KNIGHTSBRIDGE
SCHOOL

# First Aid, Medication and Medical Treatment Policy

## For children, staff, parents and visitors

**Table of Contents**



## First Aid, Medication and Medical Treatment Policy

*Please see H&S 05 Reporting of Injuries, Diseases and Dangerous Occurrences.*

*This Policy applies to the whole school, including the EYFS.*

*Please see appendices for specific arrangements for children, members of staff and visitors with particular medical conditions, e.g. asthma, epilepsy, diabetes and allergies.*

## 1 Introduction

Knightsbridge School policy covers staff, children, parents and visitors

1.1 The school complies with the:-

- First Aid for Schools (2022), guidance published by the DfE.
- The Health and Safety (First Aid) Regulations 1981 (amended 2018)

1.2 At least one qualified First Aider will always be on site when children are present as well as a Paediatric First Aider for the EYFS children. A list of First Aiders (Appendix A) is attached.

## 2 Definitions

2.1 First Aid - The arrangements in place to initially manage any injury or illness suffered at work. It does not matter if the injury or illness was caused by the work being carried out. It does not include giving any tablets or medicine to treat illness.

2.2 Full First Aider - A person who has completed a full (3-day) course of first aid training with a training establishment approved by the Health and Safety Executive, and holds a current certificate.

2.3 Paediatric First Aider – A person who has completed a 12 hour course of Paediatric First Aid training with a training establishment approved by the Health and Safety Executive, and holds a current certificate.

2.4 Appointed Person - A person who has completed a 1-day course of emergency first aid from a competent trainer and holds a current certificate.

2.5.1 First Aid Kit - An easily identifiable container, with a white cross on a green background that contains a minimum supply of in-date equipment.

## 3 Qualifications and Training Courses

3.1 First Aiders will hold a valid certificate of competence, issued by an organisation approved by the HSE. It is required that all first aid training is updated every three years. Knightsbridge School complies with this requirement.

3.2 Members of staff are notified of first aid courses at staff meetings and refresher training is carried out annually.

## 4 EYFS

4.1 Under Early Years Foundation Stage requirements, at least one person on the premises and at least one person on outings must have a paediatric first aid certificate. It must be clear from the certificate that the course followed has covered first aid for children (with the words 'children', 'child' or 'paediatric' somewhere on the certificate). The course must involve a minimum of twelve hours training. As a general principle, the first aid training should be appropriate to the age of the children in question.

4.2 No staff member working in EYFS may bring any medication for personal use (whether prescription or over the counter) into the EYFS setting. Such medication should be kept in a lockable drawer.

## 5 Risk Assessment

5.1 In deciding the level and types of cover required the Proprietor will undertake a risk assessment which considers the issues outlined below:

- The workplace hazards and risks
- The size of the organisation
- The Proprietor's history of accidents
- The nature and distribution of the workforce
- The remoteness of the site from emergency medical services
- The needs of travelling, remote or lone workers
- Employees working on shared or multi-occupied sites
- Annual leave and other absences of first aiders

5.2 The Proprietor has:

- suitably stocked first aid containers
- fully trained first aiders/appointed persons.

## 6 Reporting Accidents

6.1 Statutory requirements: under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) some accidents must be reported to the HSE.

*6.2 Please see Reporting of Injuries, Diseases and Dangerous Occurrences.*

## 7 Policy on the Administration of Medicines during School Hours

7.1 From time to time, parents request that the school should dispense medicines which need to be administered at regular intervals to children.

7.2 These requests fall into two categories:

- Children who require emergency medication on a long term basis because of the chronic nature of their illness (for example, asthma and epilepsy)
- Children who are suffering from casual ailments (for example, coughs and colds) or acute ailments (perhaps require a short course of antibiotics)

7.3 Where possible parents are responsible for the administration of medicine to their children. For casual ailments it is often possible for doses of medication to be given outside school hours. In principle if a child needs a dose of medicine at lunchtime, the child should return home for this or the parent should come to the school to administer the medicine. In reality this may not be practical and the administration of medicine in Knightsbridge School falls within our remit for the Duty of Care for the children

7.4 No member of staff is required to administer medicine to children; any involvement would be purely on a voluntary basis.

7.5 Administration of medicine to children will only occur with written permission and with precise instructions as to dosage at the written request of a person with parental responsibility for the child

7.6 All medicines must be clearly labelled with the child's name and dosage required and handed to the teacher by the parent/carer. All medicines must be kept in a locked cupboard in the Medical Room or lockable drawer in the classroom or other designated area. If it is unavoidable that a child has to take medicine in school for treatment for a long-term illness to be effective, then each individual case will be considered and an agreed plan put in place.

7.7 The normal procedure is for any necessary medication to be given by designated persons. However sometimes arrangements are made (by agreement with the Head) for special circumstances to prevail - as in the administering of "Ritalin" for example. Members of staff giving medication need to be aware of any schedule requiring completion in the School Office/Designated Area. Where staff have indicated that they are willing to give a child Ritalin they need to be aware that there is a schedule for completion in the School Office. Where it is agreed that medication is kept at school, it must be named and kept in a locked cupboard in the Medical Room/Designated Area. In the case of life saving treatment/medication a letter from the child's doctor (GP or Consultant) must be obtained stating the child's condition and details of treatment/medication that the school may be required to administer.

7.8 For the school to agree to assist in long term medication:

- Parents must write to the school giving authorisation for medicines to be administered to their children. This needs to include instructions regarding the quantity and frequency of administration.
- The child should have been having the medicine for 48 hours at home before the School administers any medicine.
- The medicines must be brought into school in the container it was dispensed in by the pharmacy which states:

(a) The name of the medicine,
(b) The dosage and
(c) The time of administration

- Staff must check the dosage requested by the parent, matches the dosage on the bottle.
- Where possible the medicine should be self-administered under the supervision of an adult. Where a member of staff administers the medicine it should be witnessed by another member of staff.
- The member of staff should then sign the Administered Medication Form stating the dosage given, date and time. This should be kept with the medicine and once treatment is complete, filed in the School Office.
- Medicines will be kept in a locked cupboard in the Medical Room, lockable drawer or Designated Area in accordance with safety requirements

7.9 Where there is a long term need for emergency medication, the school will require specific guidance on the nature of the likely emergency and how to cope with it while awaiting paramedical assistance. Detailed written instructions should be sent to the school and the parent/guardian should liaise with their child's class teacher. If the emergency is likely to be of a serious nature, emergency contact numbers must be given where an adult is available at all times.

## 8 Policy on First Aid in School

8.1 All staff are responsible for dealing with minor incidents requiring first aid.

8.2 During lesson time first aid is administered by the class teacher or First Aider. If an accident occurs out of school and first aid is required, then one of the staff on duty will administer aid.

8.3 If there is any concern about the first aid which should be administered then the qualified first aiders must be consulted. A qualified first aider will be responsible for taking control in the event of an accident or injury.

8.4 In all cases, every accident must be recorded using our Electronic Accident Book.
All staff are trained how to fill this in and an electronic report goes to the parent or guardian in the case of a pupil or to the casualty if an adult.

## 9 Location and Maintenance of Dedicated First Aid Kits

9.1 The Medical Room is fully stocked.

9.2 All classrooms have a first aid bag. This should accompany all educational visits and learning off site activities.

9.3 Dedicated First Aid Boxes are available in the Science Lab, Art Room, School Office, Staff Room and in our satellite premises.
There is a British Standard for Workplace First Aid Kit compliant to BS8599 in the Medical Room.

