Highfields Independent School and Day Nursery

First Aid Policy

Last Reviewed:	June 2017	Approved on:	7.06.17
Committee Responsible:	Pupil and Personnel		
Approved by:	Full Govs	Next Review:	31.01.19

This policy has been written with due regard to the recommendations of the DfE within their document 'Guidance on First Aid for Schools; a Good Practice Guide.'

Who is a 'designated first aider'?

Someone holding a current first aid certificate from an organisation approved by the Health and Safety Executive (HSE).

Most members of the Highfields School teaching and non-teaching staff are qualified first-aiders. These are named in Appendix One.

First Aiders must complete a training course approved by the Health and Safety Executive, which will be renewed every three years if the First Aider wishes to continue as a volunteer.

There is at least one qualified First Aider on the School site when children are present.

At the time of writing we have 34 trained First Aiders, including five who are Paediatric First Aiders.

Who is an 'appointed person'?

Appointed persons are not always First Aiders. The school will, however, ensure that they are trained in coping with emergencies. The training will include:

- what to do in an emergency;
- cardiopulmonary resuscitation;
- first aid for the unconscious casualty;
- first aid for the wounded or bleeding.

The appointed persons at Highfields are the Headmaster, the Deputy Head, the Headmaster's P.A and the School Secretary.

The appointed persons:

- take charge when someone is injured or becomes ill;
- looks after the first-aid equipment, including restocking – this is the responsibility of the School Secretary;
- ensures that an ambulance or other professional medical help is summoned when appropriate;
- They should **NOT** give first aid treatment

An appointed person will ensure that in cases of injury or illness where a child or employee has or needs to be taken to hospital, that a relative will be informed as soon as possible. An appointed person will travel with the child or employee to hospital and will remain there until the ill / injured person's relative arrives.

The duties of a First Aider

At School, the main duties of a First Aider are to:

- give immediate help to casualties with common injuries or illnesses, and those arising from specific hazards at School;
- All first aid will be administered in a timely and competent manner;

- when necessary, ensure that an ambulance or other professional medical help is called.

N.B. Teachers' Conditions of Service and employment do not include giving first aid, although any member of staff may volunteer to undertake these tasks. However, teachers and other staff in charge of pupils are expected to use their best efforts at all times, particularly in emergencies, to secure the welfare of the pupils.

EYFS AND PAEDIATRIC FIRST AIDERS

The school ensures that at all times a member of staff with a paediatric qualification is on site and present on outings when EYFS pupils are present.

First Aid Boxes – ACCESS to First Aid Kits

First Aid boxes may be found in the following locations around School

- the School Office
- the Sports Hall
- the Kitchen
- the Nursery
- Outside the Infant classrooms
- Inside the main entrance

All first-aid containers are marked with a white cross on a green background. In School, we have first-aid pouches for Games / PE lessons, boxes which are taken on educational visits (as appropriate, and where no other first-aid facility is available), and a case for residential visits.

There is no longer a mandatory list of items for a first aid kit. ACOP includes a list of recommended items to be in the box. Also, British Standard *BS 8599-1* published in June 2011 contains recommendations about the contents of the box, including a resuscitation face shield to be used as a protective barrier when administering mouth-to-mouth resuscitation.

This suggested minimum is given with possible items added per the location and type of injury likely to be evident based on a risk assessment of need.

	Minimum for 51-100 employees
Guidance card	1
Individually wrapped sterile adhesive dressings	40
Sterile eye pads, with attachment	6
Triangular bandages **NB** *These are no longer used for the immobilisation of limb injuries*	6
Sterile coverings for serious wounds (where applicable)	6
Safety pins	12
Hypoallergenic adhesive tape to use instead of safety pins	I roll
Medium size, sterile unmedicated dressings	10
Small absorbent wound dressings for finger injuries	10
Large, sterile unmedicated dressings	6
Extra large, sterile, unmedicated dressings	6
Disposable gloves *(These should be nitrile, rather than vinyl to give more dexterity and eliminate possible latex allergies)*	2
Resuscitation face shield	1

Insurance
The employer (school governors) must ensure that insurance arrangements provide full cover for claims arising from actions of staff acting within the scope of their employment.

Training
The school will provide adequate and appropriate training for first aid staff and appropriate information for all staff to enable them to carry out their duty of care.

The governors will ensure that there are sufficient trained staff to meet statutory requirements and the assessed needs, allowing for staff who are absent or off-site.

Equal opportunities
The school will take care with the first aid provision for its disabled staff and pupils. Appropriate risk assessments will be done by the person in charge of first aid, and suitable provision will be made in liaison with the Headmaster.

