First Aid:
Policy and Guidelines

A Whole-School policy including the EYFS

Responsible:	The School Nurse
Approved by:	Michael Matthews (Deputy Head Pastoral, DSL) and Fergus Llewellyn (Headmaster, DDSL)
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Reviewed annually or with government change.	

Introduction

1.0 This Policy is concerned with first aid provision for all pupils and staff.

1.1 The Headmaster and the Head of Finance have overall responsibility for health and safety. Day to day responsibility for implementation of the health and safety policy is delegated to the Heads of Departments and The Medical Team.

1.2 The aim of First aid is to give **prompt** safe and effective help to casualties with common injuries and those arising from specific hazards at school. At Cumnor first aid is administered in a timely and competent manner and supported by the effective implementation of the school's first aid policy. Staff know how to call an ambulance on 999 or 112 and know that this is the first thing to do if they feel a child's wellbeing is in danger or time is limited (further guidance on when to call an ambulance is provided in relation to specific conditions and situations throughout this policy).

1.3 First aid can save lives and prevent minor injuries becoming major ones. Under the Health and Safety legislation, employers must ensure that there are adequate and appropriate facilities for providing first aid in the workplace.

1.4 Registered nursing staff at Cumnor have indemnity cover under the School's public liability insurance plan providing that the care they provide does not exceed the bounds of their job description and professional competence.

Medical staff at Cumnor have a job description detailing their roles and responsibilities.

First-aiders must be competent in the administration of first aid. They must hold an up to date first aid certificate and only provide first aid in which they have been trained by a qualified first aid instructor.

Provision of first aid

There is always at least one qualified first-aider on site when children are present.

2.1 There is a fully qualified and registered nurse on site at Cumnor House between 8am and 5pm Monday to Friday. A first aider with an up to date first aid qualification covers the provision of first aid in the absence of the registered nurse.

2.2 The EYFS have a number of first-aiders trained in paediatric first aid. PFA training is renewed every three years. At least one person with a current PFA certificate is always on the premises when EYFS children are present and at least one member of staff with PFA accompanies EYFS

children on outings. The Prep school and boarding house also have members of staff who hold an Emergency First Aid at work certificate or First Aid at Work Certificate this includes training in the use of an AED (automated external defibrillator) and CPR. The three-day first aid at work course must be completed by staff on a 1:50 basis.

2.3 The swimming coaches, gap students and a number of the teaching staff also hold a swimming lifesaving qualification.

2.4 The list of first aiders is sent to each member of staff by email in September and a list is also displayed:
-Outside the Surgery and the Boarding House
-In the School Office, Common Room, Kitchens, Sports Hall, Sports Pavilions and classrooms.

2.5 The medical team are the nominated persons for providing first aid and medical attention to casualties at school (EYFS, Pre-Prep and Prep). The medical team are not always needed if there are minor ailments that a first aider can provide the necessary care.

2.6 On no account should any member of staff undertake first aid that they are not fully competent to carry out.

2.7 There is a first aid box in the Common Room for general use. There is also one in the Sports Hall, the Meadows boot room, the Lower Lawns Pavilion, the Science Labs, DT room, Art room, Theatre, the Hovels and the EYFS and Pre-Prep departments. If you use anything from the first aid boxes, please notify the school medical department so that it can be replaced. First aid boxes on the mini buses are required by law; any equipment used should also be replaced on return to the school. These are checked by both the maintenance team and quarterly, by the medical team.

2.8 The medical department has a supply of first aid bags for games teachers to take to matches, along with any Epipens, inhalers and other individual medication that might be needed. The member of staff taking the team will be given a brief description of a child's health or dietary needs. The school they are visiting will be emailed ahead of the team arriving with any medical and dietary needs. First aid bags for trips and match days are checked before the bag is dispatched for use (at least once weekly). There is a record of this checking procedure in the School Surgery.
Year 7 and 8 children have the responsibility of carrying their own inhalers and Epipens.
If a child is asthmatic and is going to an away match the duty nurse will be responsible for supplying a spare inhaler to go away with the first aid bag and inform the member of staff taking the team.

2.9 First aid boxes and bags are fully stocked. If equipment is used, then it is the responsibility of the member of staff using it to inform the school medical department so that first aid can be re-stocked, as necessary. Staff must also report missing first aid bags or boxes in their area of work.

2.10 First aiders must always seek follow up medical/nursing assessment if they have assisted a casualty. First aiders must never give medicines to an unwell or injured person without the training to do so or without medical or parental consent.

2.11 There is an AED (automated external defibrillator) it is situated on the wall outside of the main school office. It is locked in a yellow cabinet. The **AED** is a portable device that is used to treat cases of sudden cardiac arrests. If needed, it can be used to send an electric shock to the heart. The device is designed for anyone to use in case of an emergency and will not deliver a shock to the casualty unless it is required. The device is set up with adult pads and paediatric pads are provided in the bag beside the machine. As part of their first aiders training staff are fully trained in the use of this device. School medical staff can be contacted on 01825 792002 or **ext 2022.**

2.12 The Emergency Action Plan (EPA) if/ when the AED is needed is kept in the policy folder, it has been distributed to all staff, they are aware it is electronically stored in the policy folder. A copy of the EAP is on the Common room noticeboard, along with the code for the locked AED cabinet.

3.0 Health Questionnaires and Administration of Medication

3.1 A health questionnaire is sent to all parents on admission to the school. This information provides the school with information that may be essential to the medical team or first aider. Each member of staff has access to a list of pupils with medical conditions and allergies, which can be seen on iSAMS, where the child will have an orange flag next to their name.