9.4 There will be further full First Aid Boxes kept in the Medical Room for use on DT days and other occasions which warrant their use.

9.5 For off-site Sports, PE Staff have been provided with 3 x dedicated Sports First Aid Kits.

9.6 First Aid Kits Contents

- Scissors
- Antiseptic cream
- Bandages
- Plasters, single and strip
- Antiseptic wipes
- Cotton wool
- Sterile gauze
- Disposable gloves

9.7 Extra and additional more specialised equipment for first aid kits is kept in the Medical Room and School Office
Specialised tweezers for splinter removal are kept in the School Office first aid kit and in the Medical Room as is a Resuscitation Pocket Mask.

9.8 Supplies are also kept of:

- Dettol lint
- Eye baths
- Slings

9.9 First Aid kits are looked after by Dawn Baker but staff are responsible for checking the contents of the first aid kits on a regular basis and for placing orders to replenish stock. All staff are responsible for notifying Dawn Baker if the supplies in any of the first aid kits are running low.

9.10 All first aid bags and kits are checked at the beginning of each term and the date recorded, both in the box/bag itself and on computer. When removing a first aid box/bum-bag or supplies from the medical room, please ensure it is signed out and back in again, on the sheet clearly marked for this purpose.

9.11 It is the responsibility of staff to inform Dawn Baker of first aid items which may need to be replaced during the term.

## 10 Safety/HIV Protection Procedures for Dealing with Spillages of Bodily Fluid

10.1 Always wear disposable gloves when treating any accidents/incidents which involve body fluids. Make sure any waste (wipes, pads, paper towels etc.) are placed in a disposable bag and fastened securely. Any children's clothes should be placed in a plastic bag and fastened securely ready to take home.

## 11 Allergies/Long Term Illness

11.1 A record is kept in the general office of any child's allergy to any form of medication (if notified by the parent) any long-term illness, for example, asthma, and details on any child whose health might give us cause for concern.

## 12 Accidents

12.1 Accidents fall into four categories:

- Fatal
- Major injury
- To employees resulting in more than seven days consecutive absence
- Other accidents

12.2 Accidents in the first two categories must be reported under RIDDOR 2013 immediately to:

The Health and Safety Executive
St. Dunstan's House
Borough High Street
London SE1 1G2
Tel: 020 7556 2100

12.3 The incident should be reported immediately by telephone and then confirmed in writing. Major injuries are listed below. Category 3 incidents are reported to the Health & Safety Executive within 7 days.

12.4 If the accident is more than a minor one for child or adult, the first aider will send for an ambulance if required and then report it immediately to the Head and Operations Manager who will if needed contact parents, guardians or next of kin.

12.5 When in doubt, contact parents/guardians.

12.6 Procedure to follow for accidents which commonly occur in school:

- Fill in the online accident report form. If the parent/guardian has to be sent for to take the child to the family doctor or to hospital for further treatment this should be recorded on the form.
- All accidents, however minor, must be reported and an online accident report form completed. (near misses, potential hazards and any damage must be reported immediately).
- All accidents (near misses, potential hazards and damage) will be investigated by the Operations Manager, who will be responsible for ensuring that corrective action is taken where appropriate to prevent a recurrence.
- The Operations Manager in consultation with the Head will notify the appropriate authorities when necessary.

**13 Major Injuries**

- Fracture of the skull, spine or pelvis
- Fracture of any bone in the arm other than a bone in the wrist or hand
- Fracture of any bone in the leg other than a bone in the ankle or foot
- Amputation of a hand of foot
- The loss of sight of an eye
- Any other injury which results in the person injured being admitted to hospital as an inpatient for more than 24 hours, unless that person is detained only for observation

13.1 It might be that the extent of the injury may not be apparent at the time of the accident or immediately afterwards, or the injured person may not be immediately admitted to hospital. Once the injuries are confirmed, or the person has spent more than 24 hours in hospital, then the accident must be reported as a major injury.

**14 First Aid Procedures**

14.1 There is a requirement for a minimum of three trained First Aiders who have completed *The First Aid at Work course*. All staff are trained to a basic standard in First Aid. It is required that all first aid training is updated every 3 years. EYFS and sports staff have additional paediatric/sports injury first aid training.

**15 Practical Arrangements at the Point of Need – What to do**

15.1 What to do if a child is ill or injured

The legal responsibility of all teachers and members of the support staff is considered to be "in loco parentis" which means that we are expected to act as all prudent parents would do. Thus, we would more easily be found negligent if we did nothing than if we attempted to act in the child's best interests. The basic principle is that a teacher or member of the support staff cannot claim that a sick or injured child is not his/her responsibility. The Health and Safety at Work Act requires all employees to share responsibility for the workplace of themselves and of others using it so far as is reasonable and practical.

Children/Staff and visitors should only be in school if they can take part in all school activities, with the exception of recovery from broken limbs or similar injuries. Children/Staff who are on antibiotics or have had sickness or diarrhoea must spend the first 48 hours away from school. Further information regarding administration of medicines etc. can be found in the Health and Safety document. Parents of children or next of kin of staff who are taken ill in school should be informed through the School Office.

It is a requirement for all teaching and support staff to be trained in basic First Aid. However, NEVER perform any First Aid Procedures that you have not been adequately trained to do. The following is an aide-memoire only.

15.2 For a minor illness or slight injury:
Arrange for the child, member of staff or visitors to be taken to a First Aider or bring the First Aider to them. Please do not send sick or injured children, members of staff or visitors all over the building looking for help. Use a phone or a runner or get help from a colleague.

15.3 If a pupil, member of staff or visitor appears to be badly injured or seriously ill (e.g. serious loss of blood, severe pain in abdomen, bone or joint, unconsciousness):

DO NOT MOVE THEM. SEND FOR HELP AT ONCE.

Stop bleeding by pressure and keep the casualty warm and quiet to minimise the shock. Find out all you can about what happened and whether the casualty is in pain. Always be encouraging: never discuss how bad it might be!
ONE person must take charge who will:

1) Send for an ambulance if necessary
2) Send for a First Aider.
3) Notify the Head.
4) Make arrangements for the care of the person's property.
5) Arrange to contact the child's parent/s or next of kin for a staff member or visitor and check that this has been done.

N.B. Check the correct name of the parent or next of kin for a staff member or visitor

If the child is taken to hospital he or she must be accompanied by an adult, who must be prepared to remain there with the child.

15.4 If a child or staff member is ill or injured on a school trip the same principles apply as for 1 and 2.

Remember that when a child or staff member is ill or injured this changes the day's arrangements. Always ensure there is enough supervision for the other children on the trip, so that the sick or injured member of the group can be properly looked after. A First Aider with a First Aid kit must be on all off-site activities.

15.5 If a child or staff member is ill and needs to go home

The School Office should be informed and the member of staff on duty will telephone home and ask a parent or responsible adult to collect the child. If children are not well enough to join in all school activities they should not be in school

Parents should know that it is important that the school knows if any children are off school with diarrhoea and vomiting and the recommendation is that children see their General Practitioner during the period of absence. It is important that they should not return to school until free of symptoms for 48 hours.

If a member of staff is ill and needs to go home, they should inform their line manager so that cover can be arranged. The School Office needs to be informed and the member of staff needs to be signed out.

15.6 Major Accidents to children, members of staff or visitors

Major accidents which involve children, members of staff or visitors who are killed or taken from the site of the accident to hospital need to be reported without delay under RIDDOR 2013 to HSE, followed by Form F2508.

