity use up glucose. This can mean that a child's blood glucose level can fall too low and they'll have a hypo (see highs and lows section). Also, if their blood glucose is high before getting active, physical activity may make it rise even higher. The way a child prepares for activity will vary depending on:

- when they last injected their insulin
- the type of physical activity they'll be doing
- the timing of the activity and how long it will last
- when they last ate
- their blood glucose level
- So they may need to:
    - have an extra snack before/during/after physical activity
    - alter their insulin dose
    - inject in a particular place on their body

The child's parent, carer, PDSN or dietitian will be able to tell you about the specific preparation required, and this will also be included in the child's IHCP.

b. **Day trips**. Depending on what's planned for the trip, you might not need to make any adjustments to the child's usual school routine. Things to take on a trip include:

- insulin and injection kit, for a lunchtime injection or in case of any delays over their usual injection time
- blood testing kit
- hypo treatments (see highs and lows section)
- pump supplies (if appropriate)
- extra food or snacks in case of delays
- emergency contact numbers
- IHCP must go with the child

c. **Overnight stays**. When staying overnight on a school trip, a child who injects will need to take insulin injections and test their blood glucose levels (which may include testing at night), even if these are not usually done in school. If the child can't do their own injections, manage their pump or test their blood glucose levels, they'll need to

be done by a trained member of staff. School staff should meet with the child's parent, carer and PDSN well in advance of the trip to discuss what help is required and who will assist the child. A copy of the IHCP must go with the child.

# Annex H – Epilepsy Policy

1. The School recognises that epilepsy is a condition which can affect pupils. First aiders should have a clear understanding of what to do in the event of a seizure. The School works in partnership with the School Nurse and parents to provide a continuation of care for those pupils who suffer from the condition. Staff are informed each year of the pupils at the school who have epilepsy. Copies of individualised health care plans (IHCP) are available for staff to inspect at the Surgery.

2. **Epilepsy**. Epilepsy is a tendency to brief disruption in the normal electrochemical activity of the brain, which can affect people of all ages, backgrounds and levels of intelligence. It is not a disease or an illness, but may be a symptom of some physical disorder. However, its cause, especially in the young, may have no precise medical explanation.

3. **Tonic Clonic Seizure (Grand Mal)**. The Pupil may make a strange cry and fall suddenly. Muscles first stiffen and then relax and jerking and convulsive movements begin which can be quite vigorous. Saliva may appear around the mouth and the pupil may bite their tongue. They can also be incontinent. Ensure the safety of the pupil and gently move them away from any dangers such as banging their head on a wall. Speak calmly to the pupil and stay with them until the seizure has passed.

4. **Complex partial seizures**. These occur when only a portion of the brain is affected by excessive electrical discharge. There may be involuntary movements such as twitching, plucking at clothing or lip smacking. The pupil may appear conscious but be unable to speak or respond during this form of seizure. Ensure the safety of the pupil and gently move them away from any dangers. Speak calmly to the pupil and stay with them until the seizure has passed.

5. **Absence (Petit Mal).** This can easily pass unnoticed. The pupil may appear to daydream or stare blankly. There are very few signs that a pupil is in seizure. These types of episodes, if frequent, can lead to serious learning difficulties as the pupil will not be receiving any visual or aural messages during those few seconds. Therefore it is important to be understanding, note any probable episodes, check with the pupil that they have understood what has happened and inform parents. Teachers can play an important role in recognising a seizure, recording changes in behavioural patterns and frequency.

6. **Procedure - Total seizure, tonic clonic (Grand Mal)**.

**KEEP CALM** – pupils will tend to follow your example. Let the seizure follow its own course; it cannot be stopped or altered.