3.2 Parents are asked to sign a consent form agreeing to over-the-counter medicines being administered according to the School's Drug Authorisation and Administration policy should it be deemed necessary.

3.3 The medical team and first-aiders who hold an Administration of Medication in Schools certificate can provide medication to the children under the Cumnor House Drug Administration Policy.

3.4 Parents who wish their child to be administered medication by a member of staff who does not have a first aid or Administration of Medication certificate must give their consent in writing to that member of staff. They must also provide written consent if they wish their child to be administered any medication that is not listed on the Drug Authorisation and Administration policy such as prescription medication (antibiotics). Authorisation of Medication forms can be obtained from the school surgery (see Appendix 1).

4.0 Allergies and Medical Conditions

4.1 There is a medical conditions list for each year printed out in the medical room for staff to look at. Sports fixture lists have a symbol next to a child's name if they have an allergy or medical condition this is to prompt staff to check the allergy/medical list. Staff are responsible for ensuring that children with medical conditions have their medication with them and that they have an appropriate first aid bag.

4.2 We ask parents of day children to ensure that the medication their child requires is handed to the school medical staff for safe storage. Medication is required to be in its original packaging and clearly labelled with the child's name, the dosage, and the time of administration. This includes homeopathic and all complimentary medications. Where children are considered responsible for looking after their inhalers, Epipens and insulin pumps they will be allowed to do so. Inhalers and Epipens are not stored in a lockable cupboard.

4.3 Parents should inform the school of any change to their child's allergy or medical status. We also request that the GP or consultant liaises with the school where the child has a complex medical or allergic condition. This is to ensure that an appropriate care plan can be devised to meet your child's individual needs and that this care plan is kept up-to-date.

5.0 Serious Incidents requiring First Aid and Reporting under RIDDOR

5.1 All incidents requiring first aid in the EYFS are managed by the paediatric first aiders in the EYFS department. The accident is recorded in the accident book and parents are informed. The EYFS manager records all accidents on the EYFS accident reporting spread sheet so that accidents and action taken can be monitored by the Bursar monthly. Anything that requires immediate attention is reported at the time of the incident to the Bursar for action. Any accident that requires further medical attention is reported to the school surgery for further assessment and treatment. In the Pre-Prep the same procedure applies as detailed above. In the main school all first aid is provided by the medical team. All first aid is recorded in the child's iSAMS medical file. If a serious incident should occur this is additionally recorded in the Accident Record Book. This record is then given to the Bursar and any further action required is implemented and recorded. The record and action taken is then stored in a file in the medical room. A spread sheet is also used to record and monitor incidents and accidents. This record is reviewed monthly by the Bursar.

5.2 Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), injuries, certain diseases and dangerous occurrences are to be reported to the Health and Safety Executive.

5.3 Reportable major injuries are:

- Fracture, other than to fingers, thumb and toes
- Amputation
- Dislocation of shoulder, hip, knee or spine
- Loss of sight (temporary or permanent)
- Chemical or hot burn to eye or any penetrating injury to the eye
- Injury resulting from electric shock or electric burn leading to unconsciousness, or requiring CPR or admittance to hospital for more than 24 hours
- Unconsciousness caused by asphyxia or exposure to harmful substances

5.4 Reportable over-seven-day injury

If there is an accident at the school which results in the person being unable to attend for over-seven-days the school will report it to the enforcing authority within 10 days by completing the appropriate online form F2508. Injuries over-three-days must be recorded but not reported.

5.5 Accident Procedures

5.5.1 Information

- There is a fully equipped first aid facility in the School Surgery located in the main building
- First aid boxes and bags are located in main areas throughout the school and are checked regularly by the staff and re-stocked by the medical team
- A list of known medical conditions is available to staff in the EYFS, Pre-prep and Prep School via the electronic notice board and iSAMS
- The medical team holds all health questionnaires, medical records and consent forms submitted by parents on admission, apart from the nursery who hold the

medical books for those children until they move into reception, and they are given back to the medical team.

5.5.2 Minor injuries

- Parental consent is gained in the health questionnaire
- Disposable gloves are available in first aid boxes and in Surgery and must be worn by staff dealing with any body fluids
- Cuts and bruises are dealt with in an appropriate way
- All children who are treated for any incident, however minor, are recorded in iSAMS and stored until their 25st birthday
- Parents of EYFS children are informed as soon as possible, parents of pre-prep children are informed by the teacher at the end of the day
- The school medical staff inform parents of prep children as appropriate

5.5.3 Major injuries

- Parental consent is gained in the health questionnaire
- The school medical team is informed immediately. If the child can walk he/she is brought to surgery by an adult. If the child cannot walk, a member of the school medical team will attend the scene
- Ensure safety and keep children at a safe distance
- First aid is given and the child is comforted and reassured
- If it is necessary to go to A&E the parent will be informed and asked to come to the school as soon as possible
- **If there is a serious injury during a games session, the child must not be moved and an ambulance called 999 or 112**
- If the parent cannot be reached and the incident is serious, then an ambulance would be called. A member of the medical team or a responsible adult would accompany the child to hospital with the child's health records and parent's consent for the school to act in *loco parentis* to be used if a parent cannot be contacted and emergency treatment is required
- The accident book and accident spread sheet will be completed
- The accident will be recorded oniSAMS
- Incident reported to RIDDOR as appropriate