15.7 Minor accidents to children, members of staff and visitors

All types of minor accidents are to be recorded in the online accident book. Incidents that require medical attention outside school or a child and member of staff being sent home are covered by the online Accident Report Form.

Parents are advised of the incident by an automatically generated email from the online accident book. If the incident is serious the parent will be contacted by telephone and this will be noted in the online accident book. If a child is being sent home, there needs to be a record of this too.

15.8 Incidents / Hazards / Near Misses are recorded in our electronic Accident Book
This should be used to record the unplanned or uncontrollable event. Assessment and review will be undertaken at regular intervals to consider further action.

Reportable diseases need to be noted including:

- Date and diagnosis of the disease
- Who is affected
- The name of the disease

A copy of the list detailing incubation and exclusion periods of common communicable diseases is available in Appendix I.

Accident reports are being analysed and recorded in order to investigate causes of accident and learning from it, so as to avoid a recurrence.

15.9 Mental Health & Emotional Wellbeing

The School activity promotes mental health and emotional wellbeing through its Pastoral, Safeguarding procedures and School counselling services Place2Be. However, there may be times when first aid is required and all staff should familiar themselves with the guidance in Appendix H.

## 16 Medical Room

16.1 The Medical Room is located in the basement of the building adjacent to the dining room.

## 17 Head Injuries

17.1 A number of, largely minor, head injuries occur during break times.

17.2 Treatment for bruising to the head consists of applying a cold compress for 10 minutes, during which time the child can be monitored for signs of concussion.

17.3 All bumps to the head must have the time of the incident recorded in the online Accident Book and a note with the child's name, date and time, together with a brief description of the incident given to the relevant class teacher.

17.4 If the injury has resulted in broken skin, apply pressure for five minutes with a sterile dressing moistened with sterile saline. After five minutes, removed the dressing to assess and without exception contact the parents and advise follow through at an Accident & Emergency department. Recover the wound with a new, sterile moistened (with sterile saline) dressing.

17.5 Concussion is a temporary and reversible disturbance of the brain's normal function. It occurs when the brain moves or shakes inside the skull and is usually caused by a blow to the head or jaw.

17.6 Signs of concussion are: dizziness, blurred vision, headaches and nausea.

17.7 If a child or member of staff loses consciousness or you suspect a skull fracture he/she must be referred to hospital and parents/ next of kin notified immediately.

17.8 Any child or member of staff, who has sustained a head injury at school, needs to be reported to the Head, who will inform parents or next of kin if deemed necessary. An online accident report form needs to be filled in. This will generate an automatic email to parents and as it is a head injury will automatically inform the Head and Operations Manager.

## 18 When to Call an Ambulance

18.1 In addition to serious head injuries (i.e. fractured skull/loss of consciousness from head injury) and loss of consciousness generally, an ambulance should be considered in the following instances:

- Any suspected fracture;
- Severe allergic reactions and always if an epi pen has been used;
- Asthma attacks where breathing is severely compromised;
- Epileptic seizures;
- Open wounds requiring substantial suturing;
- If there is any doubt as to the patient's safety.
- Cardiac Arrest

## 19 Lists Medical Conditions of Children

19.1 All available details concerning medical conditions of children are available to access via the school management system. These details are updated as information is received. All such amendments should be made via the School Office, the information will then be forwarded to all relevant staff.

## 20 Asthma Class List and Quick Reference Allergy Lists

20.1 Children who have asthma/allergies are recorded on the appropriate list, a copy of which can be found on iSAMS. Complete lists are also on view in the Staff Room, School Office, given to the Caterers and PE staff, and in the medical room. These lists are updated as information is received (mainly reflecting new expiring dates of asthma medication and epi-pens). The asthma/allergy list also includes children who use epi-pens.

## 21 Automated External Defibrillator. AED.

The School has purchased and installed an Automated External Defibrillator under the Department for Education Scheme AED Guide for Schools - June 2017.

An AED is a machine used to give an electric shock when a person is in cardiac arrest.

Modern AEDs are simple to operate and safe for users. The AED will analyse the individual's heart rhythm and apply a shock to restart it, or advise that CPR should be continued. Voice and/or visual prompts will guide the rescuer through the entire process from when the

device is first switched on or opened. These include positioning and attaching the pads, when to start or restart CPR and whether or not a shock is advised.

The machine was purchased through the NHS supply chain and is a Mediana HeartOn A15.

It is situated on the 2nd Floor in the Staff Room and all staff are aware of its location.

It also has a Resuscitation Pocket Mask and preparation kit attached.

**Training**

Those members of staff who hold a current 3 day First Aid at Work qualification are trained in AED use as is the Operations Manager.

As per the advice given in the AED Guide for Schools June 2017 a demonstration video has been circulated to all staff along with an optional e-learning course.

Further and ongoing training will be given in First Aid courses and INSET days.

**Maintenance**

The Machine requires very little maintenance however a weekly check that the AED is in a serviceable condition should be carried out and recorded.

A full maintenance check and replacement of consumable accessories should be carried out after using the machine for a medical incident

**Reviewed by:** Robert Starkings (Operations Manager) **Date**: Sept 2023

**Approved by: Magoo Giles (Principal)**

**Signed**: **Date**: Sept 20223

Approved by: Aatif Hassan

**Signed:** **Date:** Sept 2023

**Appendix A**

# FIRST AIDERS

| Name | Qualification | Expiry date | Extension |
|---|---|---|---|
| Shona Colaco | 3 day at work FAW Level 3 | 14.9.2022 | 0151 |
| Grace Kemp | 3 day at work FAW Level 3 | 4.10.2022 | 0003 |
| Francesca Hall | 3 day at work FAW Level 3 | 4.10.2022 | 0051 |

| | | | |
|---|---|---|---|
| James Gibson | 3 day at work FAW Level 3 | 4.10.2022 | 0852 |
| Amy Warren | Paediatric First Aid | 6.9.2023 | 0002 |
| Kate Finlay | Paediatric First Aid | 6.9.2023 | 0004 |
| Jack Knight | Paediatric First Aid | 6.9.2023 | 0203 |
| Conor Zambuni | Paediatric First Aid | 6.9.2023 | 0203 |
| Andrew Hall | Paediatric First Aid | 6.9.2023 | 0203 |
| Gillian Conlon | Paediatric First Aid | 5.9.2024 | 0819 |
| Teresa Cuenca | Paediatric First Aid | 5.9.2024 | 0009 |
| Sophie Pace | Paediatric First Aid | 5.9.2024 | 0852 |
| Emma Gerard-Pearse | Paediatric First Aid | 5.9.2024 | 0852 |
| Mark Barnes | Paediatric First Aid | 5.9.2024 | 0852 |
| Ana Hajazi | Paediatric First Aid | 5.9.2024 | 0819 |
| Sarah Palangafkan | Paediatric First Aid | 5.9.2024 | 0004 |

## First Aid, Medication and Medical Treatment Policy
## Appendix B – Dealing with Asthma

Almost three million people in the UK have asthma and at least one in 10 children are diagnosed as having asthma in the UK. Each year 2000 people die from asthma in the UK. It is thought that the majority of these deaths are preventable. Due to this fact it is essential that we as teachers understand the causes that lead to an attack and how to deal with an attack when it happens. Most children are able to lead a normal life by managing their asthma and being aware of situations which could lead to an asthma attack. However, Heads and teachers need to be fully informed and able to cope with this potentially fatal disease.

It is important that each teacher can respond positively to these questions:
a) Do you know which, if any, children have asthma in the classes which you teach?
b) Are you aware of the situations that can lead to an asthma attack?
c) Would you know what to do if this happened in one of your lessons?