Practical arrangements at the point of need;

First aid will normally be dealt with by the qualified first aiders at the scene. First Aid boxes are taken outside at break time and lunchtimes by the members of staff on duty

- If the accident happens indoors and it is appropriate / possible for the child to be moved, the child needing attention (accompanied by a friend) will be sent to the Office or, in the case of more serious incidents, to send a child to fetch one of the Appointed Persons.
- Treatment will normally be given in the Office or on the playground, in the case of incidents happening at breaktime or lunchtime.
- Hands must be washed before and after dealing with any cuts or grazes.
- The First Aider must use disposable gloves if the wound is bleeding.
- Water only will be used to clean cuts or grazes. No lotions or creams will be used.
- If necessary, the First Aider should cover the cut with a plaster or other dressing.
- The child's name, injury and treatment will be entered in the accident book (this must be done for all but the very minor scratches and bumps). The First Aider dealing with the incident should add their own name and the date.
- Accident books are held in the School Office and in the Foundation Stage Department.

N.B. A recorded incident in the Foundation Stage Department must be shown to the parent of the 'injured child', and the parent must sign to state that they have seen the record.

- Minor knocks and grazes are recorded in the Accident Book which is kept in the First Aid cupboard in the School Office.
- The member of staff who deals with the injury / applies First Aid is responsible for completing the Accident Book.
- Parents will be told of any injury or accident on the same day or as soon as reasonably practicable and any first aid treatment given.
- If a child is feeling unwell and needs to go home the parents should be contacted as soon as possible.
- Children normally stay in the Office until collected, or may return to the Form room to collect personal possessions.

Any head injury must be reported to parents immediately and usually by a member of the Office staff or the Headmaster.

Hygiene / Infection Control

The school's policy for infectious diseases is to consult the Health and Safety Executive website hse.gov.uk and follow guidelines for incubation and exclusion periods from school and advice to be given to parents.

All staff should take precautions to avoid infection and must follow basic hygiene procedures. Single-use disposable gloves should be used, particularly with incidents involving body fluids (including blood, vomit, mucus, faeces and urine).

Hands should be washed thoroughly and any wounds must be covered with a plaster (or appropriate dressing) prior to giving first aid.

Dressings and equipment which have been contaminated with blood or other body fluids must be disposed of in the yellow bags which are contained in the School's first-aid cupboard, in the School Office.

Spillages of blood, vomit, urine and excreta should be cleaned up promptly. The following general actions must be taken by the person dealing with the spill:

- Clear the immediate area of people. Hazard signs and cordoning may be necessary, according to the circumstances.
- Disposable personal protective equipment (PPE), including gloves (latex or nitrile) or equivalent and a disposable plastic apron must be worn.
- Any spilt blood or other body fluids should be cleaned up, either with disposable absorbent paper towels. Special 'flocking powder' may be used – this can be found in the Site Manager's office.
- Dispose of absorbent towels and latex gloves within a yellow bag, for the purpose, which may be found in the First Aid cupboard in the School Office.
- Ensure the area is cleansed with a suitable antiseptic solution.

Guidance on when to call an ambulance (based upon advice from St John Ambulance)

Upon being summoned in the event of an accident, the first aider/appointed person is to take charge of the first aid administration/emergency treatment commensurate with their training.

Following their assessment of the injured person, they are to administer appropriate first aid and make a balanced judgement as to whether there is a requirement to call an ambulance.

The first aider/appointed person is to always call an ambulance on the following occasions:

• In the event of a serious injury
• In the event of any significant head injury
• In the event of a period of unconsciousness
• Whenever there is the possibility of a fracture or where this is suspected
• Whenever the first aider is unsure of the severity of the injuries
• Whenever the first aider is unsure of the correct treatment

In the event of an accident involving a child, where appropriate, it is our policy to always notify parents of their child's accident if it:
• is a serious (or more than minor) injury
• requires attendance at hospital.

Our procedure for notifying parents will be to use all telephone numbers available to contact them and leave a message should the parents not be contactable.

If parents cannot be contacted and a message has been left, our policy will be tocontinue to attempt to contact the parents every hour. In the interim, we will ensurethat the qualified first aider, appointed person or another member of staff remains with the child until the parents can be contacted and arrive (as required).

If the child requires hospital treatment and the parents cannot be contacted prior to attendance, the qualified first aider/appointed person/another member of staff will accompany the child to hospital and remain with them until the parents can be contacted and arrive at the hospital.

When managing a casualty, it may be necessary to need to call for an ambulance. The steps below should be followed:

There are several numbers that can be calledto reach an ambulance**.**
From alllandlines phone 999.
From a mobile phone 112.