5.5.4 Telephone Numbers

- Royal Alexandra Hospital (01273) 328 145
- Royal Sussex County Hospital (01273) 696 955
- Princess Royal Hospital (01444) 441 881
- MIU East Grinstead Queen Victoria (01342 414000
- Uckfield Community Hospital (01825 745001)

6.0 Basic Life Support Procedures

The most important aspect of first aid is to remember the following sequence of events for every situation:

Adult Basic Life Support
UNRESPONSIVE ?
Shout for help (request AED)
Open airway
NOT BREATHING NORMALLY ?
Call 999 (**for internal school phones dial 112**)
30 chest compressions
2 rescue breaths (Only if trained and happy to do so, otherwise administer continuous chest compressions)
30 compressions 6.1 Basic life support consists of the following sequence of actions:

- Make sure the casualty, any bystanders, and you are safe
- Check the casualty for a response
- Gently shake his shoulders and ask loudly, 'Are you alright?'

If he/she responds:

- Leave him in the position in which you find him provided there is no further danger
- Try to find out what is wrong with him/her and get help if needed
- Reassess him/her regularly

If he/she does not respond:

- Shout for help (request AED)
- Turn the casualty onto his/her back and then open the airway using head tilt and chin lift:
- Place your hand on his/her forehead and gently tilt the head back
- With your fingertips under the point of the casualty's chin, lift the chin to open the airway
- Keeping the airway open, look, listen, and feel for normal breathing.
- Look for chest movement
- Listen at the casualty's mouth for breath sounds
- Feel for air on your cheek
- In the first few minutes after cardiac arrest, a casualty may be barely breathing, or taking infrequent, noisy, gasps
- Do not confuse this with normal breathing
- Look, listen, and feel for no more than 10 sec to determine if the casualty is breathing normally. If you have any doubt whether breathing is normal, act as if it is not normal

If he/she is breathing normally:

- Turn him/her into the **recovery position** (**see below**)
- Send or go for help, or call for an ambulance
- Check for continued breathing

If he/she is not breathing normally:

Ask someone to call for an ambulance and return with AED or, if you are on your own, do this yourself; you may need to leave the casualty. Apply AED if you know how to use this device and start chest compression as follows:

- Kneel by the side of the casualty
- Place the heel of one hand in the centre of the casualty's chest
- Place the heel of your other hand on top of the first hand
- Interlock the fingers of your hands and ensure that pressure is not applied over the casualty's ribs
- Do not apply any pressure over the upper abdomen or the bottom end of the bony sternum (breastbone)
- Position yourself vertically above the casualty's chest and, with your arms straight, press down on the sternum 4 - 5 cm
- After each compression, release all the pressure on the chest without losing contact between your hands and the sternum
- Repeat at a rate of about 100 times a minute (a little less than 2 compressions a second)
- Compression and release should take an equal amount of time

Combine chest compression with rescue breaths (only if trained and happy to do so)

- After 30 compressions open the airway again using head tilt and chin lift
- Pinch the soft part of the casualty's nose closed, using the index finger and thumb of your hand on his/her forehead
- Allow the mouth to open, but maintain chin lift
- Take a normal breath and place your lips around the mouth, making sure that you have a good seal
- Blow steadily into the mouth whilst watching for the chest to rise; take about one second to make the chest rise as in normal breathing; this is an effective rescue breath
- Maintaining head tilt and chin lift, take your mouth away from the casualty and watch for the chest to fall as air comes out
- Take another normal breath and blow into the casualty's mouth once more to give a total of two effective rescue breaths. Then return your hands without delay to the correct position on the sternum and give a further 30 chest compressions

Continue with chest compressions and rescue breaths in a ratio of 30:2

Stop to recheck the casualty only if he/she starts breathing **normally**; otherwise, **do not interrupt resuscitation.**

If you have used the AED and a shock is required ensure that no one is touching the casualty.

If your rescue breaths do not make the chest rise as in normal breathing, then before your next attempt:

- Check the casualty's mouth and remove any visible obstruction
- Recheck that there is adequate head tilt and chin lift

Do not attempt more than two breaths each time before returning to chest compressions

If there is more than one rescuer present, only changeover if you are too tired to continue. Ensure the minimum of delay during the changeover of rescuers

- Chest-compression-only CPR:

  If you are not able, or are unwilling, to give rescue breaths, give chest compressions only

  If chest compressions only are given, these should be continuous at a rate of 100 a minute

  Stop to recheck the casualty only if he/she starts breathing **normally**; otherwise, do not interrupt resuscitation.
- **Continue resuscitation until:**

  Qualified help arrives and takes over

  The casualty starts breathing normally, or

  You become exhausted

7.0 Recovery position

There are several variations of the recovery position, each with its own advantages. No single position is perfect for all casualties. The position should be stable, near a true lateral position with the head dependent, and with no pressure on the chest to impair breathing. The Resuscitation Council (UK) recommends this sequence of actions to place a casualty in the recovery position:

- Remove the casualty's spectacles
- Kneel beside the casualty and make sure that both his/her legs are straight
- Place the arm nearest to you out at right angles to his body, elbow bent with the hand palm uppermost
- Bring the far arm across the chest, and hold the back of the hand against the casualty's cheek nearest to you
- With your other hand, grasp the far leg just above the knee and pull it up, keeping the foot on the ground
- Keeping his hand pressed against his cheek, pull on the far leg to roll the casualty towards you onto his side
- Adjust the upper leg so that both the hip and knee are bent at right angles
- Tilt the head back to make sure the airway remains open
- Adjust the hand under the cheek, if necessary, to keep the head tilted
- Check breathing regularly
- If the casualty has to be kept in the recovery position for **more than 30 min** turn him to the opposite side to relieve the pressure on the lower arm