*Causes of Asthma*
Asthma causes narrowing of the airways, the bronchi, in the lungs, making it difficult to breath. An asthma attack is the sudden narrowing of the bronchi. Symptoms include attacks of breathlessness and coughing and tightness in the chest, which can exacerbate the difficulty in breathing. People with asthma have airways which are almost continuously inflamed (red and sore) and are therefore very sensitive to a variety of common stimuli. It is not an infectious, nervous or psychological condition, although stress may sometimes lead to symptoms.

A child's inflamed airways are quick to react to certain triggers (irritants) that do not affect other children without asthma. The things that trigger asthma vary from child to child. The known triggers include:
- viral infections (common cold)
- allergies, e.g. grass pollen, animals (hamsters, rabbits, cats, birds, etc.)
- exercise
- cold weather or strong winds
- excitement or prolonged laughing
- sudden changes in temperature
- numerous fumes such as glue, paint and tobacco smoke

*Effects on Child*
- Breathlessness during exercise
- Coughing during which wheezing or whistling is heard coming from the child
- General difficulty in breathing
- Tightening of the chest
- Anxiety of the child.

*When an Asthmatic joins the class*
- Ask parents about child's asthma and current treatment.
- All children should have easy access to medication.
- If necessary, discreetly remind child to take medication.

*Sport and the Asthmatic Child*

Exercise is a common trigger for an asthma attack but this should not be the reason for children not to participate in PE or Games. As far as possible, children should be encouraged to participate fully in all sporting events. Swimming is to be encouraged. Prolonged spells of exercise are more likely than short spells to induce asthma attacks. Teachers of PE should be particularly aware of children with asthma when working outside on cold, dry days or when there are strong winds.

Asthmatic children are commonly allergic to grass pollen so this should be considered, especially during the summer months. Teachers should beware of competitive situations when children with asthma may over exert themselves. Exercise triggered asthma will be helped if the teacher ensures that the child uses his/her inhaler before exercise begins and keeps it with them during the lesson. No child should be forced to continue games if they say they are too wheezy to continue.

*Technology*

Teachers should be particularly aware of asthma sufferers during activities producing dust and fumes, e.g. paint, glue and varnish.

*Medication*

There are two types of treatments:

Preventers - these medicines are taken daily to make the airways less sensitive to the triggers. Generally preventers come in brown and sometimes white containers.
Relievers - these medicines are bronchodilators which quickly open up the narrowed airways and help the child's breathing. Generally relievers come in blue containers.

**Trade Name**
**General Name**
**A**
**B**

| |
|---|

Preventers
Intal
sodium cromoglycate
*

| |
|---|

Becotide
beclomethasone
*

| |
|---|

Pulmicort

Budesonide
*

Relievers - Bronchodilators
Atraovent
ipratropium
bromide
*

Bricanyl
Terbutaline
*
*

Ventolin
Salbutamol
*
*

Longer Acting Relievers
Nuelin
Theophylline

*

Phyllocontin
Aminophylline

*

Serevent
Salmeterol
*

Key:
A - Aerosol, puffer of dry-powder inhaler
B - Tablet and/or syrup

**How you can help during an attack**
Children with asthma learn from their past experience of attacks; they usually know just what to do and should carry the correct emergency treatment. Because asthma varies from child to child, it is impossible to give rules that suit everyone.

However, the following guidelines may be helpful:
1. Ensure that the reliever medicine (such as Attrovent, Bricanyl or Ventolyn) is taken promptly and properly.
This will be in aerosol, puffer or dry powder inhaler form. A reliever inhaler (usually blue) should quickly open up narrowed air passages: try to make sure it is inhaled correctly. Preventer medicine (such as Intel, Becotide or Pulmicort) is of no use during an attack; it should be used only if the child is due to take it.

2. Stay calm and reassure the child.
Attacks can be frightening, so stay calm and do things quietly and efficiently. Listen carefully to what the child is saying and what he or she wants: the child has probably been through it before. Try tactfully to take the child's mind off the attack. It is very comforting to have a hand to hold but don't put your arm around the child's shoulder as this is very restrictive.

3. Help the child to breathe.
In an attack people tend to take quick and shallow breaths, so encourage the child to breathe slowly and deeply. Most people with asthma find it easier to sit fairly upright or leaning forwards slightly. They may want to rest their hands on their knees to support the chest. Leaning forwards on a cushion can be restful, but make sure that the child's stomach is not squashed up into the chest. Lying flat on the back is not recommended.

In addition to these three steps loosen tight clothing around the neck and offer the child a drink of warm water because the mouth becomes very dry with rapid breathing.

**Call a doctor urgently if:**
- *The child is either distressed or unable to talk.*
- *The child is getting exhausted.*
- *You have any doubts at all about the child's condition.*

**If a doctor is unobtainable call an ambulance.**

*After the attack*

Minor attacks should not interrupt a child's concentration and involvement in school activities. As soon as the attack is over, encourage the child to continue with normal school activities.

*How teachers can help*

- Ensure all asthmatic children take any necessary treatment before sport or activities.
- Ensure relievers are readily available for use by asthmatic children when required.
- Check with child, parent, school nurse, that correct treatments and instructions are supplied for school outings.
- Be aware that materials brought into the classroom may trigger a child's asthma, and additional treatment may be necessary.
- Make a point of speaking to parents of children needing to use their inhaler for relief more often than usual.
- Act as an educator to children with asthma and their peers.
- Know what to do in an emergency.

*Do's and Don'ts in Acute Asthma*

- *Don't panic.*
- *Do be aware of procedure to follow if the child does not improve after medication.*
- *Don't lie the child down - keep her/him upright.*
- *Don't open a window - cold air might make the condition worse.*
- *Don't crowd the child - give space - not cuddles.*
- *Do give reliever medication - bronchodilators.*
- *Don't give inhaled steroids (e.g. Becotide, Pulmicort).*
- *Do reassure the child.*
- *Do reassure the other children and keep them away.*

*What to do in an emergency*

1. Keep calm.
2. Allow child space to breathe (no sudden change in temperature).
3. Use reliever inhaler.
4. If no improvement after 5 minutes repeat inhaler giving a high dose. Dial 999 or take to hospital (two adults required).
5. Ask someone to warn the hospital you are on the way.
6. Demand immediate attention on arrival at hospital.

SEEK MEDICAL HELP URGENTLY IF:

1. the reliever (medication) has no effect after five to ten minutes;
2. the child is either distressed or unable to talk;
3. the child is getting exhausted;
4. you have any doubts at all about the child's condition.

CALL THE PARENTS AND AN AMBULANCE

Minor attacks should not interrupt a child's concentration or involvement in School. When the attack is over encourage them to continue with their lessons/activities. This information has been taken from the National Asthma Campaign booklet "Asthma at School".

*Further information*

The National Asthma Campaign publishes a useful booklet entitled “Asthma at School: a teachers guide.” Available from:
National Asthma Campaign,
Providence House, Providence Place, London, N1 ONT
Admin: 020 722 622 260 Helpline: 0345 00203
Further information from Asthma Training Centre: 01789 296944 and
BAALPE 01395 263247

**First Aid, Medication and Medical Treatment Policy**
**Appendix C – Dealing with Epilepsy**

Types of seizure:

Major fit ('grand mal' or 'convulsion'). This type of fit can be very frightening when seen for the first time. The child may make a strange cry, (a physical effect that does not indicate fear of pain), and fall suddenly. Muscles first stiffen and then relax, and jerking or convulsive movements begin which can be quite vigorous.