INSTRUCTIONS TO THE PERSON MAKING THE EMERGENCY CALL

- They will ask you what service you require. Say ambulance.
- They will ask where you are located. Be precise as possible.
- They will ask you how many casualties.

- They will ask what is wrong with casualty. Tell them what you are sure of (to avoid giving mis-information).
- They will ask if other services required.
- After you hang up you must wait with the casualty until the ambulance arrives.

Illness during the School Day

Pupils

Where a child complains of feeling ill during a lesson, if, at the teacher's discretion and the nature of the medical complaint, one of two courses of action:

1. If the child can do so, the child should be sent to the School Office, accompanied by at least one other child.
2. Depending upon the nature of the medical complaint, the teacher or teaching assistant may feel that it is more appropriate to send for the, in the first instance, a School Secretary or the Headmaster.

If a pupil 'bangs' his / her head, depending upon the severity of the 'bang' and any grazing / lumps, the parent or relative of the child must be telephoned and informed. The parent / relative should be given the option of collecting their child and taking him / her to receive medical attention.

Staff

If a member of staff becomes ill during the School day, a senior member of staff will decide if the person should be sent home and if the employee can transport themselves by their normal means.

If an employee is sent home and they travel alone, the employee should be asked to call the School to inform the Headmaster / senior member of staff of their safe arrival at home.

If the employee's illness is such that s/he is unsafe to drive home, the School will endeavour to contact a member of the employee's family.

Reporting Accidents and Record Keeping

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995), under which schools are required to report to the Health and Safety Executive (telephone 0845 300 99 23).

RIDDOR '95 means the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, which came into force on 1 April 1996. RIDDOR '95 requires the reporting of work-related accidents, diseases and dangerous occurrences. It applies to all work activities, but not to all incidents.

Reporting accidents and ill health at work is a legal requirement. The information enables the enforcing authorities to identify where and how risks arise and to investigate serious accidents. The enforcing authorities can then help and advise the School on preventive action to reduce injury, ill health and accidental loss - much of which is uninsurable.

With regards to EYFS children any serious accident, illness or injury to or death of any child whilst in the care of the school ISI will be notified and of the action taken.

The Headmaster or their representative needs to report:

· deaths
· major injuries
· accidents resulting in over 3-day injury
· diseases
· dangerous occurrences
. gas incidents

Death or major injury
If there is an accident connected with work **and**:

- an employee, child or a self-employed person working on your premises is killed or suffers a major injury (including because of physical violence); **or**
- a member of the public is killed or taken to hospital;

The School will notify the enforcing authority without delay.

Reportable major injuries are:
· fracture other than to fingers, thumbs or toes;
· amputation;
· dislocation of the shoulder, hip, knee or spine;
· loss of sight (temporary or permanent);
· chemical or hot metal burn to the eye or any penetrating injury to the eye;
· injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
· any other injury: leading to hypothermia, heat-induced illness or unconsciousness; or requiring resuscitation; or requiring admittance to hospital for more than 24 hours;
· unconsciousness caused by asphyxia or exposure to harmful substance or biological agent;

· acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
· acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

Over-three-day injury
If there is an accident connected with work (including an act of physical violence) and your employee, or a self-employed person working on your premises, suffers an over-three-day injury you must report it to the enforcing authority within ten days.

An over-3-day injury is one which is not "major" but results in the injured person being away from work OR unable to do their full range of their normal duties for more than three days.

Disease
If a doctor notifies the School that an employee suffers from a reportable work-related disease then the School must report it to the enforcing authority.

Dangerous occurrence
If something happens which does not result in a reportable injury, but which clearly could have done, then it may be a dangerous occurrence which must be reported immediately (e.g. by telephone or completing a form on the RIDDOR web site).

Reportable dangerous occurrences are:

1. collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
2. explosion, collapse or bursting of any closed vessel or associated pipework;
3. failure of any freight container in any of its load-bearing parts;
4. plant or equipment meeting overhead power lines;
5. electrical short circuit or overload causing fire or explosion;
6. any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
7. accidental release of a biological agent likely to cause severe human illness;
8. collapse or partial collapse of a scaffold over five metres high, or erected near water where there could be a risk of drowning after a fall;
9. dangerous occurrence at a pipeline;
10. failure of any load-bearing fairground equipment, or derailment or unintended collision of cars or trains;
11. a road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
12. a dangerous substance being conveyed by road is involved in a fire or released;
13. The following dangerous occurrences are reportable except in relation to offshore workplaces: unintended collapse of: any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work; any false-work;
14. explosion or fire causing suspension of normal work for over 24 hours;
15. sudden, uncontrolled release in a building of: 100 kg or more of flammable liquid; 10 kg of flammable liquid above its boiling point; 10 kg or more of flammable gas; or of 500 kg of these substances if the release is in the open air;
16. accidental release of any substance which may damage health.