8.0 Choking

8.1 Recognition- Because recognition of choking (airway obstruction by a foreign body) is the key to successful outcome, it is important not to confuse this emergency with fainting, heart attack, seizure, or other conditions that may cause sudden respiratory distress, cyanosis, or loss of consciousness

Foreign bodies may cause either mild or severe airway obstruction. The signs and symptoms enabling differentiation between mild and severe airway obstruction are summarised in the table below. It is important to ask the conscious casualty 'Are you choking?'

8.2 General signs of choking

- Attack occurs while eating
- Casualty may clutch his/her neck

8.2.1 Signs of mild airway obstruction

- *Response to question 'Are you choking?'*
- Casualty speaks and answers yes
- Casualty can speak, cough, and breathe

8.2.2 Signs of severe airway obstruction

- *Response to question 'Are you choking?'*
- Casualty unable to speak
- Casualty may respond by nodding
- Casualty unable to breathe
- Breathing sounds wheezy
- Attempts at coughing are silent
- Casualty may be unconscious

8.3 Adult choking treatment (This sequence is also suitable for use in children over the age of 1 year)

- **Unconscious**
  - start CPR
- **Conscious**
  - 5 back blows
  - 5 abdominal thrusts
- **Encourage cough**
- Continue to check for deterioration or ineffective cough or relief of obstruction
- Assess severity

8.3.1 Severe airway obstruction

- Ineffective cough

8.3.2 Mild airway obstruction

- Effective cough

8.3.3 If the casualty shows signs of mild airway obstruction:

- Encourage him to continue coughing, but do nothing else

8.3.4 If the casualty shows signs of severe airway obstruction and is **conscious:**

- Give up to five back blows
- Stand to the side and slightly behind the casualty
- Support the chest with one hand and lean the casualty well forwards so that when the obstructing object is dislodged it comes out of the mouth rather than goes further down the airway
- Give **up to** five sharp blows between the shoulder blades with the heel of your other hand
- Check to see if each back blow has relieved the airway obstruction

8.3.5 The aim is to relieve the obstruction with each blow rather than necessarily to give all five.

- If five back blows fail to relieve the airway obstruction give up to five abdominal thrusts.
- Stand behind the casualty and put both arms round the upper part of his abdomen.
- Lean the casualty forwards
- Clench your fist and place it between the umbilicus (navel) and the bottom end of the sternum (breastbone).
- Grasp this hand with your other hand and pull sharply inwards and upwards
- Repeat up to five times.
- If the obstruction is still not relieved, continue alternating five back blows with five abdominal thrusts

8.3.6 If the casualty becomes unconscious:

- Support the casualty carefully to the ground
- Immediately call an ambulance
- Begin CPR (from 5B of the Adult BLS Sequence)
- Healthcare providers, trained and experienced in feeling for a carotid pulse, should initiate chest compressions even if a pulse is present in the unconscious choking casualty

8.3.7 Explanatory notes

- Following successful treatment for choking, foreign material may nevertheless remain in the upper or lower respiratory tract and cause complications later.

- Casualties with a persistent cough, difficulty swallowing, or with the sensation of an object being still stuck in the throat should therefore be referred for a medical opinion.

- Abdominal thrusts can cause serious internal injuries. All casualties who receive abdominal thrusts should be examined for injury by a doctor.

9.0 Paediatric Basic life support

- Many children do not receive resuscitation because potential rescuers fear causing harm. This fear is unfounded; it is far better to use the adult BLS sequence for resuscitation of a child than to do nothing
- For ease of teaching and retention, therefore, laypeople should be taught that the adult sequence may also be used for children who are not responsive and not breathing
- The following minor modifications to the adult sequence will, however, make it even more suitable for use in children

9.1 Paediatric basic life support modifications

- Give five initial rescue breaths before starting chest compressions (adult sequence of actions 5B)
- If you are on your own, perform CPR for approximately 1 min before going for help
- Compress the chest by approximately one-third of its depth. Use two fingers for an infant under 1 year; use one or two hands for a child over 1 year as needed to achieve an adequate depth of compression.

9.1.1 Paediatric Basic Life Support sequence

- UNRESPONSIVE?
- Shout for help (request AED and ensure that paediatric pad are in place)
- Open airway
- Not breathing normally?
- 5 rescue breaths
- No signs of life? (apply AED if you know how to do so and start chest compressions)
- 30 chest compressions
- 2 rescue breaths

Call Cumnor Office to obtain AED and send help. Use mobile phone to call 999, loud speaker option. DO NOT LEAVE PATIENT. Continue CPR unless AED states otherwise until more help arrives.

9.2 **Basic First Aid Procedures for an Asthma Attack**

What to do?

- Keep calm
- Encourage the child or young person to sit up and slightly forward – do not hug or lie them down
- Make sure the child or young person takes two puffs of reliever inhaler (usually blue) immediately – preferably through a spacer
- Ensure tight clothing is loosened

- Reassure the child
- If there is no immediate improvement continue to make sure the child or young person takes one puff of reliever inhaler every minute for five minutes or until their symptoms improve.