Saliva may appear round the mouth, occasionally blood-flecked, if tongue or cheeks have been bitten. The child may pass water.

This type of fit may last several minutes, after which the child will recover consciousness. He/she may be dazed or confused – a feeling that can last from a few minutes to several hours – and may want to sleep or rest quietly after the attack. Although alarming to the onlooker this type of fit is not harmful to the child and is not a medical emergency unless one fit follows another and consciousness is not regained. Should this happen, medical aid should be sought without delay. This condition is known as status epilepticus.

Minor fit ('absence' or 'petit mal'). This type of seizure may easily pass unnoticed by parents or teachers. The child may appear merely to daydream or stare blankly. There may be frequent blinking of the eyes, but otherwise none of the outward signs associated with a major seizure. Though brief, these periods of clouded consciousness can be frequent. They can lead to a serious learning problem if not recognised and treated, because the child is totally unaware of his surroundings and receives neither visual nor aural messages during a seizure.

Psychomotor fit ('complex partial' or 'temporal lobe') This occurs when only part of the brain is affected by the excessive energy discharge. There may be involuntary movements such as twitching, plucking at clothes or lip smacking. The child appears to be conscious may be unable to speak or respond.

'Sub-clinical seizures'. These are often not recognised because, as the name suggests, they cannot be seen. They may be indicated if a child's attainment level drops significantly, or the standard of oral or written work is below expectations for no accountable reason. Where sub-clinical seizures are suspected, the matter should immediately be brought to the attention of the Head.

Calm observation of any seizure may well provide vital information for the doctors, who rarely see the child having a seizure. Co-operation between teachers, parents and the family doctor/paediatrician can prevent a child with epilepsy from becoming a handicapped adult.

***Classroom First Aid***

The reaction and competence of the teacher is the most important factor in any classroom acceptance of a seizure. In a minor fit, understanding and a matter-of-fact approach are really all that are needed. A teacher should be aware of the possibility of mockery when the fit has passed and deal with it, if it arises, according to the age group concerned. If the child has a major seizure, classmates will respond to the calm behaviour of the teacher. Ensure that the child is out of harm's way, but move him/her only if there is danger from sharp or hot objects, or electrical appliances.

Observe these simple rules and LET THE FIT RUN ITS COURSE.

- Cushion the head with something soft (a folded jacket would do but DO NOT try to restrain convulsive movements).
- DO NOT try to put anything at all between the teeth.
- DO NOT give anything to drink.
- Loosen tight clothing around the neck, remembering that this might frighten a semi-conscious child and should be done with care.
- DO call an ambulance or doctor if you suspect status epilepticus.
- As soon as possible, turn the child to the side in the semi-prone position to aid breathing and general recovery. Wipe away saliva from around the mouth.
- If possible stay with the child to offer reassurance during the confused period which often follows this form of seizure.

**First Aid, Medication and Medical Treatment Policy**
**Appendix D – Dealing with Diabetes**

You MUST know if you are teaching a diabetic child. All diabetic children should be registered with the School Medical Service and the school office kept up to date with details of where parents can be contacted in an emergency, also telephone numbers of the Child's Doctor, Hospital etc.

The child should always be carry glucose or sugar in his or her pocket and may need to eat in class or before PE and games lessons. It is very important that diabetics eat meals at regular times and are allowed to eat small snacks at other times when they need extra food. The only major problem the diabetic child is likely to have in school will be an INSULIN REACTION (Hypoglycaemia). Some of the first signs may consist of confusion, poor work, poor handwriting. If any of these are noticed – sugar in any form is the correct treatment (sugar, sweets, sugary drinks). If reaction has not developed too far the child will return to normal, but SHOULD NEVER BE SENT OUT OF THE ROOM WITHOUT SUPERVISION.

Insulin reactions do not occur very frequently. They are usually brought on by more exercise than usual, delay in getting meals or inadequate meals or excessive Insulin dosage. If a reaction occurs at school – Parents should be advised by telephone and in writing.

If the child has developed an Insulin reaction or is unwilling to swallow sugar, this should be considered an EMERGENCY - AND THE CHILD TAKEN TO HOSPITAL. Every effort should be mad to contact the parents as soon as possible.

**Symptoms of hypoglycaemic reaction;**
Trembling, numbness

Late symptoms – sweating, tingling of the mouth and fingers, poor orientation, weakness, loss of memory, drowsiness, blurring of vision, unconsciousness, headache, abnormal gait, convulsions, abnormal behaviour.

NOTE:
The child may be wearing a Medic-Alert of Necklet which would identify the condition, if the teacher has not already been made aware of the child's Diabetic condition.

## Health & Safety Annex 4 – First Aid, Medication and Medical Treatment Policy
## Appendix E – Dealing with Severe Allergies requiring Epi-Pens

**Epi-Pen Policy and Procedures**

If a child has an allergy that is so severe that anaphylactic shock is possible then they should have been prescribed Epi-Pen Auto Injectors. These are available in different doses so they are child specific.

There should be 2 x Epi-pens for the individual child which should accompany the child at all times.
They should be with the form teacher or other supervising adult.

These adults should be trained in the use of an Auto Injector as well as the signs and symptoms of anaphylaxis and should also be aware of the related First Aid procedures i.e. Basic Life Support, Unconsciousness management, calling an ambulance, and incident reporting etc.

We should request these Auto Injectors from the Parent / Guardian and gain written consent for their use by trained staff. The written consent should state the same instructions those printed on the Auto Injectors

The Form teacher should be responsible for ensuring that the Epi-pens accompany the child and safe storage within the classroom. The storage location should not be a locked place. The form teacher should also be aware that they have a shelf life and should be kept in date.

It is recommended that where a child requires an Epi-pen then the form teacher and teaching assistant should be Epi-pen trained. In addition other teaching, administration and senior staff should also be trained in Auto Injector use and be aware of those children who are at risk of anaphylaxis.

Where a member of staff is at risk of anaphylaxis they should be responsible for carrying their own pair of Epi-pens but should be included on the School Allergy List and other members of staff should be aware of the risk.

Where possible individuals with Auto Injectors should be encouraged to self-administer but staff should go ahead with the treatment if needed.

## First Aid, Medication and Medical Treatment Policy
## Appendix F – Dealing with Wounds and Bleeding

Remember: NEVER perform any First Aid Procedures that you have not been adequately trained to do. The following is an aide-memoire only. The aims of First Aid for bleeding and wounds are to:

- Stop bleeding as quickly as possible, because severe loss of blood could be serious and lead to death.
- Prevent infection, by keeping germs out.

Treatment:

- Place the casualty in a lying position, preferably with legs raised.
- Elevate injured part, unless a fracture is suspected, and loosen tight clothing.
- Expose wound, removing as little clothing as possible.
- Control bleeding by pressing sides of wound firmly together or by applying direct pressure to the part that is bleeding, over a clean dressing preferably, a clean towel, handkerchief or any other item of clean linen.
- Apply sterile dressing into the depth of the wound until it projects above the wound, cover with padding and bandage firmly.
- If foreign bodies are present in the wound, or bone is projected, cover the wound with a sterile dressing and apply enough pads round the wound to enable bandage to be applied in a diagonal manner, avoiding pressure on projecting foreign body or bone.
- If bleeding continues through dressing, put another dressing over the previous dressing and bandage it firmly. Never remove dressings that are already in place – this disturbs the blood clot and can easily make bleeding worse.
- At all times reassure the patient and keep him/her relaxed and lying as still as possible; any unnecessary movement will tend to make bleeding more severe.
- Keep casualty warm with blankets.
- Except in cases of only slight injuries with small loss of blood, get the casualty as comfortably and quickly as possible.