Serious symptoms

- Cold, clammy skin
- Blue-grey tinge around lips

- Weakness/dizziness
- Rapid shallow breathing

Progressing further

- Restlessness
- Aggressiveness
- Gasping for air
- Unconsciousness

Treatment

- Ask the other pupils to leave the room where possible and ask a responsible pupil to fetch a School Nurse/first aider for assistance
- Note the time of the seizure
- Protect the pupil from harm. Never move the pupil whilst convulsing unless they are in immediate danger. If possible move objects that may cause injury away from the immediate area
- When convulsions have ceased place the pupil on their side – this does not have to be the recovery position but just so that the tongue can fall forward and excessive saliva can drain out of the mouth
- Support the pupils head and stay away with the pupil until completely recovered
- Remove to the Surgery when safe to do so
- A School Nurse/first aider should then make a full assessment of the seizure and note any injuries that may have been sustained
- Allow the pupil to rest and sleep following the seizure as this may be the first in a cluster of seizures. Ensure they remain on their side
- Inform parents and, if a day pupil arrange for collection
- If the fit last longer than 5 minutes, call an ambulance immediately, it is very important the pupil is assessed at the hospital. A pupil experiencing a first seizure or cluster **MUST** also be sent to hospital
- If the ambulance is summoned, then report the seizure in as much detail as you can, especially how long it has lasted
- In the case of a day pupil a member of staff should accompany the pupil in the ambulance to hospital and stay with them until the parent/s arrive. In the case of a boarding pupil a member of the boarding house staff should accompany the pupil to hospital

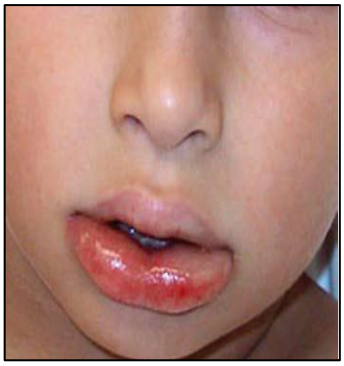
# Annex I – Anaphylaxis Policy (Allergies)

## 1. Anaphylaxis

Food allergy is common, affecting 2.3% of 11 to 15 year olds, and evidence suggests that the number of severe food allergic reactions is increasing. In the UK there were 48 deaths from food allergy between 1999 and 2006 with peanut and tree nut allergy accounting for the majority of deaths. Although a previous history of anaphylaxis, asthma and peanut allergy have been identified as risk factors for anaphylaxis, there is no reliable way of predicting who will have a life-threatening reaction. Teenagers are at particular risk with the peak incidence of deaths from anaphylaxis associated with peanut and tree nut allergy occurring in the 15 to 24 age group.

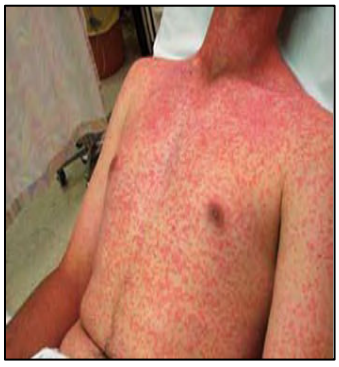
Anaphylaxis is a severe and potentially life-threatening allergic reaction at the extreme end of the allergic spectrum. Anaphylaxis may occur within minutes of exposure to the allergen, although sometimes it can take hours. It can be life-threatening if not treated quickly with adrenaline. Any allergic reaction, including anaphylaxis, occurs because the body's immune system reacts inappropriately in response to the presence of a substance that it perceives as a threat. Anaphylaxis can be accompanied by shock (known as anaphylactic shock): this is the most extreme form of an allergic reaction. Common triggers of anaphylaxis include:

- Peanuts and tree nuts – peanut allergy and tree nut allergy frequently cause severe reactions and for that reason have received widespread publicity. **For severe reactions these symptoms normally occur 10-15 minutes after food is eaten**
- Other foods (e.g. dairy products, egg, fish, shellfish, Kiwi fruit and Soya)
- Insect stings (bees, wasps, hornets)
- Latex (gloves and PPE)
- Drugs (illegal and prescription)



Anaphylaxis has a whole range of symptoms. Any of the following may be present, although most people with anaphylaxis would not necessarily experience all of these:

- Generalised flushing of the skin anywhere on the body
- Nettle rash (hives) anywhere on the body
- Difficulty in swallowing or speaking
- Swelling of throat and mouth
- Alterations in heart rate
- Severe asthma symptoms (see asthma section for more details)
- Abdominal pain, nausea and vomiting
- Sense of impending doom



- Sudden feeling of weakness (due to a drop in blood pressure)
- Collapse and unconsciousness

2. **Administration of Medicine.**
   Medicines legislation restricts the administration of injectable medicines. Unless self administered, they may only be administered by or in accordance with the instructions of a doctor. However, in the case of adrenaline there is an exemption to this restriction which means in an emergency, a suitably trained lay person is permitted to administer it by injection for the purpose of saving life. The use of an Epipen to treat anaphylactic shock falls into this category. Therefore, first aiders may administer an Epipen if they are dealing with a life threatening emergency in a casualty who has been prescribed and is in possession of an Epipen and where the first aider is trained to use it.

   When anaphylactic shock symptoms are are evident, it is vital when the patient is feeling faint or weak, looking pale, or beginning to go floppy that they lay down with their legs raised. **They should not stand up – key is to reduce their heart rate as exertion exacerbates the reaction.** High pollen counts can also adversely affect allergic reactions.

If there are also signs of vomiting, the patient should also be placed on their side to avoid choking.

If they are having difficulty breathing caused by asthma symptoms and/or by swelling of the airways, they are likely to feel more comfortable sitting up.

## The key action is that aid comes to the patient

One person must take charge - ask other staff to assist, particularly with making phone calls, and ensure that the following are undertaken

- Ring 999 immediately to get the ambulance on the way
- Ring or radio Surgery 216 – state what has happened so that they can bring the appropriate medication to the location
- Use their prescribed adrenaline device (named for the person) or for pupils where both a medical authorisation and parental consent emergency AAIs may be used
- Ensure that the Grounds Team/Bursar is aware that an ambulance is coming onto site
- Stay in the immediate area to assist/or direct the Emergency Services

**IF SURGERY IS UNMANNED EVERY CHILD HAS A NAMED EPIPEN IN A CLEARLY LABELLED PLASTIC BOX - YOU MUST TAKE THE WHOLE BOX LABELLED FOR THE CORRECT CHILD**

**3.0 Additional Adrenaline Auto-Injectors (AAIs) in Schools (Reference C refers).** The legislation changed from 1st October 2017 (Human Medicines amendment Regulations 2017) to allow schools to buy additional adrenaline auto-injectors without prescription for use in case of emergency for children who are at risk of anaphylaxis and whose own device is not available

or not working (broken or out of date). There are strict rules governing their usage, the guidance is non-statutory:

- The principles of safe usage of AAI(s) are universal and based on recognised good practice
- AAIs must not be locked away in a cupboard or an office where access is restricted – they are to be kept in a suitably safe central location and located not more than 5 minutes away from where they are needed
- The spare AAI devices held in the clearly labelled Emergency Kit should be kept separate from any pupil's own prescribed AAI, which may be stored nearby
- AAIs are available in different doses
    - For children under 6 years – a dose of 150 microgram (0.15 milligram) of adrenaline is used
    - For children aged 6-12 years - a dose of 300 microgram (0.3 milligram) of adrenaline is used
    - For teenagers age 12+ years - a dose of 300 or 500 microgram (0.3 milligram) of adrenaline can be used
- Only for pupils where both a medical authorisation and parental consent have been provided for the spare AAI to be used on them – **they are not for general use** – this includes children at risk of anaphylaxis who have been provided with a medical plan confirming this, but who have not been prescribed an AAI (for this specific consent from a healthcare professional and parent/guardian must be obtained)
- The spare AAIs can be used instead of pupil's prescribed AAI(s), if these can not be administered correctly, without delay
- Only qualified medical professions (Doctor or Nurse) can administer an AAI **in addition** to the normal prescribed dosage contained in a patient's care plan