  Call 999 or a doctor urgently if:

  • The child's, or young person's, symptoms do not improve in 5–10 minutes.
  • The child, or young person, is too breathless or exhausted to talk.
  • The child's, or young person's, lips are blue.
  • You are in doubt.

  Ensure the child, or young person, takes one puff of their reliever inhaler every minute until the school nurse, ambulance or doctor arrives.

  It is essential for people who work with either children or young people with asthma, to know how to recognise the signs of an asthma attack and what to do if they have an asthma attack.

  Common signs of an asthma attack
  - coughing
  - shortness of breath
  - wheezing
  - tightness in the chest
  - being unusually quiet
  - difficulty speaking in full sentences
  - sometimes younger children express feeling tight in the chest as a tummy ache

  After a minor asthma attack
  - Minor attacks should not interrupt the involvement of a pupil with asthma in school
  - When the pupil feels better, they can return to school activities
  - The parents/carers must always be told if their child has had an asthma attack

  Important things to remember in an asthma attack
  - Never leave a pupil having an asthma attack
  - If the pupil does not have their inhaler and/or spacer with them, send another teacher or pupil to the School Surgery or their classroom to get their spare inhaler and/or spacer (the schools allergy list and a * symbol on match lists helps staff identify children who need to have medication or special care at school, staff should ensure that children in their care have their medication with them for sport and school trips. Parents of day children should also ensure that their child has their inhaler in their bag each day and they should supply a spare inhaler to be stored by the School Nurse in the Surgery)
  - In an emergency school staff are required under common law, duty of care, to act like any reasonably prudent parent
  - Reliever medicine is very safe. During an asthma attack do not worry about a pupil overdosing

- Send another pupil to get a member of the school medical team or another teacher/adult if an ambulance needs to be called
- Contact the pupil's parents or carers immediately after calling the ambulance/doctor
- A member of staff should always accompany a pupil taken to hospital by ambulance and stay with them until their parent or carer arrives

ALWAYS CHECK THAT A CHILD WITH ASTHMA HAS HIS/HER INHALER WITH THEM FOR GAMES AND OUTINGS.

THERE ARE EMERGENCY INHALERS IN THE SURGERY, COMMON ROOM, CAT SHED, PRE-PREP CONSERVATORY, AND SWIMMING POOL OFFICE AND IN THE MEDICAL CABINETS IN THE PAVILIONS ON LOWER LAWNS AND MEADOWS.

9.3 **Allergies**

Remove child from the allergen and send to the school medical team for assessment. If you consider the child to be at risk of severe allergic reaction then administer antihistamine (Piriton)

9.3.1 **Anaphylactic Shock**

- Always check School Allergy List and match list so that you are aware of any known children with this condition
- If you suspect someone to be having an anaphylactic reaction look for a 'Medi-Alert' bracelet/necklace but also remember that anyone can have an anaphylactic reaction
- Anaphylaxis is a severe, sometimes life-threatening, allergic reaction that occurs within minutes of exposure to an offending substance
- The person suffering the reaction must receive an immediate injection of epinephrine (Epipen)
- In a severe allergic reaction, the body's immune system responds to the presence of an allergen (foreign substance which triggers an immune reaction) by releasing histamine and other immune-related body chemicals
- These chemicals cause the symptoms of allergies, which are usually mild but annoying, such as the runny nose of hay fever (allergic rhinitis) or itchy rash
- However, in some cases, the symptoms can be much worse and involve the entire body.

9.3.2 Anaphylaxis is the most severe allergic reaction in which immune chemicals, such as histamine, produce serious skin symptoms (hives, swelling) as well as severe breathing problems (swelling in the throat, narrowing of the lower airways, wheezing). They also produce a dramatic widening of the blood vessels, which results in a rapid, severe drop in blood pressure (shock). Anaphylactic shock is a life-threatening medical emergency.

9.3.3 Anaphylaxis usually happens quickly and can produce the following symptoms:
- Itchy nettle rash (urticaria, hives)
- Faintness and unconsciousness due to very low blood pressure.

- Unlike an ordinary fainting attack, this does not improve so dramatically on lying down
- Swelling (angioedema)
- Swelling in the throat, causing difficulty on swallowing, or breathing
- Asthma symptoms
- Vomiting
- Cramping tummy pains
- Diarrhoea
- A tingling feeling in the lips or mouth if the cause was a food such as nuts
- Death due to obstruction to breathing or extreme low blood pressure

9.3.4 **What Are the Emergency Procedures in Case of an Anaphylactic Reaction?**

- Epinephrine is the drug of choice for treating an anaphylactic reaction. It works to reverse the symptoms of an anaphylactic reaction and helps prevent the progression of it. It is given using an Epipen, which any known person with this condition should have on their person in their school bag/bum-bag or with their teacher in their classroom. A spare Epipen is also stored in The School Surgery
- Antihistamines, such as Piriton, are often used to improve further the recovery of a person with an anaphylactic reaction. Antihistamines and asthma medications may be administered with epinephrine, but never instead of epinephrine because they cannot reverse many of the symptoms of anaphylaxis
- When appropriate children with anaphylaxis are shown by the medical team how to self-administer their medication and staff are shown by the medical team how to administer Epipens to children suffering from anaphylaxis

9.3.5 The 3 R's for treating anaphylaxis

- Recognize symptoms
- React quickly
- Review what happened and be sure to prevent it from reoccurring

9.3.6 Steps for treating an anaphylactic reaction

If you suspect an anaphylactic reaction is occurring, do not lose precious time. Do the following:

- Get child's prescription Epipen, hold like handle bars of a bicycle, remove grey safety cap from EpiPen with your free hand and give immediately into the front part of the thigh (jabbing black end of Epipen into the thigh)
- The needle can be given through the clothes
- Send someone for a member of the school medical team immediately and phone 999 (112 for internal school phones) for an ambulance
- Give Piriton and 2 puffs of reliever inhaler (usually blue)
- Call parents and inform them of situation
- Give second Epipen if no improvement after 10 minutes has passed
- Remember to dispose of sharps safely

9.4 **Nose Bleeds**

- Gloves should be worn by staff treating children for nose bleeds
- Encourage child/adult to breathe through mouth and to press soft part of nose
- Do not tip head backwards.
- If bleeding continues for more than 10 minutes reassure the child and send them to the School Surgery with an escort.

9.5a **Diabetes**

9.5.1 If a child has diabetes or any other medical condition, they will have an individual Care Plan to meet their needs and this will be held in the School Surgery. It is important that a person with diabetes participates in all aspects of school life and does not allow the condition to restrict them in any way.

9.5.2 Dietary requirements will be managed according to the individual's diabetic care plan.

9.5.3 The person will require regular medication either by injection or in tablet form. Diabetic insulin pumps may also be used and self-managed. Insulin pens are stored in the School Surgery and the child is supported in the administration of this medication according to their level of competency in self-administration. Where sliding scales and carbohydrate counting are used to calculate insulin dosages on a daily bases, parents are required to advise on insulin dosages.

9.5.4 Sometimes a diabetic may experience low blood sugar (**hypo**glycaemia) and display the following symptoms: shakiness, dizziness, confusion, and irritability. In such cases give the person some glucose e.g., coke, honey, jam anything that can be swallowed easily or rubbed into the inside of their cheek.

9.5.5 A Diabetic at times may also suffer from high blood sugar (**hyperglycaemia**); in such cases there may be a smell of pearl drops on their breath and they may be breathing rapidly and feeling generally unwell. In all cases the child/adult should be sent to the medical team for assessment.

9.5.6 Children with diabetes will need to check their blood glucose level during the school day. They can carry a testing kit with them and check their blood glucose level wherever they feel comfortable to do so. Their testing pens need to be rotating safety pens so that there is no risk to others from used needle stick injury. Sharps are to be disposed of according to sharps policy.

9.5.7 Children are taught in PSHE sessions about various medical conditions that are managed within the school environment and they are made aware of the safety implications.

9.5b Seizures/epilepsy

If you see someone having a seizure or fit, there are some simple things you can do to help.

It might be scary to see someone having a seizure, but don't panic. Try to comfort them and make sure they're not hurting themselves.

If they're having a tonic-clonic seizure, they may be trapped behind something or kicking against something. If you are with someone who is having a tonic-clonic seizure (fit):

- move them away from anything that could cause injury – such as a busy road or hot cooker
- cushion their head if they're on the ground
- loosen any tight clothing around their neck – such as a collar or tie, to aid breathing
- when their convulsions stop, turn them so that they're lying on their side
- stay with them and talk to them calmly until they have recovered
- note the time the seizure starts and finishes

Don't put anything in the person's mouth, including your fingers. They may bite their tongue, but this will heal. Putting an object in their mouth could cause more damage.

As the person is coming round, they may be confused, so try to comfort them.

Ambulance?

You don't necessarily have to call an ambulance, because people with epilepsy don't need to go to hospital every time they have a seizure.

Some people with epilepsy wear a special bracelet or carry a card to let medical professionals and anyone witnessing a seizure know that they have epilepsy. If they know they have epilepsy, they might just prefer to get on with their day.

However, you should dial 999 if:

- it's the first time someone has had a seizure
- the seizure lasts for more than five minutes
- the person doesn't regain full consciousness, or has a series of seizures without regaining consciousness

Remember what happens

Make a note of what happens during the seizure, as this may be useful for the person or their doctor.

Be aware of what the person does during the seizure. Make a note of what they're like afterwards (e.g. sleepy, confused, or aggressive), and record how long the seizure lasts.

9.6 **Stings**

- Do not remove the sting with tweezers
- Remove with paper/card in a sweeping/flicking action
- Refer to the school medical team for treatment: (clove oil) antihistamine

9.7 **Meningitis**

- What are the symptoms?

  In bacterial meningitis, symptoms develop rapidly, often within hours, whereas the symptoms of viral meningitis may take a couple of days to develop.
  In meningococcal meningitis, caused by the bacteria Neisseria meningitidis, a rash may develop that starts as purple-red, pin-prick spots and rapidly spreads to become blotchy. An important sign is that the rash does not blanch (fade) when pressed.

- Symptoms in adults and older children

  High fever
  Severe headache
  Stiff neck
  Dislike of bright light
  Drowsiness
  Confusion and irritability
  Vomiting
  Muscle pains, stomach cramps and diarrhoea
  Cold and pale hands and feet
  A rash that does not fade under pressure (try pressing a glass against the skin)

- Delays in treatment increase the risk of long-term damage. If you suspect meningitis, get urgent medical advice.

9.8 **Temperature**

- Any child with a temperature should be seen by a member of the school medical team or the houseparent and assessed. Any child with a temperature above 38c will be sent home with medical advice.
- Pupils who have had an elevated temperature which has not been resolved with the administration of medication must be temperature free for 24 hours before returning to school.