Who do we report to?
All accidents, diseases and dangerous occurrences may be reported to the Incident Contact Centre. The Contact Centre was established on 1st April 2001 as a single point of contact for receiving all incidents in the UK.

Incidents must be reported by one of the following routes:

Telephone - 0845 3009923
Internet - by completing the relevant form on the RIDDOR website - http://www.riddor.gov.uk/reportanincident.html

Form -- by completing the relevant hard copy form and sending:

By Facsimile - 0845 3009924
By post to:
Incident Contact Centre
Caerphilly Business Park
Caerphilly
CF83 3GG

Keeping records
The School and its employees must keep a record of any reportable injury, disease or dangerous occurrence. This must include the date and method of reporting; the date, time and place of the event, personal details of those involved and a brief description of the nature of the event or disease. The record may be kept in any form that we wish.

Monitoring and review
The head will review the first aid needs and arrangements annually, and will ensure that the appropriate level of first aiders/appointed persons are in post, and that the appropriate standards are met.

The governing body will receive an annual report from the head and will review the policy every two years.

Headmaster's signature:

Staff First Aid Training			Updated 17.01.17	
STAFF NAME	**DEPT**	**Date Expiry**	**Date Expiry**	**Date Expiry**
ALLEN Julie	Kitchen		Jan-20	
ATKIN Emma		Jan-11	**PAEDIATRIC FA** Jun -17	
ARTHUR Debbie			Jan-20	
BARKER Helen	Volunteer	Sep-12	Jan-20	
BEAUMONT Sue	Operations		Jan-20	
BECKETT Katie	ASC		**PAEDIATRIC FA** Nov 12	**Bkd Jan 17**
COX Elizabeth		Jan-11	**PAEDIATRIC FA** Oct-16	Oct-19
COZENS Rowan	Music		Jan-20	
CROCKER Sarah		Jan-11	Jan-20	
DANYLEC Susan	Kitchen		Jan-20	
DAVIDSON Jade			Jan-20	
DAVY Shirley	ASC		**PAEDIATRIC FA** Jun -17	
DENTON Jane	Office	Nov-14	Jan-20	
DOWSE Christine	Office	Nov-14	Jan-20	
FLOCKHART Mr J	Nursery		**PAEDIATRIC FA**	Jun-18
HALLAM Shelley	Nursery			
HURST Sue	Kitchen	Nov-14	Jan-20	
KEEN Pamela		Nov-14	Jan-20	
LEWIS Rhys			Jan-20	
LING Peter	Kitchen		Jan-20	
MARTIN Gail			Jan-20	
McDONNELL Lyn		Jan-11	Jan-20	
McGIVERN Annemarie		Jan-11	Jan-20	
NICHOLSON Chelsee	Nursery			**Bkd Jan 17**
PARSONS Justin	Site Manager		Jan-20	
PATTERSON Lucy	Nursery		**PAEDIATRIC FA** Oct-16	Oct-19
PATTISON Jordan	Kitchen		Jan-20	
RANDS Jennifer	Office		Jan-20	
ROBINSON Kate			Jan-20	
RUDKIN S	Kitchen	Sep-12	**PAEDIATRIC FA** Oct-16	Oct-19
SAUNDERS Anna		Jan-11	**PAEDIATRIC FA** Sep-15	Jan-19
SHELBOURN Kim	Nursery		**PAEDIATRIC FA** Nov-15	Jan-19
SMITH Kate			Jan-20	
SMITH Steph		Jan-11	Jan-20	
STANIFORTH Cleo	Office		Jan-20	
THOMSON Richard	Head		Jan-20	
TOWN Susan			Jan-20	
TURNER Alison		Nov-14	Jan-20	
WINDLE Kirsty			Jan-20	
Alex Davy	ASC/KG			
LEAVERS				
BRYAN Georgia	ASC		**PAEDIATRIC FA** Sep-15	Jan-19

APPENDIX TWO - arrangements for pupils with particular medical conditions (for example, asthma, epilepsy, diabetes) As also contained with the School's medicine policy

COMMON CONDITIONS
PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

INTRODUCTION

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This appendix provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

From April 2004 training for first-aiders in school settings must include recognising and responding appropriately to the emergency needs of children with chronic medical conditions.

ASTHMA

What is Asthma?