WARNING

Stab wounds and puncture wounds can cause injury and infection deep inside the body, even though the skin wound is only small. Therefore such wounds should be regarded as serious and the casualty sent to hospital.

## Appendix G – Dealing with Burns and Scalds

- Cool immediately. If limb or extremity is affected, immerse in cold water or place under a gently running tap, until pain is reduced.
- Remove burnt clothing only if absolutely necessary and after cooling has begun. Stuck clothing should be left alone.
- Do not break blisters; keep immersed in cold water if still painful.
- Remove anything of a constricted nature – e.g. rings, bangles, belts, boots – before swelling starts.
- Cover the burn with a large sterile dressing. If no dressing is available, use the cleanest non-fluffy covering available. Dressing should cover an area bigger than the burn. If necessary use several dressings.
- If burn is larger than the palm of the hand, send casualty to a hospital as quickly as possible.

WARNING

DO NOT apply lotion, antiseptics or anything greasy to burns.
DO NOT use hairy or fluffy materials to cover a burn.

In the case of electrical burns, do not touch the casualty until you are certain that the electricity is switched off.

**First Aid, Medication and Medical Treatment Policy**
**Appendix H – Mental Health**

The most important role school staff play is to familiarise themselves with the risk factors and warning signs outline below and if staff have concerns about a pupil they speak to a member of the safeguarding team or a member of the school counselling service Place2Be

Procedure following a concern - ALGEE

Ask, Assess,Act

Where a child or young person is distressed, a member of staff should ask them what help they need and want. Assess the risk of harm to self or others and try to reduce any risk that is present

Listen non – judgementally

Give them time to talk and gain their confidence to take the issue to someone who could help further

Give reassurance and information

Tell them how brave they have been. Gently explain that you would like to help them. Do not promise confidentiality – it could be a safeguarding matter

Enable the child or young person to get help

Work through the avenues of supports. Explain that you would like to share their thoughts with someone else so that they can get the best help. Encourage them to speak to our school counsellor and offer to go with

Encourage self-help strategies

All staff have a duty of care towards children and should respond accordingly when first aid situations occurs. Records must be kept of all incidents, first aid treatment and support given.

School staff may experience a range of feelings in response to dealing with mental health issues in particular were it involves self-harm in a child. The can range anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to child it is important to try and maintain a supportive and open attitude – a child who has chosen to discuss their concerns with a member of school staff is showing a considerable amount of courage and trust. If you find this difficult please seek

immediate help from a member of the safeguarding team or the school counselling service Place2Be

**Identifiable mental health issues:-**

- Anxiety and Depression
- Eating disorders
- Self Harm

**Signs and symptoms of mental or emotional concern :-**

**<u>Anxiety disorders</u>**

Anxiety is a natural, normal feeling we all experience from time to time. It can vary in severity from mild uneasiness through to a terrifying panic attack. It can vary in how long it lasts, from a few moments to many years.

All children and young people get anxious at times; this is a normal part of their development as they grow up and develop their 'survival skills' so they can face challenges in the wider world. In addition, we all have different levels of stress we can cope with - some people are just naturally more anxious than others, and are quicker to get stressed or worried.

Concerns are raised when anxiety is getting in the way of a child's day to day life, slowing down their development, or having a significant effect on their schooling or relationships. It is estimated that 1 in 6 people will suffer from General Anxiety Disorder at some point in their lives.

Anxiety disorders include:

- Generalised anxiety disorder (GAD)
- Panic disorder and agoraphobia
- Acute stress disorder (ASD)
- Separation anxiety
- Post-traumatic stress disorder
- Obsessive-compulsive disorder (OCD)
- Phobic disorders (including social phobia)

Symptoms of an anxiety disorder

These can include:

Physical effects

- Palpitations, chest pain, rapid, heartbeat, flushing
- Hyperventilation, shortness of breath
- Dizziness, headache, sweating, tingling and numbness
- Choking, dry mouth, nausea, vomiting, diarrhoea
- Muscle aches and pains, restlessness, tremor and shaking

Psychological effects

- Unrealistic and/or excessive fear and worry (about past or future events)
- Mind racing or going blank
- Decreased concentration and memory
- Difficulty making decisions
- Irritability, impatience, anger
- Confusion
- Restlessness or feeling on edge, nervousness
- Tiredness, sleep disturbances, vivid dreams
- Unwanted unpleasant repetitive thoughts

Behavioural effects

- Avoidance of situations
- Repetitive compulsive behaviour e.g. excessive checking
- Distress in social situations
- Urges to escape situations that cause discomfort (phobic behaviour)

***How to help a child/adult having a panic attack***

If you are at all unsure whether the child/adult is having a panic attack, a heart attack or an asthma attack, and/or the person is in distress, call an ambulance straight away.

If you are sure that the child/adult is having a panic attack, move them to a quiet safe place if possible.

Help to calm the child/adult by encouraging slow, relaxed breathing in unison with your own. Encourage them to breathe in and hold for 3 seconds and then breathe out for 3 seconds.

Be a good listener, without judging.

Explain to the child/adult that they are experiencing a panic attack and not something life threatening such as a heart attack.

Explain that the attack will soon stop and that they will recover fully.

Assure the child/adult that someone will stay with them and keep them safe until the attack stops.

Many young people with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression and long periods of depression can provide symptoms of anxiety. Many young people have a mixture of symptoms of anxiety and depression as a result.

***Depression***

A clinical depression is one that lasts for at least 2 weeks, affects behaviour and has physical, emotional and cognitive effects. It interferes with the ability to study, work and have satisfying relationships. Depression is a common but serious illness and can be recurrent. In England if affects at least 5% of teenagers, although some estimates are higher. Rates of depression are higher in girls than in boys.

Depression in young people often occurs with other mental disorders, and recognition and diagnosis of the disorder may be more difficult in children because the way symptoms are expressed varies with the developmental age of the individual. In addition to this, stigma associated with mental illness may obscure diagnosis.

***Risk Factors***

Experiencing other mental or emotional problems
Divorce of parents
Perceived poor achievement at school
Bullying
Developing a long term physical illness
Death of someone close
Break up of a relationship

Some people will develop depression in a distressing situation, whereas others in the same situation will not.

***Symptoms***

Effects on emotion: sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness

Effects on thinking: frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death or suicide

Effects on behaviour: crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation. Engaging in risk taking behaviours such as self harm, misuse of alcohol and other substances, risk-taking sexual behaviour.

Physical effects: chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, unexplained aches and pains.

**Eating Disorders**

***Definition of Eating Disorders***

Anyone can get an eating disorder regardless of their age, gender or cultural background. People with eating disorders are preoccupied with food and/or their weight and body shape, and are usually highly dissatisfied with their appearance. The majority of eating disorders involve low self-esteem, shame, secrecy and denial.
Anorexia nervosa and bulimia nervosa are the major eating disorders. People with anorexia live at a low body weight, beyond the point of slimness and in an endless pursuit of thinness by restricting what they eat and sometimes compulsively over-exercising. In contrast, people with bulimia have intense cravings for food, secretively overeat and then purge to prevent weight gain (by vomiting or use of laxatives, for example).