9.9 **Burns/scalds**

- Douse the burn in plenty of cold liquid for at least 10 minutes. Seek medical assistance immediately and refer to hospital. Continue to cool the area until pain is relieved. Remove clothes immediately as they retain heat.
- DO NOT REMOVE CLOTHES IF THEY ARE STUCK TO THE SKIN.
- Remove rings, watches and belts, if they are in the affected area. Wear plastic gloves if available and cover the area in a sterile dressing. Always consider treating for **shock.**
- Do not over cool
- Do not remove anything sticking to the burn
- Do not touch or otherwise interfere with the burned area
- Do not burst any blisters
- Do not apply any lotions, ointment, fat, or adhesive dressing to the burned area

10.0 Electrical shock

- Always turn off power supply before touching the casualty. Treat for burns (check hands and feet) and shock. Seek medical assistance; call 999 for ambulance.

11.0 Shock

- This is a life-threatening condition and occurs when the circulatory system fails. It requires immediate emergency treatment to prevent organ damage and death.

Causes	**Recognition**
Blood loss	Rapid pulse
Diarrhoea/vomiting	Pale, cold, clammy skin, sweating
Burns	Grey/blue skin
Heart disease	Weakness/dizziness
Infection	Sickness/vomiting
Low blood sugar	Thirst
Hypothermia	Rapid shallow breathing
Severe allergy	Weak “thready” pulse
Severe injury	Restlessness and agitation

11.1 Do NOT

- Give the casualty anything to eat or drink
- Leave the casualty unattended (except if required to call an ambulance)
- Warm the casualty with direct source of heat e.g., hot water bottle

11.2 DO

- Treat the cause
- Lie the casualty down with feet elevated (consider fractures)
- Loosen clothing
- Keep warm with blankets/coats
- Call for an ambulance

- Continue to monitor

12.0 Head Injury Policy

12.1 All head injuries at school need to be assessed neurologically by a member of the school medical team or in their absence a full-qualified first aider (following first aid guidelines for assessment).

- The NHS guidelines for the management of head injury must also be adhered to
- A GCS score sheet must be completed and regular observations documented
- Boarders must be placed under parental overnight supervision as it is not possible to monitor situation at school
- Parents taking children home following head injury must be given written head injury advice or informed that advise is available from NHS direct: 0845-4647 or **www.nhsdirect.nhs.uk**.
- If parents are away, the child must be seen by a doctor and deemed fit to stay at school
- Children should be accompanied to School Surgery or a member of the school medical team should be requested to go to them especially if **neck injury** is all so suspected (phone the medical team on 2022)
- Parents should be informed by email of any head injury
- The parent will be emailed a head injury advice leaflet to take home
- Parents should be advised to seek further medical advice if they are concerned about their child's behaviour or notice anything different from the norm
- First aiders should always seek further medical advice for children in their care that have sustained a head injury
- A first aider can ask a parent to collect their child and advise that they seek a medical assessment. If you cannot contact a parent then you could phone NHS direct on 0845 4647 or phone the medical team, first aider or governor for medical matters for advice. If you are unable to contact the above you must take the child to a minor injuries unit or A&E for assessment.
- We follow a strict GRTP (graduated return to play) guidelines following any head injury and/or concussion. We employ a play pathway consisting of 6 steps from a rehabilitation stage of complete rest finalised by a return to play. Before progressing to level 5 an assessment by a medical doctor is required.

12.2. Management of head injury during games

- **Never move a conscious casualty if they cannot mobilise themselves; leave them in the position you found them until medical support arrives. Only move the casualty if they are in further danger.**

- If there is any suspicion of loss of consciousness (LOC) then they must stop play and medical/nursing assistance sought immediately

- If there is no sign of LOC, and the player gets up unaided within 10 seconds without any symptoms of head injury, then he/she can play on and report to the medical team following play
- If the player spends more than 10 seconds on the ground then he/she must stop play and be assessed by the medical team either at surgery or on the pitch depending on the player's ability to move
- If the player spends more than 60 seconds on the ground then an ambulance should be called and the player taken to hospital with either their parent or a member of staff
- Parents, the school office, **Headmaster and school medical** team must always be notified immediately if a child is being, or has been, taken to hospital

12.3 School policy for games following a head injury

- If a child sustains a head injury and shows any signs of concussion then they must be seen by the medical team or a first aider. They will be treated as appropriate and referred to the GP for further assessment and treatment if required.

- If a child is diagnosed with a concussion, then the school will follow the GP's advice and the guidelines set by the National Institute of Clinical Excellence (NICE) regarding a graduated return to play. The details of these guidelines can be viewed **here**

12.4 Care of injured child at away matches

If a child is injured while at an away match you must:

- Ensure that the child is assessed by a member of the school medical team prior to leaving the school
- If they recommend that further medical assessment or treatment is required (e.g., x-ray) you must ensure that this is carried out on the day (parents must be informed immediately of any injury that has required nursing attention at an away school). This can be carried out by you (with parental consent) or by the parent.
- If a child requires an x-ray, you must seek parental consent
- You must notify the Cumnor school office and the medical department
- You must complete an incident report form on return to school
- You must not send a child to hospital with another parent without the child's parent's consent to do so

If there is no nursing care at the school you must:

- You must always inform the parent of the injured child and provide details of the incident/injury.
- Phone the Cumnor medical department prior to 5pm and inform them that you have an injured child. They will then advise appropriately

- After 5pm you must phone the Houseparent if the child is a boarding pupil. The Houseparent will provide first aid treatment on return, inform parents of injury and care provided and ask if they would like any further medical advice to be sought.
- If parents would like further medical advice, the Houseparent will phone a member of the medical team. If the medical team is uncontactable, Houseparents will arrange for the child to be seen at Haywards Heath A&E department or East Grinstead Minor injuries unit.