1. Asthmais common and appears to be increasingly prevalent in children and young people.One in ten children have asthma in the UK.

2. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

3. However, in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines th ey should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. Ide ally this should be supported by a written asthma management plan together with regular training and support for staff.

Medicine and Control

1. There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before and after exercise**. Preventers** (brown, red / white, orange and purple inhalers, and sometimes tablets) are usually used out of school hours.

2. **Children with asthma need to have immediate access to their reliever inhalers when they need them.** A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

3. Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility

for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

4. For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the School.

5. The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

6. When a child has an attack, they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

7. It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma Management Plan (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

8. A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that, where one exists. a copy of their child's management plan is made available to the School.

9. Children with asthma should be encouraged to participate in all aspects of the School 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before and after any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

10. Reluctance to participate in physical activities should be discussed with parents, staff and the child. However, children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

11. Children with asthma may not attend School on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents.

12. All staff, particularly PE teachers, should have training or be provided with information about asthma on a regular basis. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY

What is Epilepsy?

1. Children with epilepsy can have a tendancy to have epilecticseizures that are associated with abnormal electrical activity in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

2. Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide as much information to School as possible, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure, details should be recorded and communicated to parents including:

a. any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
b. any unusual "feelings" reported by the child prior to the seizure
c. parts of the body demonstrating seizure activity e.g. limbs or facial muscles
d. the timing of the seizure – when it happened and how long it lasted
e. whether the child lost consciousness
f. whether the child was incontinent

3. This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

4. What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure. These are often referred to as 'focal epilepsy' or 'temporal lobe epilepsy.'

5. In some cases, seizures may cause the child to lose consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. There may be jerking movements as muscles relax and tighten rhythmically. During a seizure breathing, may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves. This is referred to as a 'grand mal' seizure.

6. After a seizure, a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours. This is referred to as the 'post ictal period.'

7. Another type of seizure involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such 'absence' seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

1. Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

2. Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

3. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

4. During a seizure, it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

5. An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the usual period as advised by parents
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as advised by the parents

6. Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. Health care professionals and parents should provide guidance as to when to administer it and why.

7. Training in the administration of rectal diazepam will be needed and will be arranged in consultation with the School's medical advisor. Staying with the child afterwards is important as diazepam may cause drowsiness.

8. Children and young people requiring rectal diazepam may vary in age, background and ethnicity, and may have differing levels of need, ability and communication skills. Arrangements should be made for two adults, at least one of the same gender as the child, to be present for such treatment to be administered Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.(see Intimate Care Policy)

DIABETES

What is Diabetes?

1. Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the individual's needs or the insulin is not working properly (Type 2 diabetes).

2. About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly. Individuals with Type 2 diabetes are usually treated by diet and exercise alone.

3. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

4. The diabetes of most children is controlled by injections of insulin each day. Most younger children will be once or twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at School supervision may be required, and a suitable, private place to carry it out.

5. Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

6. Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

7. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

8. Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in

charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

9. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

a. hunger
b. sweating
c. drowsiness
d. pallor
e. glazed eyes
f. shaking or trembling
g. lack of concentration
h. irritability
i. headache
j. mood changes, especially angry or aggressive behaviour

11. Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

    If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

10. An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes

- the child becomes unconscious

11. Some children may experience **hyperglycaemia**(high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

ANAPHYLAXIS

What is anaphylaxis?

1. Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

2. Common triggers include nuts, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

3. The most severe form of allergic reaction is anaphylactic shock, when the blood

pressure falls dramatically and the patient loses consciousness. Fortunately, this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma / wheezing. Any symptoms affecting the breathing are serious.

4. Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalized flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

1. The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

2. Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

3. Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. **In cases of doubt it is better to give the injection than to hold back.**

4. There should be two adrenaline devices within School for each individual; one is available within the individual's classroom and, ideally, a second is provided, which is available at all times within the Office. At all times, staff and the individuals concerned are aware of the location of their devices.

5. Where children are sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff.

6. Important issues specific to anaphylaxis to be covered within training include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

7. Once staff have agreed to administer medicine to an allergic child in an emergency, regular training sessions will be provided in consultation with the School's medical advisor. Staff should have the opportunity to practice with trainer injection devices.

8. Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. It is the responsibility of the parents to ensure that School and the catering manager is fully aware of the child's particular requirements.

9. Parents often ask for the Headmaster / Catering Manager to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

10. Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they encounter a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

11. Anaphylaxis is manageable. With sound, precautionary measures and support from the staff, school life may continue as normal for all concerned.

Signed:

R Thomson
Headmaster

Willliam Bicknell
Chair of Governors