## *Risk Factors*

The following risk factors, particularly in combination, may make a young person more vulnerable to developing an eating disorder:

## *Individual Factors*

- Difficulty expressing feelings and emotions
- A tendency to comply with other's demands
- Very high expectations of achievement

## *Family Factors*

- A home environment where food, eating, weight or appearance have a disproportionate significance
- An over-protective or over-controlling home environment
- Poor parental relationships and arguments
- Neglect or physical, sexual or emotional abuse
- Overly high family expectations of achievement

## *Social Factors*

- Being bullied, teased or ridiculed due to weight or appearance

- Pressure to maintain a high level of fitness/low body weight for e.g. sport or dancing

## *Warning Signs*

School staff may become aware of warning signs which indicate a child is experiencing difficulties that may lead to an eating disorder. These warning signs should **always** be taken seriously and staff observing any of these warning signs should seek further advice from Safeguarding team or the school counselling service Place2Be.

## *Physical Signs*

- Weight loss
- Dizziness, tiredness, fainting
- Feeling Cold
- Hair becomes dull or lifeless
- Swollen cheeks
- Callused knuckles
- Tension headaches
- Sore throats / mouth ulcers
- Tooth decay

## *Behavioural Signs*

- Restricted eating
- Skipping meals
- Scheduling activities during lunch
- Strange behaviour around food
- Wearing baggy clothes
- Wearing several layers of clothing
- Excessive chewing of gum/drinking of water
- Increased conscientiousness
- Increasing isolation / loss of friends
- Believes she is fat when she is not
- Secretive behaviour
- Visits the toilet immediately after meals
- Excessive exercise

## *Psychological Signs*

- Preoccupation with food
- Sensitivity about eating
- Denial of hunger despite lack of food
- Feeling distressed or guilty after eating
- Self dislike
- Fear of gaining weight
- Moodiness

- Excessive perfectionism

**Management of eating disorders in school**

## *Exercise and activity – PE and games*

Taking part in sports, games and activities is an essential part of school life for all pupils. Excessive exercise, however, can be a behavioural sign of an eating disorder The school will not discriminate against pupils with an eating disorder and will enable them whenever appropriate, to be involved in sports. Advice will be taken from medical professionals, however, and the amount and type of exercise will be closely monitored.

## *When a pupil is falling behind in lessons*

If a pupil is missing a lot of time at school or is always tired because their eating disorder is disturbing their sleep at night, the class teacher or head of EYFS/Junior or Seniors will initially talk to the parents/carers to work out how to prevent their child from falling behind. If applicable, the DSL consult with the professional treating the child.

## *Children Undergoing Treatment for/ Recovering from Eating Disorders*

The decision about how, or if, to proceed with childrens schooling while they are suffering from an eating disorder should be made on a case by case basis.
The reintegration of a child into school following a period of absence should be handled sensitively and carefully and again, the children, their parents, school staff and members of the multi-disciplinary team treating the child should be consulted during both the planning and reintegration phase.

## *Further Considerations*

Any meetings with child, their parents or their peers regarding eating disorders should be recorded in writing including:

- Dates and times
- An action plan
- Concerns raised
- Details of anyone else who has been informed

This information should be stored in DSL.

**Self Harm**

## *Introduction*

Recent research indicates that up to one in ten young people in the UK engage in self-harming behaviours. Girls are thought to be more likely to self-harm than boys. School staff can play an important role in preventing self-harm and also in supporting students, peers and parents of students currently engaging in self-harm.

## *Definition of Self- Harm*

Self-harm is any behaviour where the intent is to deliberately cause harm to one's own body for example:

- Cutting, scratching, scraping or picking skin
- Swallowing inedible objects
- Taking an overdose of prescription or non-prescription drugs
- Swallowing hazardous materials or substances
- Burning or scalding
- Hair-pulling
- Banging or hitting the head or other parts of the body
- Scouring or scrubbing the body excessively

## *Risk Factors*

The following risk factors, particularly in combination, may make a young person particularly vulnerable to self-harm:

**Individual Factors:**

- Depression/anxiety
- Poor communication skills
- Low self-esteem
- Poor problem-solving skills
- Hopelessness
- Impulsivity
- Drug or alcohol abuse

## *Family Factors*

- Unreasonable expectations
- Neglect or physical, sexual or emotional abuse
- Poor parental relationships and arguments
- Depression, self-harm or suicide in the family

## *Social Factors*

- Difficulty in making relationships/loneliness
- Being bullied or rejected by peers

## *Warning Signs*

School staff may become aware of warning signs which indicate a child is experiencing difficulties that may lead to thoughts of self-harm or suicide. These warning signs should **always** be taken seriously and staff observing any of these warning signs should seek further advice from the Safeguarding team or the school counselling service Place2Be Possible warning signs include:

- Changes in eating/sleeping habits (e.g. child may appear overly tired if not sleeping well)
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood e.g. more aggressive or introverted than usual
- Lowering of academic achievement
- Talking or joking about self-harm or suicide
- Abusing drugs or alcohol
- Expressing feelings of failure, uselessness or loss of hope
- Changes in clothing e.g. always wearing long sleeves, even in very warm weather
- Unwillingness to participate in certain sports activities e.g. swimming

## *Staff Roles in working with children who self- harm*

Any member of staff who is aware of a child engaging in or suspected to be at risk of engaging in self-harm should seek further advice from the Safeguarding team or the school counselling service Place2Be
Following the report, the Safeguarding team or the school counselling service Place2Be should :-

- Arranging professional assistance
- Arranging an appointment with a counsellor
- Immediately removing the child from lessons if their remaining in class is likely tocause further distress to themselves or their peers
- In the case of an acutely distressed child, the immediate safety of the child is paramount and an adult should remain with the child at all times
- If a child has self- harmed in school a first aider should be called for immediate help

It is important to encourage children to let staff know if one of their group is in trouble, upset or showing signs of self-harming. Friends can worry about betraying confidences so they need to know that self-harm can be very dangerous and that by seeking help and advice for a friend they are taking responsible action and being a good friend. They should also be aware that their friend will be treated in a caring and supportive manner. The peer group of a young person who self-harms may value the opportunity to talk to a member of staff either individually or in a small group. Any member of staff wishing for further advice on this should seek further advice from the Safeguarding team or the school counselling service Place2Be. When a young person is self-harming it is important to be vigilant in case close contacts with the individual are also self-harming.

**– Extract Public Health England re infectious conditions**

**1. Rashes and skin infections**

Children with rashes should be considered infectious and assessed by their doctor.

**Infection or complaint**
**Recommended period to be kept away from school, nursery or childminders**
**Comments**

Athlete's foot
None
Athlete's foot is not a serious condition.
Treatment is recommended

Chickenpox
Until all vesicles have crusted over
*See: Vulnerable Children and Female Staff – Pregnancy*

Cold sores,
(Herpes simplex)
None
Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting

German measles
(rubella)*
Four days from onset of rash (as per "Green Book")
Preventable by immunisation (MMR x2 doses). *See: Female Staff – Pregnancy*

Hand, foot and mouth
None
Contact your local HPT if a large number of children are affected. Exclusion may be considered in some circumstances

Impetigo
Until lesions are crusted and healed, or 48 hours after starting antibiotic treatment
Antibiotic treatment speeds healing and reduces the infectious period

Measles*
Four days from onset of rash
Preventable by vaccination (MMR x2). *See:*
*Vulnerable Children and Female Staff – Pregnancy*

Molluscum contagiosum
None
A self-limiting condition

Ringworm
Exclusion not usually required
Treatment is required

Roseola (infantum)
None
None

Scabies
Child can return after first treatment
Household and close contacts require treatment

Scarlet fever*
Child can return 24 hours after starting appropriate antibiotic treatment