3.1 **Location of AAIs**. The AAIs will be kept in specialised containers located as follows:

- Main reception
- Lower School in the medical cabinet in the Manor House
- Surgery – on the wall outside
- 
- Pavilion – on an as required basis when match teas are served on the bottom pitches

3.2 **The Emergency Anaphylaxis Kit**. The AAIs will be stored in separate and clearly labelled boxes that have been bought for this purpose – they are to be kept separate from any pupil's own prescribed AAI which might also be stored nearby. These kits will be kept alongside emergency asthma inhaler kits and contain:

- 1 or more AAi(s) – clearly labelled as a spare
- Instructions on how to use the devices
- Storage instructions
- Manufacturer's information
- A checklist of injectors, identified by batch number and expiry date with monthly checks recorded

- A note on the arrangements for replacing the injectors
- A list of pupils to whom the AAI can be administered
- An administration record

3.3 **Staff with Responsibility**. The School Nurse is the nominated member of staff responsible person for maintaining the spare anaphylaxis kits. Her responsibilities include:

- Overseeing the protocol for the use of spare AAI(s), monitoring its implementation and maintaining the allergy register
- Checking and recording on a monthly basis the AAIs are present in each kit
- Ensuring the Emergency Anaphylaxis kits contain the right and completed paperwork as set out in 4.2
- Ensuring replacement AAIs are obtained when expiry dates approach
- Ensuring staff are appropriately trained to administer the AAIs
- The correct disposal of used or out of date AAIs

3.4 **Register**. The register should be relatively succinct, should be displayed throughout the site and include:

- Name of pupil
- Known allergens and risk factors for anaphylaxis
- Whether a pupil has been prescribed AAI(s) and if so what type and dose
- Where a pupil has been prescribed an AAI whether parental consent has been given for use of the spare AAI which may be different to the personal AAI prescribed for the pupil
- A photograph of each pupil to allow a visual check to be made – this requires parental consent

3.5 **All Staff**. All staff are expected to:

- Understand the causes of anaphylaxis
- Understand the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild symptoms
- Appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective)
- Be aware of the anaphylaxis policy
- Be aware to check if a pupil is on a register
- Be aware of how to access the AAI
- Be aware who the designated member of staff is, the policy and how to access their help

3.6 **Staff Training**. Staff should be trained to:

- Recognise the range and symptoms of severe allergic reactions
- Respond appropriately to a request for help from another member of staff
- Recognise when emergency action is necessary
- Administer AAIs according to the manufacturer's instructions
- Make appropriate records of allergic reactions

## Annex J – Hygiene Procedures for dealing with Spillage of Body Fluids

1. **Hazards.** Body fluids are a source of both blood borne infections and micro-organisms (bacteria, viruses and fungi). The main risk is infection following hand to mouth/nose/eye contact. There is also a risk of infection via broken skin (cuts or scratches).

2. **Coughing and Sneezing.** Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

3. **Cleaning of the Environment.** Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, COSHH and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

4. **Cleaning of blood and body fluid spillages.** All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

5. **Laundry.** Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

6. **Procedures.** The first aider/school nurse should take the following precautions to avoid risk of infection.
    - Ensure a good standard of ventilation
    - Wear suitable personal protective equipment such as disposable gloves and apron when dealing with blood or other bodily fluids
    - Use sterile wipes and clean water to cleanse wound
    - Cover any cuts and grazes with a water proof plaster
    - Use the spillage kits located in the Middle and Upper Surgery and Lower School to deal with bodily fluids and scrape up residues into a closable container for safe disposal
    - Bag up contaminated material that needs laundry or disposal
    - Wash surfaces with detergent before disinfecting. Infection control in health care settings we would also consider a deep clean after vomit/blood (high risk of infection compared with urine). The General Services Manager should be contacted to ensure the affected area is deep cleaned
    - Wash hands after every procedure
    - If the first aider/ school nurse suspects that they or any other person may have been contaminated with blood or other bodily fluids, the following action should be taken:
        - Wash splashes off skin with soap and running water.
        - Wash splashes out of eye with water or saline pods (in first aid kits)
        - Report incident and take medical advice if appropriate