13.0 Off games Policy

13.1 Children are off games if:

- Their parent has emailed or telephoned the medical department and provided a valid reason. If deemed necessary the medical team can assess the child and provide feedback.
- Their parent has verbally requested that their child is off games - this should be requested via the school office
- They have been deemed unfit by their GP or medical team
- Teachers who select match teams should check the 'off games list' the day before matches and on the morning of a match to see who is fit to play
- On Monday morning, children are removed from the off games list unless a parent has requested that they remain off games until a particular date

14.0 Fractures

14.1 If any child should suffer an injury to a limb while at school, that child will be assessed by a member of the school medical team for a fracture. If there is no obvious sign of fracture, such as:

- No sign of deformity
- The child has full range of movement to injured limb/thumb/finger
- The child has full strength to arm/wrist/leg
- The child is fully weight bearing on injured leg/ankle
- The child's pain is relieved by mild analgesia (paracetamol or Ibuprofen)
- Good sensation and circulation to injured limb/finger/thumb
- No signs of shock
- History is not typically associated with fracture

14.2 In the presence of the above symptoms the child will be advised to:

- Rest injured limb/finger/thumb
- Treat for swelling by elevating injured limb/finger/thumb
- Treat for pain and inflammation with ice
- The parents will be informed and advised to seek further medical advice if there is no improvement or full recovery in 24 hours

14.3 If history of injury and symptoms are consistent with a fracture, the child will be kept comfortable, the limb will be immobilised, and the parents informed and advised to take the child for x-ray. If the fracture presents as an open fracture or with deformity, the child will be immobilised and treated for shock. An ambulance will be called and parents informed.

15.0 Diarrhoea and Vomiting

15.0 Diarrhoea and Vomiting

15.1 Diarrhoea and/or vomiting is usually caused by a stomach bug (like norovirus) or food poisoning. Pupils with diarrhoea and/or vomiting will be assessed by the medical team. Medication may be given if appropriate and consent has been gained. Pupils with diarrhoea and/or vomiting will be isolated in the school sick bay. Parents will be called to come and collect their child and they will be informed that the child will need to stay off school for 48 hours from the last episode of diarrhoea or vomiting. Pupils who have had diarrhoea will need to stay off swimming for two weeks.

15.2 An isolated episode of vomiting can have a non-contagious cause (for example travel sickness or migraine). If a pupil has a history of vomiting from such a cause and the school has received prior notice to that effect then the medical staff can exercise clinical judgement in individual cases to decide whether the child may come back to school sooner than 48 hours. In these circumstances, if a pupil vomits, parents will be called to come and collect them and take them home. If the child is well enough, they may return to school the following day.

15.3 The school will notify Ofsted of any food poisoning affecting two or more children cared for at the premises as soon as possible and no later than 14 days of the incident.

16.0 Procedures for the management of body fluids

- Spills of body fluids: blood, faeces, nasal and eye discharges, saliva and vomit must be cleaned up immediately

- Wear disposable gloves and mask. Be careful not to get any of the fluid you are cleaning up in your eyes, nose, mouth, or any open sores you may have. Protective clothing is available from the cleaning storage cuboards.

- Clean and disinfect any surfaces on which body fluids have been spilled. Use a product which combines both a detergent and a disinfectant

- Powered disinfectant which is designed for the purpose of cleaning body fluids from the floor may be used according to the manufactures instructions

- Discard fluid-contaminated material in a plastic bag along with the disposable gloves and mask. The bag must be securely sealed and disposed of according to local guidance

- Do not use mops to clean up blood and body fluid spillages. Use paper towels instead

- Ensure contaminated clothing is laundered at the hottest wash the fabric will tolerate

17.0 Mental Health and emotional wellbeing

17.1 Cumnor House Sussex recognises that there needs to be a parity of esteem between one's physical and mental health. Mindfulness is offered to all the pupils through the Jigsaw PSHE Wellbeing curriculum. The Pastoral Leadership Team are always available to talk to pupils and parents about their child's wellbeing. The medical team works closely with Beacon House a local psychological support centre for children and families with mental health needs.

Appendix 1.

CUMNOR HOUSE SUSSEX

Authorisation form for the administration of medication by a teacher or for the administration of medication not listed in the School's drug authorisation and administration Policy

It is my wish that my child (name) ……..

Is administered (name of medication) ……..

Dosage and frequency .....

For the treatment of ……..

Parent signature …….

Print name……..

Date ……

Teacher's signature …….

Print name ……..

Date ……

Medication received by:

Teacher's signature……..

Date.....

Medication returned to:

Parent/carer signature …….

Related Policies:
Child Protection and Safeguarding
Pandemic
Boarders' Care - Information pack and consent forms
Drug Authorisation and Administration
Bicycles, Scooters and Skateboards at Cumnor - Procedures and consent form
Medical Disclaimer
Safe Handling of Sharps
Asthma Protocol and Management
Authorisation of Medication to Boarders
Health and Safety
Dietary Needs and Disordered Eating
Self-harm and Suicidal Thoughts
Health and Wellbeing Policy
PSHE Handbook