Antibiotic treatment is recommended for the affected child

Slapped cheek/fifth disease. Parvovirus B19
None (once rash has developed)
*See: Vulnerable Children and Female Staff – Pregnancy*

Shingles
Exclude only if rash is weeping and cannot be covered
Can cause chickenpox in those who are not immune, ie have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact your local PHE centre. *See: Vulnerable Children and Female Staff – Pregnancy*

Warts and verrucae
None
Verrucae should be covered in swimming pools, gymnasiums and changing rooms

## 2. Diarrhoea and vomiting illness

**Infection or complaint**
**Recommended period to be kept away from school, nursery or childminders**
**Comments**

Diarrhoea and/or vomiting
48 hours from last episode of diarrhoea or vomiting

*E. coli* O157 VTEC Typhoid* [and paratyphoid*] (enteric fever)
Shigella
(dysentery)
Should be excluded for 48 hours from the last episode of diarrhoea. Further exclusion may be required for some children until they are no longer excreting
Further exclusion is required for children aged five years or younger and those who have difficulty in adhering to hygiene practices. Children in these categories should be excluded until there is evidence of
microbiological clearance. This guidance may also apply to some contacts who may also require microbiological clearance. Please consult your local PHE centre for further advice

Cryptosporidiosis
Exclude for 48 hours from the last episode of diarrhoea
Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

## 3. Respiratory infections

**Infection or complaint**
**Recommended period to be kept away from school, nursery or childminders**
**Comments**

Flu (influenza)
Until recovered

*See: Vulnerable Children*

Tuberculosis*
Always consult your local PHE centre
Requires prolonged close contact for spread

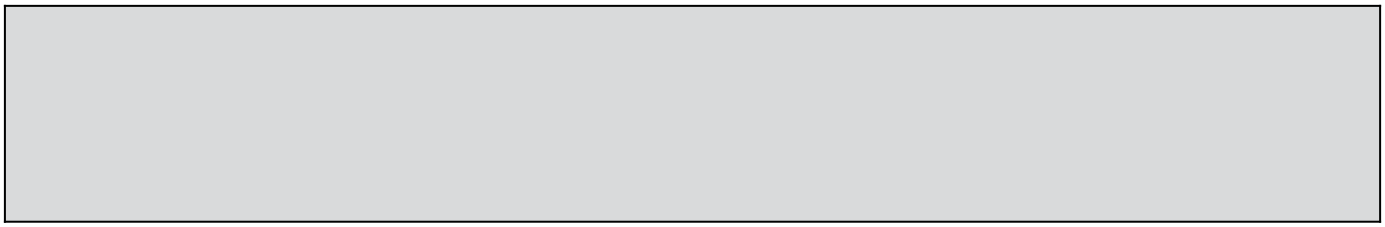
Whooping cough*
(pertussis)
Five days from starting antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment
Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks.
Your local PHE centre will organise any contact tracing necessary

## 4. Other infections

**Infection or complaint**
**Recommended period to be kept away from school, nursery or child minders**
**Comments**

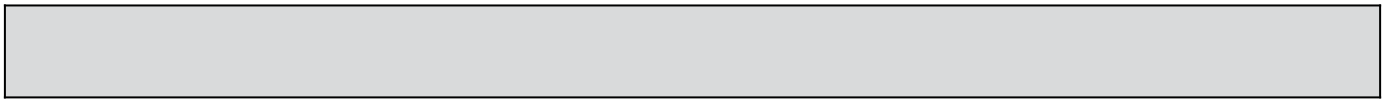
Conjunctivitis
None
If an outbreak/cluster occurs, consult your local PHE centre

Diphtheria *
Exclusion is essential. Always consult with your local HPT
Family contacts must be excluded until cleared to return by your local PHE centre. Preventable by vaccination. Your local PHE centre will organise any contact tracing necessary



Glandular fever
None

Head lice
None
Treatment is recommended only in cases where live lice have been seen

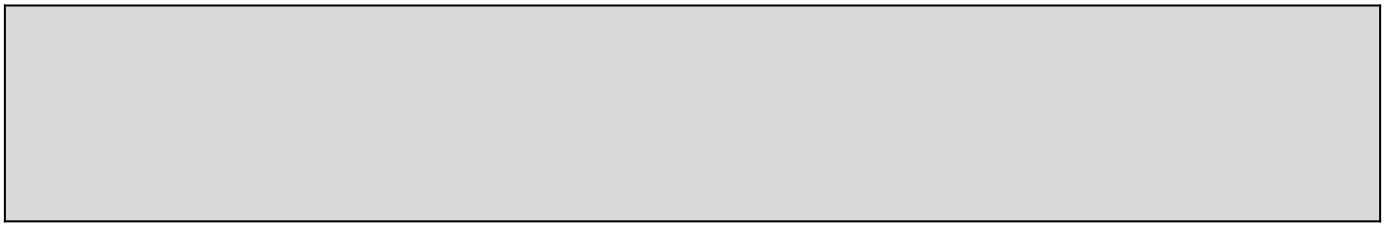


Hepatitis A*
Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)
In an outbreak of hepatitis A, your local PHE centre will advise on control measures

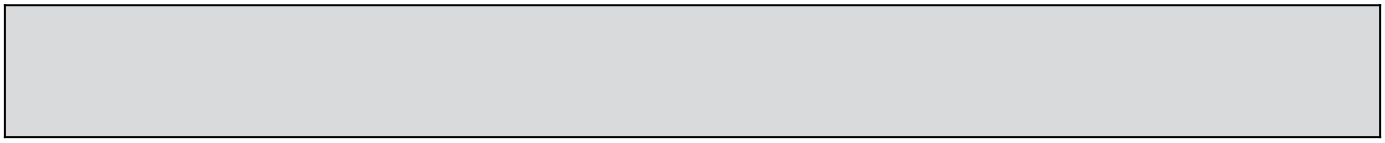
Hepatitis B*, C*, HIV/AIDS
None
Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills s*ee: Good Hygiene Practice*

Meningococcal meningitis*/ septicaemia*
Until recovered
Meningitis C is preventable by vaccination There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close school contacts. Your local PHE centre will advise on any action is needed

Meningitis* due to other bacteria
Until recovered
Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. Your local PHE centre will give advice on any action needed

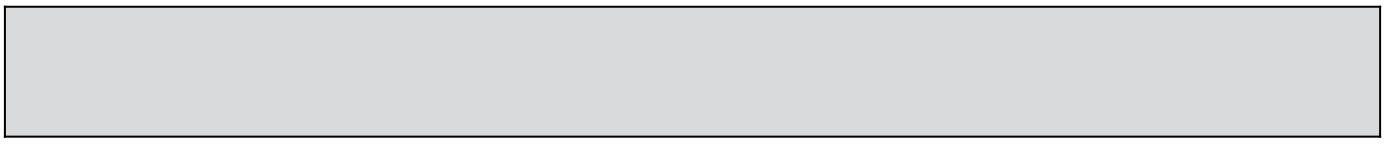


Meningitis viral*
None
Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required



MRSA
None
Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact your local PHE centre

Mumps*
Exclude child for five days after onset of swelling
Preventable by vaccination (MMR x2 doses)



Threadworms
None

Treatment is recommended for the child and household contacts

Tonsillitis
None
There are many causes, but most cases are due to viruses and do not need an antibiotic

* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control). In addition, organisations may be required via locally agreed arrangements to inform their local PHE centre. Regulating bodies (for example, Office for Standards in Education (OFSTED)/Commission for Social Care Inspection (CSCI)) may wish to be informed – please refer to local policy.