- Instruct all staff and pupils in the locality to wash before eating or drinking, and after touching any surface or object that might be contaminated

# Annex K – Accident/Injury Aide Memoire

1. In the event of a severe accident, the supervising member of staff is to assess the situation, decide the best course of action in order to mitigate any further injury, conduct appropriate first aid and call for the nurse. In any emergency situation, particularly one involving children, it is important to keep calm, to act logically and to consider the following points:

a. **Assess the Situation. Consider the following:**

- What happened?
- How did it happen?
- Is there any continuing **danger**?
- Is there more than one injured person – check **Response**?
- Is there **anyone immediately available** who can help?
- Do I need an ambulance?

**D**anger
**R**esponse
**S**hout for Help
**A**irway
**B**reathing
**C**irculation

b. **Think of Safety - Consider the following.**

- Do not risk injuring yourself - you can't help if you become a casualty
- Remove any source of danger from your casualty if safe to do so

c. **Treat Serious Injuries First – think Airway, Breathing, and Circulation**

- In the event of an accident where more than one person has been injured, go to the quiet casualty first - they may be unconscious
- **DO NOT MOVE** the casualty if there is a risk of significant head, neck or spinal injury, unless there is immediate danger to life
- If casualty stops breathing, commence mouth-to-mouth resuscitation immediately
- If the casualty is bleeding seriously then it must be brought under control

c. **Get Help**

- Shout for help - someone may hear you although it may not be obvious that there are people nearby
- If there is someone with you, tell them to fetch the School Nurse or another member of staff – telephone (Ext 216) or radio on channel 7/7
- If an ambulance is required than call 999
    - Arrange for staff to meet and direct the ambulance
    - Arrange for adult to accompany pupil to hospital
- Manage the emergency or incident to the best of your ability until relieved by a member of the SLT or duty team

d. **Once the Incident is stabilised**

- Communicate with a member of the SLT
- If off site, arrange for the rest of the group to return to School/safety
- Note witnesses – names and addresses. Do not discuss legal liability
- Refer any media at the scene back to the Head or Bursar
- Write down all details while fresh in memory - who/why/what/where/when
- Complete accident form
- For Lower School and EYFS one copy is placed in the child's file and the other is stapled into home & school contact book

- For Middle and Upper School the completed accident form is placed in the child's file
- Inform parents of any accidents, administration of medicine or first aid given on the same day or as soon as reasonably practicable.

## Annex L – Taking Children in an Emergency to Hospital by Car

When a child needs urgent medical attention at a hospital, the first aider/Nurse must ensure they are escorted by the most appropriate member of staff and that parents and tutors are informed and updated.

Where possible, the School Nurse should stay on the premises; however, this is not always possible and the School Nurse will need to discuss this with the Bursar, or in their absence the Head.

### Process

- Assess the child in surgery/sickbay or other place as situation necessitates. Administer first Aid. If a child cannot be fully treated at school consider where they need to be treated
- In the case of a full/weekly boarder, inform the Boarding parents who will contact the parents to make them aware of the situation
- Inform the Admin office and Head of intention i.e. what/where/who/when
- If possible, either contact parents yourself or instruct another member of Surgery staff to do so (best done in person in order to give an accurate account)
- Take school mobile with you (kept in the office) or inform the office of your mobile number (ensure that your own phone is charged and switched on)
- Children under 135cm should ideally sit in the back of the car
- If you are escorting an ill child, one member of staff will be needed to drive and another to sit in the back with the child. Take vomit bucket, tissues, old towels if necessary and child's details
- Keep office at SHS informed of progress and any likely times of return for staff and pupils
- Complete any formal reports/treatment book records, medical records